United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

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I. Background

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

Restraints

- Areas of progress included:
  - Trained Restraint Monitors were arriving on site within the first 15 minutes in most cases, conducting face-to-face reviews of the restraint, and a debriefing was being conducted to capture details about what happened before the restraint and what might have been done differently.
  - The medical restraint ordering and documentation process appeared to be improving with the increased use of Medical Restraint Plans. The State Office policy on restraint had been revised and appeared to address some of the issues with the medical restraint process. However, the Monitors were not ready to comment officially on the revisions until they have had more time to review them.
  - The process for Quality Assurance (QA) monitoring of restraints was focused and appeared to be useful in self-assessing progress toward compliance with some of the Settlement Agreement requirements.
  - The Restraint Reduction Committee continued to meet to review and analyze systemic trends, and to review when restraint was used more than three times in a rolling 30-day period.

- Some areas that needed improvement included:
  - The curriculum for Restraint Monitors had not 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, and did not make it clear that when a Restraint Monitor needed to assist with the restraint, that another Restraint Monitor should be summoned to take on that role. There was an Action Plan in place to make this revision.
  - Corrective action plans needed to be developed, particularly where there were systemic or cross-disciplinary issues related to restraint use.
  - While progress had been made in capturing good descriptions of what was going on before the behaviors that caused restraints, more work was needed. One question to ask in addition to what was going on before the behavior that caused the restraint is what was supposed to be going on. Such a question could help to surface issues with gaps in the activity and engagement levels that might contribute to behaviors that result in restraints.

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

- Progress was noted in a number of areas. Highlights of progress included:
  - The injury audit process was well underway.
  - A log of recommendations and concerns from investigation reports had been established to track concerns to completion and to verify with a Program Compliance Monitor (PCM) quality check.
  - Some of the issues with extracting data from the system seemed to have been resolved, though there was still room for progress. The new Data Analyst should prove helpful in moving forward.
  - There was some additional analysis of trend reports, which should help to identify where corrective action plans might be needed. However, to make this process complete and useful, more work will be needed to assure that analysis includes comparisons of the trended data across the several databases. For example, it can be useful to compare data on injuries, peer-to-peer aggression, unusual incidents, abuse/neglect allegations, and restraints to see whether some individuals are experiencing high numbers within each category, or whether some homes are experiencing high numbers within each category as a method for identifying where corrective action might be productively directed.
  - The injury audit process was well underway, including review of trends identified in the audit process. The Facility's plans to supplement that process with a review of the general trend data on injuries to determine if there are any patterns or numbers of injuries for some individuals that should be investigated was underway and to determine the cause and to institute action to reduce injuries to those individuals, particularly when injuries were caused by peer-to-peer altercations.
- Some of the areas in which improvements were necessary for the Facility to progress towards full compliance with the Settlement Agreement included:

- When it is clear in an investigation that staff did not report abuse, neglect, and exploitation (A/N/E), recommendations in the Department of Family and Protective Services (DFPS) report and the Unusual Incident Report (UIR) need to address that failure to report.
- It will be important to continue to work complete all recommendations timely, and monitor results to assure that the actions achieved the desired results.
- Trend data needs to be analyzed across incident and allegation data to determine if individuals or homes are in need of additional supports. Corrective Action Plans need to be developed when that analysis indicates supports are needed.

Quality Assurance

- Since the Monitoring Team's last visit, the Facility had made progress with regard to Section E:
  - At the last visit, it appeared that the Quality Assurance (QA) system had matured to a point where many Settlement Agreement section leads were commenting on monitoring and Corrective Action Plan (CAP) development in their section presentations. This time all sections were taking responsibility for quality and were including comments, indicating that quality improvement had become an integral part of the work of each discipline.
  - The QA Plan had been revised to separate the QA Plan and the QA policy, creating a more defined process for monitoring quality.
  - Work had continued on the QA Plan matrix to include measurement through the use of key indicators as well as the Quality Monitoring Tools. Work on key indicators was proceeding with careful thought and consideration, and it was good the Facility was delaying the collection of data until the set of indicators was clearly in place.
  - The data inventory had progressed to include a column for the source of each entry and to create a searchable field allowing searches by source of data.
  - A matrix for the monitoring tools had been added to track tools in use as they were revised.
  - The number of CAPs increased from 21 to 43 at the time of the site visit, and nearly all 20 sections of the Settlement Agreement had at least one CAP in place.
  - The process for regularly reviewing progress on CAPs at Quality Assurance/Quality Improvement (QA/QI) Council meetings was in place and being followed.
  - A CAP audit process had replaced the Section E monitoring tool, which had not proven useful in determining substantial compliance. While the CAP audit tool needed further development, it was already proving more useful than the old tool in determining compliance at least with regard to CAPs.
- Some of the areas that will need to continue to improve for the Facility to progress towards substantial compliance with the Settlement Agreement included the need for the Facility to:
  - Develop and refine the draft Data Matrix to define how the key indicators will be measured as well as to set goals for the progress identified through the key indicators as well as the Quality Monitoring tools.

- Improve the CAP tracking sheet by including additional detail on when steps were completed and the date the CAP was considered complete.
- Add descriptors of the desired outcome of each CAP and the baseline from which that outcome was being measured.

Integrated Protections, Services, Treatments and Supports

- As noted in the last report, 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 Individual Support Plan (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. This model seemed to provide some advantages, such as the ability to provide more concentrated training and supervision to the different types of QIDPs, and to utilize staff's skills and interests better. However, staff will need to guard against the weaknesses of the system, such as the need for Home QIDPs to share their knowledge of the day-to-day events that impact annual planning for individuals with the Facilitator QIDPs, who generally do not know the individuals as well.
- 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.
- Although timeliness had improved, the quality of the assessments prepared for the annual ISP meetings continued to be problematic.
- 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 continued to become more measurable, 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).
- Since the last review, a group of QIDPs had met with the goal of improving the monthly review process. Based on review of the minutes of these meetings, the group raised a number of important questions and worked to identify practical solutions. A focus was placed on improving the quality of the monthly reviews, and making them efficient to produce and usable to all team members. In the weeks prior to the Monitoring Team's onsite review, a new monthly review template was implemented.

Integrated Clinical Services

- For Section G, the Facility tracked attendance at a number of interdisciplinary meetings. Attendance at the morning medical meeting was tracked, as well as other meetings, such as Infection Control, Restraint Reduction, Medication Variance, and Pharmacy and Therapeutics (P&T) Committee meetings. However, holding these committee meetings did not result in integrated care, particularly when the percentage of participation and representation of departments was low.
- The morning medical meeting business was tracked by thorough minutes. However, several areas needed to be tracked to ensure integrated clinical services, such as Individual Support Plan Addendum (ISPA) development. The Facility had not successfully developed post-hospital ISPAs in a timely manner, and with content sufficient to address prevention of recurrence and prevention of repeat hospitalization to the extent possible. Other concerns needing closure were assigned, but not tracked to closure.
- Primary care providers (PCPs) and interdisciplinary teams' (IDTs) follow-up to consultant recommendations needed tracking.

Minimum Common Elements of Clinical Care

- For Section H, the completion and timeliness of departmental assessments for ISP development were tracked for all clinical departments. For the Medical Department, the annual medical assessment timely completion rate had improved, but was still not attaining a 90 percent threshold. The quarterly medical reviews also were progressing in timely completion. Dental annual assessments were completed in a timely manner.
- Numerous audit tools were developed to determine whether or not appropriate evaluations were taking place (e.g., tests ordered at a certain frequency based on a diagnosis). National standards often were used as clinical guidelines to ensure the PCPs were ordering the correct test at the correct time. However, there was less monitoring to determine the outcome of health rather than simply the PCP ordering tests. The Facility should have data that allows assessment of the degree of health by individual and by diagnosis. Additionally, once test results are available or once an exam is completed with abnormal findings, the Facility should use a monitoring tool to determine adequacy and timeliness of the PCP response to the abnormal findings.
- A remaining challenge for the Medical Department was ensuring all appropriate diagnoses were aggressively evaluated and treated.

At-Risk Individuals

- Since the last review, the Facility had spent considerable time reviewing and refining the Facility's At-Risk policy and Change of Status process, and had identified a number of areas that were in need of training. At the time of the review, Facility staff indicated that the operationalized At-Risk policy had been completed and the Facility's Policy Committee approved it. In addition, the Facility had reviewed and defined the Change of Status process and integrated this information into the Facility's At-Risk Policy.
- Also, the Facility had developed a very promising comprehensive ISP Observation monitoring tool that had been implemented at the time of the review. In January 2014, the Facility began observations of the ISP meetings and

reviewed the Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs). In the next six months, the Facility planned to begin to review the data collected and implement follow-up interventions in response to the findings. In addition, a Lead Qualified Intellectual Disability Professional (QIDP) Facilitator was identified to coordinate and facilitate training and mentoring of the QIDP Facilitators.

- Since the last review, the Facility had invested much effort in reviewing the processes and systems regarding the At-Risk system at ABSSLC. However, there continued to be significant problematic issues regarding the quality of the documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events and health issues. Consequently, at the time of the review, the Facility's efforts had not yet translated into any consistent measurable progress in the documentation reviewed.
- Regarding the IHCPs, the nursing protocols that were found in the IHCPs were implemented only in the event of an acute issue related to the high/medium health-risk indicator. At this juncture of the compliance review process, it was very troubling that no nursing protocols were included in the IHCPs reviewed that required nursing to conduct regular nursing assessments for high and medium health risks that the individuals were already experiencing, and which warranted the elevated risk ratings from the IDTs. Consequently, the IHCPs reviewed only reflected the long-standing inadequate reactive care systems at ABSSLC.
- In addition, although nursing interventions are crucial components of the IHCPs, other disciplines involved in the individuals' care also need to include specific interventions addressing the high and medium risk indicators as required by an "integrated" health care plan. 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.

<u>Psychiatric Care and Services</u>

- Deficits in the documentation and implementation of chemical restraint caused concerns in the past. During the prior six months, no episodes of chemical restraint were documented, potentially due to improved psychiatric and behavioral interventions. Historically, the rates of chemical restraint had varied considerably and, thus, random variation might also have played a role in this finding.
- It appeared that the Dental team, working in conjunction with the Psychiatry and Behavioral Health Services Departments made significant progress by developing effective strategies primarily based on common sense and a thorough knowledge of the individual's likes and dislikes. However, there had not been any progress in developing strategies to reduce the need for pretreatment sedation for medical procedures and appointments.
- With regard to the provision of direct psychiatric care and the documentation of those services, evidence for this could be found in the Psychiatric Quarterly Reviews, the Comprehensive Psychiatric Evaluations (CPEs), the Psychiatric Treatment Plans (PTPs), and the ISP documentation. The Facility's internal data indicated that, over the past six months, the psychiatric providers had attended 99 percent of the ISPs for the individuals they

served. The current review found that the Quarterly Reviews were being performed as specified, and that the CPEs/PTPs were up-to-date. The most recent ISP documentation also had improved considerably.

- The Polypharmacy Committee appeared to be working well, and the rate of active polypharmacy where the efficacy of each prescribed medication had yet to be proven continued to be in the range of five to six percent.
- For the Monitoring Team's two previous reviews, the Facility was in substantial compliance with regard to the MOSES/DISCUS side effect monitoring with solid ratings around 95 percent. Shortly after the Monitoring Team's last review, problems with the implementation of the electronic medical records dropped the completion and timely review rates to the 60 percent range, but Facility staff appeared to have mastered the system because the completion rates were currently approaching the previously high levels.
- The risk-benefit discussions were both rigorous and comprehensive, and were present in all of the records reviewed. However, the ISP documentation was still deficient for many individuals. Signed consents for psychotropic medication were in all of the records reviewed.
- Finally, it is worth noting that the Psychiatry Department's internal QA process appeared to be assisting them in their efforts to continuously improve the quality of their work.

<u>Psychological Care and Services</u>

- The Facility had completed a great amount of work towards meeting the requirements outlined in Section K of the Settlement Agreement. Staff in the Behavioral Health Services Department had continued to work on obtaining certification. Supervision by Board Certified Behavior Analysts (BCBA) had increased. Peer review had been extended to include weekly meetings of the Internal Peer Review Committee. This allowed for a review of particularly difficult cases and provided a mechanism for reviewing progress on new positive behavior support plans (PBSPs) following initial implementation. Hopefully, this review process will allow for timely identification of difficulties and needed program revision. Observation of meetings of the Behavior Support Committee and the Internal Peer Review Committee revealed good participation and robust discussion.
- The format used when developing Positive Behavior Support Plans continued to evolve. With all new plans noting whether the individual had a Crisis Intervention Plan (CIP), staff were alerted to review another document as needed. Staff training also was addressed in this new format. A three-tiered staff training program involved competency assessed through verbal report, role-play, and on-the-job performance. Behavior Health Specialists, Behavior Health Assistants, and Behavior Coaches provided training. It was particularly positive to observe the flexibility in scheduling of behavior coaches to ensure training across all shifts. Weekly meetings with direct support professionals in all of the homes had also been initiated.
- Behavioral Health Services staff also had begun conducting regular assessment of data accuracy, data integrity, and treatment integrity. The frequency of these measures was determined at peer review meetings and was specified in the PBSP.
- To move towards substantial compliance, the focus should be on the following areas: continued emphasis on ongoing review of challenging cases with assessment of the benefits of the revised process for external peer

review; continued work on data collection systems to ensure that reported measures of behavioral events are accurate and reliable; completion of assessments that provide information on current structural and functional variables that contribute to problem behavior; development of PBSPs that emphasize training on functionally equivalent replacement behavior, comprehensive preventative strategies, and adequate schedules of reinforcement that utilize individually identified preferences; and continued emphasis on staff training on PBSP implementation, particularly as evidenced while working directly with the individual.

Medical Care

- The Medical Department had made significant gains towards achieving compliance. Based on the findings from the Facility's quality assurance processes, a number of templates were created to assist the PCPs in identifying all contributing factors toward the development of acute respiratory distress. In many instances, this resulted in a more aggressive and complete work-up of respiratory distress. Critical decision-making for respiratory distress and other acute care issues was evident at the morning medical meeting, although not consistent across all discussions.
- A new template for the quarterly medical reviews had made this document more practical and valuable to the practitioner. Completion rates were tracked and had shown significant improvement over the past four months.
- A number of monitoring tools had been created to meet the health care needs of the individual. These were separate from the external and internal medical peer review audits, which continued to occur. The timeliness of closure to action plans from the peer review audits had initially been problematic, but more recent corrective actions had been completed in a more timely manner.
- Open record reviews were done routinely for those recently hospitalized. Although more work was needed, the internal Medical Department quality improvement process had shown improvement.
- The morning medical meeting continued to struggle with efficiency in getting all significant clinical areas reviewed and addressed. The minutes, although thorough, needed to be abbreviated yet retain the important clinical points that had been documented.
- Improved tracking for several areas was needed. For example, timeliness of post-hospital ISPAs, content of post-hospital ISPAs, and closure of other concerns needing additional information at the morning medical meeting required improvement and tracking.
- A remaining challenge for the Medical Department was ensuring all appropriate diagnoses were aggressively evaluated and treated. As illustrated in the Monitoring Team's review of a sample of at-risk individuals, at times, medical assessments and follow-through to ensure needed treatment was provided was lacking.
- Another significant concern was the use of Do Not Resuscitate (DNR) Orders at the Facility. At the time of the review, 28 individuals had DNR Orders in place. Sixteen listed no medical justification. For other individuals, the clinical justifications required State Office's review or a second opinion to ensure the State Office guidelines were followed in determining a terminal condition. At times, Ethics Committee reviews of these DNRs showed approval even without the necessary terminal diagnosis. Of further concern, in 2014 the Facility and/or State

Office policy reduced the choice(s) offered to guardians/families concerning treatment options. Previously, an individual was ordered to be full code but without chest compressions due to severe osteoporosis that would result in flail chest, or due to abnormal anatomic location of the heart in which chest compression would not be effective. However, intravenous (IV) medication, intubation, bagging, and oxygen were permitted. The Facility policy no longer allowed for such options. The rationale for the new policy was not provided. However, families made the decision to institute the DNRs for 13 of the 28 individuals based on the change in policy.

Nursing Care

- Some of the Facility's positive steps forward included:
  - The Facility continued to create a stellar Presentation Book addressing the data and activities related to Infection Control. The Presentation Book included a significant amount of organized and detailed information regarding the Facility's infection control activities, but also demonstrated the increased depth of knowledge regarding infection control practices the Infection Control Nurses have gained since the review process was initiated.
  - An incident regarding the identification of a bed bug showcased the Facility's prompt action to implement the appropriate treatment and prevent an infestation. In response to this incident, the Facility developed an instruction sheet in the event this situation was to reoccur, and added education regarding bed bugs to the Infection Control new employee training and refresher classes.
  - In addition, since the last review, the Nurse Managers began collecting and reporting medication variances by unit during the monthly Medication Variance Committee meetings. This had enabled the Facility to promptly trend errors and implement interventions.
- Although the Facility had made some positive steps forward in the areas noted above, there continued to be a significant overall lack of progress found regarding the integrated health care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Nursing Assessments, and the actual implementation of nursing protocols. It was very troubling to find that nursing was still not implementing regular, proactive, and individualized nursing assessments for individuals who had clear histories of repeated hospitalizations, Infirmary admissions, multiple orders for treatments addressing their chronic health issues, and whose teams had assigned high and medium health risk ratings indicating the need for such interventions related to existing health conditions. There is no clinical justification for nurses or IDTs to wait for an individual to experience a change in his/her status to implement proactive and individualized nursing assessments in alignment with nursing protocols, especially when the individual has known health conditions.
- From discussions with ABSSLC's Nursing Leadership, a candid yet very alarming barrier was raised regarding the implementation of nursing protocols and the associated nursing assessments. The Chief Nurse Executive indicated that there was a concern amongst nursing staff regarding their ability to consistently implement regular nursing assessments in alignment with the nursing protocols for individuals that warranted these

assessments for existing health issues due to resources and staffing issues. Although these concerns were clearly articulated during this review, they might be relevant within other SSLC Nursing Departments and should be openly discussed with Facility Administration and the appropriate State Office staff for prompt remediation to ensure individuals are provided the clinical services that they require. Given the significant nursing resources currently available, discussions should include consideration of the realignment of responsibilities within the Nursing Department and/or for individuals with higher acuities, as identified through the at-risk system.

Pharmacy Services and Safe Medication Practices

- The Pharmacy resolved an important issue related to medication prescribing and dispensing, specifically the consistent documentation of allergies across various reports and forms. This will increase the safety of medications being prescribed. This area was added to the Quarterly Drug Regimen Reviews (QDRRs) as an ongoing clinical indicator. The QDRRs remained an important periodic review that continued to guide the PCPs. QDRRs remained timely. Adverse drug effect training was well documented, both as part of new employee training and as refresher courses for clinical staff.
- The new order process documentation appeared to need further review. The patient intervention reports were not always sufficiently complete. The accuracy of the Pharmacy's review of new orders in relation to review of significant laboratory findings or follow-up with lab findings needed further focus, as well as demonstration of the related impact on prescriber practice.
- Medical variances continued to occur and the Pharmacy will need to be aggressive in developing system approaches to ensure the Medical and Nursing Departments reduce medication variances. In addition, there should be continued focus on medication variances internal to the Pharmacy Department.

Physical and Nutritional Supports

- At the time of the Monitoring Team's review, the Physical and Nutritional Management Team (PNMT) had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. With a few exceptions, the necessary members attended the meeting consistently.
- 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 physical and nutritional Management (PNM) monitoring.
- The PNMT members were identifying systemic issues in meeting minutes, but documentation was missing to show resolution had occurred of these issues, or actions were underway. In addition, 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.
- At times, Interdisciplinary Teams (IDTs) were not referring individuals who met the PNMT referral criteria and/or their referrals were not timely. PNMT assessments did not include necessary elements. PNMT recommendations were not incorporated into individuals' IHCPs. In addition, PNMT meeting minute

documentation did not consistently include information about action steps and their completion. The plans of individuals who were discharged from the PNMT did not provide objective clinical data to justify the discharge and did not include criteria for referral back to the PNMT if it differed from criteria included in policy.

- Individuals' Physical and Nutritional Management Plan (PNMP) content continued to improve. However, some PNMPs were missing important elements. Annual ISP meeting and/or ISPA documentation did not reflect that individuals' PNMPs were reviewed to determine their effectiveness and changes made, as appropriate.
- Every dining plan had been revised to include color photographs of individuals' primary and/or secondary mealtime position as well as assistive equipment. Individuals at high risk for aspiration and/or choking were identified with a red dot on their dining plan. 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.
- The Facility continued to implement the Mealtime Management System. At the time of the review, over 500 staff had been trained in Eating, Mealtime Management, and Nutrition Services, as well as Mealtime Coordinator Training. In addition, the Facility had developed and implemented Snack Time Management training for new employees and veteran staff, and competency-based training for food service managers, cooks, and food service workers to ensure correct diet textures and consistency. The Facility also retooled the mealtime management system in the Cottages. The ongoing implementation of a Mealtime Management System was a significant positive initiative in enhancing a safe environment for individuals during mealtimes and snacks. Unfortunately, due to an influenza outbreak, the Monitoring Team was not able to observe meals during the week of the onsite review.

<u>Physical and Occupational Therapy</u>

- Review of the Facility-selected sample of three individuals' OT/PT assessments revealed that 14 of 20 applicable assessment elements being present in each of the assessments reviewed. A number of important elements were still missing from the assessments.
- Due to limited progress, the Monitoring Team conducted a streamlined review of most of Section P. However, the Facility's Provision Action Information, Presentation Book, and staff interviews indicated that two experienced PTs, who were former employees, began in January, 2014; competency-based training for PNMP coordinators and Habilitation Therapy Technicians had been completed; the Habilitation Therapies Director met with QA Director to implement a new database to show review of ISP documentation for adequate review of the PNMP, and auditing had begun of ISPs; competency-based training had been completed with Habilitation Therapy Technicians to conduct monthly wheelchair inspections, simple repairs, and document repairs; competency-based training had been provided to the PCPs regarding bedrail reduction; and effectiveness monitoring had begun of wheelchairs to develop a priority list for individuals without an adequate seating system and needing a comprehensive seating assessment. The action plans for these subsections included valuable action steps. If implemented, they should move the Facility towards substantial compliance.

Dental Services

- The Dental Department maintained the progress it had made with regard to several components of dental services. The annual exams were timely. Many areas of dental care were tracked. Desensitization had a number of success stories. The data related to routine dental care appeared thorough and accurate, and was analyzed at intervals, which led to revisions. Individuals with poor oral hygiene were identified, and discussions with the IDTs were reflected in the ISPAs, as well as the dental section of the IRRF.
- The Dental Department was mostly limited by lack of staff. There was currently only one dentist in the Department. The successful desensitization program required increased hours from dental staff, but an expansion of hours was not possible. The lapse of time from the annual dental exam to completion of the annual dental summary for the ISP remained excessive for some individuals. Training and monitoring needed to occur in the home setting for individuals with poor oral hygiene ratings, who were at risk as a result. Focus was needed particularly for individuals who were responsible for self-brushing, but had poor or worsening oral hygiene. In addition, the Dental Department needed to track and analyze the cause for dental extractions (e.g., new admissions, trauma, etc.) to assist in determining common causes for which preventive strategies should then be developed, as appropriate.

Communication

- The Facility had five full-time Speech Language Pathologists (SLPs) and one full-time Speech Language Assistant (SLA). There was one SLP vacancy.
- Due to limited progress, the Monitoring Team conducted a streamlined review of most of Section R. Review of the Facility-selected sample of three individuals' SLP/communication assessments revealed that 16 of 23 assessment elements were present in each of the assessments reviewed.
- The Facility's Provision Action Information, Presentation Book, and staff interviews indicated the Habilitation Therapy (HT) staff made the following progress: developed a schedule for SLP evaluations to be completed; continued to utilize the assessment audit tool to ensure assessments contained essential elements; the HT Director met with the QA Director to implement a new database tracking SLP assessments and PBSPs to determine collaboration between SLPs and Behavior Health Specialists (BHSs); and SLPs presented new training for the communication portion of New Employee Orientation (NEO) to Occupational Therapists (OTs) and Physical Therapists (PTs) for feedback, and began teaching the new training of the communication portion of NEO.

Habilitation, Training, Education, and Skill Acquisition Programs

- A review of documents, observation of an Individual Support Plan meeting, and discussions with staff revealed a continued limitation to habilitation planning and implementation. Too often skill acquisition programs (SAPs) were continued from one year to the next, opportunities for instruction were limited, problems with program implementation were not identified or addressed in a timely manner, and the individual's preferences and strengths were not adequately addressed. Assessments were not utilized to identify a range of skill needs for

the individual. ISPs were limited with regard to the number and scope of training objectives designed to help the individual grow and develop his/her skills and independence. Opportunities for instruction were severely limited and reinforcement for correct responding was not individualized. In addition, training in the community was extremely limited. Many of the concerns raised in past reports remain relevant.

Most Integrated Setting

- Assessments prepared for annual ISP meetings generally 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. However, teams often did not provide adequate justifications for their decisions, particularly when all or most 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.
- On a more positive note, since the Monitoring Team's last review, 12 individuals had transitioned to the community, and 26 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, as noted in the last few reports, the Transition Specialists were working 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. This individualized approach to education was important and it 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.
- It was clear that the Transition Specialists were exerting significant effort to identify providers that could support individuals with complex medical and physical and nutritional support needs, but these providers were few, and they had limited capacity to serve more individuals than they were currently serving. Similarly, supports for individuals with complex behavioral health needs also were limited.
- Since the last review, some limited improvement was noted with regard to the comprehensiveness of pre-move and post-move required supports. However, the CLDPs continued to be missing a number of important protections, services, and supports needed to transition safely and successfully to the community. Although ABSSLC staff were working hard to make improvements, it did not appear State Office was providing proper guidance or training to move the CLDP process forward.
- On a very positive note, based on interview as well as review of CLDPs and post-move documentation, for individuals with complex behavioral needs, some teams had begun including interaction between an ABSSLC

Behavioral Health Services staff person and the community provider direct support professionals to provide more hands-on training and modeling as a post-move required support in CLDPs. Similarly, some CLDPs specified that a Behavioral Health Services staff member would accompany the Post-Move Monitor on visits and/or have ongoing contact with the provider staff and community BCBA staff. These supports appeared to result in positive outcomes for a couple individuals. Facility staff indicated that similar initiatives had been started with Habilitation Therapies and nursing staff.

- The Facility did not provide a full list of the potentially negative outcomes that occurred after individuals transitioned to the community. However, based on the Monitoring Team's review of other documentation, a minimum of 19 had occurred, including a death, Emergency Room (ER) visits and hospitalizations, police contact, psychiatric hospitalizations, placement in nursing homes/rehabilitation facilities, and movement to other community providers. Based on a review of follow-up action, the Facility and community teams did not critically review all aspects of the CLDPs for these individuals or their implementation. As a result, the teams did not identify the missing supports, of which there were many, nor did the teams make the recommendations necessary to improve transition planning and implementation going forward.
- Post-move monitoring had been completed in a timely manner for individuals who had transitioned to the community. The Post-Move Monitor and Transition Specialists' comments generally provided a thorough description of the methods used to evaluate the item and the findings, and reviews were completed thoroughly. In addition, most often, 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. In one instance, where additional help likely should have been sought from the Local Authority and/or DADS State Office, it was not clear this had occurred.

<u>Consent</u>

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

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

- 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. On a more systemic level, since the last review, the Competency Training Department (CTD) had retrained supervisory staff on recordkeeping requirements. Supervisory staff were expected to play a role in overseeing recordkeeping practices, and intervening when they noted problems. The Unified Records Coordinators sent lists of staff that had been identified through record audits as failing to comply with recordkeeping guidelines, and CTD was scheduling competency-based training for them.
- The Facility had a working system for policy and procedure development and the completion of related training. The Policy Review Committee provided a reasonable mechanism to ensure that an interdisciplinary group was available to critically review policies and procedures. The Facility also had a system to make decisions about

training on policies and procedures. With the involvement of CTD, the Facility had a working system to track staff's completion of the related training.

- Although quality assurance efforts will necessarily have to continue to be modified based on audit findings and the Facility's priorities, ABSSLC had implemented the basic requirements of a quality assurance system for recordkeeping. This system included auditing of a random sample of at least five records monthly, analysis of the resulting data, and follow-up and development of corrective action plans, as necessary to address findings on an individual record as well as systemic level.
- In the Monitoring Team's last report, the Monitoring Team noted that 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. Since then, Facility staff engaged in efforts to identify and correct problems with the accuracy of the documentation. Training on recordkeeping practices was re-done for all direct support professional staff, the Records Department was looking more closely at the data collection issue in its audits, supervisors were responsible for developing and implementing plans of correction for issues identified, supervisors were conducting their own monitoring in a number of residences, and supervisors were providing on-the-spot training when problems were noted. Although these efforts were in the early stages, they appeared to be having a positive impact.

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 Restraint, dated April 2013; o Psychology Procedure: Reducing the Need for Repeated Restraint, dated 8/17/13; o Medical Restraint Plan form, dated 8/2013; o ABSSLC Self-Assessment, dated 4/28/14; o ABSSLC Action Plan, dated 4/28/14; o Presentation Book for Section C; o Psychologists Restraint Documentation Checklist, undated; o QA Reports for Restraint Use, October 2013, November 2013, January 2014, February 2014 and March 2014; o Medical Restraints 10/1/13 to 3/31/14; o Nursing Protocol: Pre-Treatment and Post-Sedation; o Nursing Protocol: Post Anesthesia Care; o ABSSLC Restraints Trend Analysis Reports for November 2013 to February 2014; o Restraint Reduction Committee Minutes, dated, 10/25/13, 11/7/13, 1/31/14, 2/27/14, and 3/27/14, and handouts from the 5/15/14 meeting; o Do Not Restrain/Modification of Restraint List, undated; o List of Restraint Monitors, dated May 2014; o Curriculum for Restraint Monitors, dated 5/31/12, but with more recent amendments noted; o ABSSLC Course Delinquency List for PMAB 4, RES0115, RES0110, and RES0105, undated; o List of individuals with Crisis Intervention Plans (CIPs), undated; o List of Restraint Monitors, dated May 2014; o **Sample #C.1**: Chosen from list individuals restrained as crisis intervention between 10/1/13 and 3/15/14 per II.7 of document request. The list included 124 incidents of crisis restraint. A sample of 19 (15%) of the restraint episodes was drawn. The restraint record included: • Restraint checklist form; • Face-to-face/debriefing form; • The individual's Crisis Intervention Plan, if applicable; • The Individual's Positive Behavior Support Plan; • Any and all reviews of this use of restraint; • Any addenda or changes to the ISP or Safety Plan that resulted; • Any injury reports related to the restraint, and • Related Integrated Progress Notes (IPNs).

Sample #	Name	Date and time
C1.1	Individual #199	1/4/14 at 4:29 p.m.
C1.2	Individual #199	1/4/14 at 11:57 a.m.
C1.3	Individual #199	1/4/14 at 11:57 a.m.
C1.4	Individual #318	11/13/13 at 1:21 p.m.
C1.5	Individual #318	1/11/14 at 2:55 p.m.
C1.6	Individual #379	10/27/13 at 6:19 p.m.
C1.7	Individual #379	10/27/13 at 7:29 p.m.
C.1.8	Individual #379	10/27/13 at 7:29 p.m.
C1.9	Individual #299	1/3/14 at 4:46 p.m.
C1.10	Individual #354	3/9/14 at 2:15 p.m.
C1.11	Individual #354	3/9/14 at 2:20 p.m.
C1.12	Individual #354	3/9/14 at 2:59 p.m.
C1.13	Individual #354	3/9/14 at 3.19 p.m.
C1.14	Individual #231	11/20/13 at 12:25 p.m.
C1.15	Individual #81	2/9/14 at 1:13 p.m.
C1.16	Individual #74	10/28/13 at 11:18 a.m.
C1.17	Individual #483	12/21/13 at 6:25 p.m.
C1.18	Individual #304	10/22/13 at 1:30 p.m.
C1.19	Individual #530	3/24/14 at 4:52 p.m.

Note: a reduced sample was used for some provisions as noted in this report. The reduced sample included #C1.1-C1.10.

- Nursing Restraint documentation from the Restraint Checklists for the following individuals:
  - Individual #199 on 1/4/14 at 11:57 a.m.;
  - Individual #318 on 11/13/13 at 1:21 p.m., and 1/11/14 at 2:55 p.m.;
  - Individual #379 on 10/27/13 at 6:19 p.m., and 10/27/13 at 7:29 p.m.;
  - Individual #299 on 1/3/14 at 4:46 p.m.;
  - Individual #354 on 3/9/14 at 2:15 p.m., and 3/9/14 at 2:59 p.m.;
  - Individual #231 on 11/20/13 at 12:25 p.m.;
  - Individual #8 on 2/9/14 at 1:13 p.m.; and
  - Individual #530 on 3/24/14 at 4:52 p.m.;
- **Subsample of three records from #C.1** for use in indicators C.4.e and f was drawn. The records included:
  - Annual Medical Summary Active Problems list;
  - The form used by the Facility to document restraint considerations/restrictions;

and

- ISPs/ISPAs indicating that restraint considerations that any member of the IDT identified had been addressed and documented.

Sample #	Name	Date and time
C1.1	Individual #199	1/4/14 at 4:29 p.m.
C1.10	Individual #354	3/9/14 at 2:15 p.m.
C1.19	Individual #530	3/24/14 at 4:52 p.m.

- **A subsample of five records from #C.1** for use in evaluating compliance with Section C.8 was drawn:

Sample #	Name	Date and time
C1.1	Individual #199	1/4/14 at 4:29 p.m.
C1.4	Individual #318	11/13/13 at 1:21 p.m.
C.1.8	Individual #379	10/27/13 at 7:29 p.m.
C1.12	Individual #354	3/9/14 at 2:59 p.m.
C1.16	Individual #74	10/28/13 at 11:18 a.m.

- **Sample #C.2:** The following documentation for a selected sample of 24 staff included:
  - Their start dates;
  - Their training transcripts showing dates of the two most recent:
    - PMAB training, and
    - Training on use of restraints.
- **Sample #C.3:** Chosen from the list provided in response to document request II.7b of 141 (188 less 47 uses of abdominal binder by the same individual) medical/dental restraint reports involving 80 individuals. The sample of 25% of the individuals (15% of the restraint episodes) was drawn and a total of 21 records. 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 #239	12/12/13 at 1:00 p.m.
C3.2	Individual #74	2/28/14 at 6:00 a.m.
C3.3	Individual #74	3/24/14 at 2:00 p.m.
C3.4	Individual #69	2/28/14 at 12:50 p.m.
C3.5	Individual #285	2/16/14 at 12:00 p.m.
C3.6	Individual #304	1/30/14 at 2:45 p.m.
C3.7	Individual #540	3/20/14 at 6:00 a.m.
C3.8	Individual #2	2/26/14 at 6:00 a.m.
C3.9	Individual #533	2/20/14 at 8:30 a.m.
C3.10	Individual #472	10/15/13 at 2:05 p.m.
C3.11	Individual #172	2/13/14 at 9:45 a.m.
C3.12	Individual #518	12/18/13 at 8:10 a.m.
C3.13	Individual #80	12/19/13 at 1:00 p.m.
C3.14	Individual #203	10/16/13 at 3:35 a.m.
C3.15	Individual #510	3/31/14 at 7:45 a.m.
C3.16	Individual #16	2/13/14 at 6:10 a.m.
C3.17	Individual #399	2/28/14 at 7:15 a.m.
C3.18	Individual #523	2/12/14 at 6:45 a.m.
C3.19	Individual #480	11/7/13 at 11:30 a.m.
C3.20	Individual #307	11/12/13 at 6:50 a.m.
C3.21	Individual #542	1/25/14 at 8:15 a.m.

Note: a reduced sample was used for some provisions. The reduced sample included sample #C3.1-C3.6.

- **Sample #C.4: Chemical Restraints for Crisis Intervention**: Chosen from the list provided in II.7a in response to the document request. The total number of chemical restraints for crisis intervention was three. The sample size was two or 67%. Both records were used for provisions with shortened monitoring. The two restraints in the sample are the same as in sample #C.1 above and included evidence of contact between the psychologist and physician prior to the use of the restraint.

Sample Identification #	Name	Date and Time
C.1.8	Individual #379	10/27/13 at 7:29 p.m.
C1.18	Individual #304	10/22/13 at 1:30 p.m.

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

Sample Identification #	Name	Off-grounds Restraint

C5.1	Individual #318	12/22/13 at 10:00 a.m.
C5.2	Individual #379	10/22/13 at 9:10 a.m.
C5.3	Individual #323	10/1/13 at 7:40 p.m.
C5.4	Individual #444	12/19/13 at 10:42 p.m.

- For Section C.4:
  - Historical Summary of Desensitization, from 10/10 to 4/10/14;
  - Monthly Desensitization Reports for Formal Plans, from 10/1/13 to 3/31/14;
  - Monthly Desensitization Reports for Dental/Home Strategies, from 10/1/13 to 3/31/14;
  - Dental Desensitization Assessment: Individual #118, Individual #451, Individual #126, Individual #488, Individual #305, Individual #307, Individual #422, Individual #29, Individual #158, Individual #308, Individual #217, Individual #432, Individual #120, Individual #127, Individual #318, Individual #330, Individual #240, Individual #18, Individual #255, Individual #241, Individual #40, Individual #191, Individual #430, Individual #439, Individual #67, Individual #35, Individual #169, Individual #513, Individual #233, and Individual #386;
  - ABSSLC Current Desensitization Plans and Strategies, dated 3/28/14;
  - Formal Dental Desensitization Plans: Individual #393, Individual #455, Individual #127, and Individual #363;
  - Dental Desensitization Strategy: Individual #65, Individual #422, Individual #239, Individual #49, and Individual #40;
  - Medical Restraint Plan for Medical: Individual #540, Individual #533, Individual #248, Individual #235, and Individual #400; and
  - Medical Restraint Plan for Dental: Individual #65, Individual #120, Individual #526, and Individual #527;
- **Sample #C.6:**
  - List of restraints, from 10/1/13 to 3/15/14, dated 4/7/14;
  - Crisis Restraint Checklist and Face-to-Face Assessment and Debriefing Form for the following restraints (the asterisk indicates restraints where this information was requested, but was not provided):

Individual	Date	Time(s)
Individual #199	1/2/14	5:15 a.m., 5:29 p.m.*
	1/3/14	7:09 p.m.
	1/4/14	11:57 a.m.*, 4:29 p.m.
	1/6/14	4:38 p.m.
Individual #318	10/25/13	10:45 a.m.
	10/30/13	1:22 p.m.
	11/13/13	1:21 p.m.
	11/16/13	2:34 p.m.

Individual #379	10/19/13	7:30 p.m., 9:00 p.m.*
	10/22/13	9:10 a.m.
	10/26/13	7:55 p.m.
	10/27/13	6:19 p.m., 7:29 p.m. (physical and chemical)

- Individual Support Plans for: Individual #199, Individual #318, and Individual #379;
- Psychological Evaluations/Updates for: Individual #30, Individual #202, and Individual #109;
- Functional Assessment for: Individual #379;
- Positive Behavior Support Plans for: Individual #199, Individual #318, and Individual #379;
- Individual Support Plan Addenda minutes for Individual #379, dated 10/22/13;
- Psychology Monthly Progress Notes for: Individual #199 (1/14 and 2/14), Individual #318 (10/13 and 11/13), and Individual #397 (8/13 to 10/13);
- Crisis Intervention Plan for: Individual #199, Individual #318, and Individual #379; and
- Protective Mechanical Restraint for Self-Injurious Behavior Plan for Individual #199;

- Meeting minutes of the Restraint Reduction Committee: 10/25/13, 11/7/13, 1/31/14, 2/27/14, and 3/27/14;
- **Sample #C.7: Protective Mechanical Restraints to Prevent Self-Injurious Behavior (PMR-SIB):** This sample was chosen from the list of Protective Restraints, dated 4/9/14 and submitted in response to Document Request 11.7.

Sample Identification #	Name	Date
C7.1	Individual #74	10/3/13
C7.2	Individual #199	1/31/14
C7.3	Individual #2	3/21/14

- **Interviews with**:
  - Linda Hinshaw, Facility Director;
  - Jolene Willis, Assistant Director of Programs;
  - David Daniel, Director for Quality Assurance;
  - Ron Manns, Chief Psychologist;
  - Rene Kellum Program Compliance Monitor;
  - Direct Support Professionals, on 5/12/14;
  - Kathy Theiss, BCBA, Clinical Director:

	○ Pam Acevedo, Registered Dental Hygienist; ○ Amy Jo Bramlett, LVN, Risk Coordinator; and ○ Mary White, RN, Chief Nurse Executive (CNE). ▪ **Observations of**: ○ Quality Assurance/Quality Improvement (QA/QI) Council Meeting, on 5/12/14; ○ Restraint Reduction Committee, on 5/5/14; ○ Unit IV Team Meeting, on 5/13/14; and ○ Incident Management Review Team (IMRT) meeting, on 5/13/14.
	Facility Self-Assessment: The ABSSLC State Supported Living Center Self-Assessment indicated the Facility was in substantial compliance with two of the 14 provisions in Section C of the Settlement Agreement, including Sections C.2 and C.3. The Monitoring Team found the Facility to be in substantial compliance with one of the 14 provisions, specifically, Section C.3. In its Self-Assessment, dated 4/28/14, 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, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, and interviews with staff: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled Psychologists Restraint Documentation Checklist. The Director of Behavioral Services, his staff, and the Quality Assurance Program Compliance Monitor used the same template to conduct reviews. These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. While the language in the monitoring tool was consistent with a number of the provisions of the Settlement Agreement, it did not cover all aspects of Section C, but instead, focused on reasons for restraint, attempts to avoid restraint, the process for administering the restraint, and restraints that occurred more than three times in 30 days. To be a useful process, the Facility needs to monitor measures that will determine compliance, such as those used in the various metrics in this report. ▪ The monitoring tools included some adequate methodologies, such as the review of documentation. Information from other sources was sometimes used, such as training records. ▪ 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. ▪ The monitoring/audit tool, included instructions/guidelines, which were generally adequate to ensure consistency in monitoring. The following staff/positions were responsible for completing the audit tools: The Program Compliance Monitors from the Quality Assurance Department worked collaboratively with Department staff to conduct the audits. Department staff positions were not identified in the documentation reviewed. ▪ For Section C, information was provided regarding inter-rater reliability. ▪ The Facility used some relevant data sources and was beginning to use some key indicators/outcome measures. For example, in addition to conducting audits, the Facility used data sources such as its training database. Preliminary work was underway to develop key indicators

	(performance indicators) as explained in more detail with regard to Section E of this report. ▪ The Facility consistently presented some of the data in a meaningful/useful way, but some concerns were noted. As examples of both, the Facility: o Generally presented findings consistently based on specific, measurable indicators rather than on overall composite scores. o Presented data in charts and tables across six months to allow for easy comparisons. o Included comments and examples to explain differences or irregularities in data. o The data included in the self-assessment was graphed and displayed in helpful ways. o Did not included reviews of quality as well as presence on items such as IMRT Reviews or Medical Restraint Plans. ▪ When the Facility data identified some areas in need of improvement, it provided 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. 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 11 action steps. Two steps were recorded as completed, seven 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 nine steps in these plans would bring the Facility into compliance with this section.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in substantial compliance with one out of 14 provisions of Section C, as opposed to no provisions that were in substantial compliance during the last review. Areas of progress included: Progress was noted in a number of areas. Highlights of progress included: ▪ Efforts to minimize the use of restraints as crisis interventions had succeeded in keeping use at a low level. ▪ Trained Restraint Monitors were arriving on site within the first 15 minutes in most cases, conducting face-to-face reviews of the restraint, and a debriefing was being conducted to capture details about what happened before the restraint and what might have been done differently. ▪ The medical restraint ordering and documentation process appeared to be improving with the increased use of Medical Restraint Plans. The State Office policy on restraint had been revised and appeared to address some of the issues with the medical restraint process. However, the Monitors were not ready to comment officially on the revisions until they have had more time to review them. ▪ The process for QA monitoring of restraints was focused and appeared to be useful in self-assessing progress toward compliance with some of the Settlement Agreement requirements. ▪ The Restraint Reduction Committee had continued to meet to review and analyze systemic trends, and to review when restraint was used more than three times in a rolling 30-day period. Some areas that needed improvement included:

	▪ The curriculum for Restraint Monitors had not 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, and did not make it clear that when a Restraint Monitor needed to assist with the restraint, that another Restraint Monitor should be summoned to take on that role. There was an Action Plan in place to make this revision. ▪ Corrective action plans needed to be developed, particularly where there were systemic or cross-disciplinary issues related to restraint use. ▪ While progress had been made in capturing good descriptions of what was going on before the behaviors that caused restraints, more work was needed. One question to ask in addition to what was going on before the behavior that caused the restraint is what was supposed to be going on. Such a question could help to surface issues with gaps in the activity and engagement levels that might contribute to behaviors that result in restraints.

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

<table>
<tr><th>Type of Restraint</th><th>4/1/13 to 9/30/13</th><th>10/1/13 to 3/31/14</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>115</td><td>103</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>10</td><td>3</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>94</td><td>17</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>219</td><td>123</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>35</td><td>27</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>19</td><td>16</td></tr>
<tr><td>Medical/dental restraints</td><td>132</td><td>97</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>75</td><td>65</td></tr>
<tr><td>TOTAL protective mechanical restraints for SIB</td><td>94</td><td>67</td></tr>
<tr><td>TOTAL individuals restrained per PMR/SIB</td><td>2</td><td>1</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Prone Restraint a. Based on Facility policy review, prone/supine restraint was prohibited. b. Based on review of other documentation (trend reports and lists of restraints) prone restraint was not identified. However, in Section D.3.i.4 of this report, an abuse investigation revealed the use of supine restraint. A reduced sample of Sample C.1 was used for review of this provision that included the first 10 of the restraints in the larger sample (Samples #C1.1 to #C1.10). c. Based on a review of the restraint records for individuals in Sample #C.1 involving five individuals, none (0%) showed use of prone restraint. d. The following was not rated during this site visit due to issues with influenza at the Facility: ▪ Based on questions with 10 direct support professionals, ____ were aware of the prohibition on prone restraint. Other Restraint Requirements 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 had been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for reduced Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms with the following results: ▪ f. In ten of the ten records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. ▪ g. For the ten restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that ten (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. ▪ h. In nine of the records (90%), 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. In sample #C1.9, it was not clear that the individual had been engaged for a full minute at least every ten minutes,	

#	Provision	Assessment of Status	Compliance
		since he was "waiting for dinner." Since the PBSP required engagement at least every ten minutes and it was not clear that was happening, staff apparently did not exhaust alternatives. ▪ i. Facility policies did not identify a full 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 last report, the Facility policy needs to include a list of mechanical restraints that may be used. The Facility was using wristlets, Kevlar vests, abdominal binders, and a lap belt, none of which were specified in its most recent policy, except in the checkboxes within the Restraint Checklist. Since a revised State Policy on restraints was issued in April 2014 and the Facility indicated they would be updating Facility policy to coincide, that might be a good time to include a list of approved restraints for the Facility. ▪ j. Based on the review of ten restraints, involving five individuals, all (100%) were approved restraints, according to the check boxes in the Restraint Checklist. k. In nine of these records (90%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. However, in Sample #C1.9, the individual was described as waiting for dinner, when his PBSP clearly stated that he should be engaged at all times and that there should be no more than 10 minutes without anything for him to do. l. Of the 67 restraints that the Facility considered to be PMR –SIB, the Monitoring Team reviewed three (Sample C.7). Of these, none (0%) followed State Office policy regarding the use, management, and review of PMR-SIB. ▪ Sample #C7.1: the nurse did not sign, indicating the condition of the restraint was acceptable, and circulation checks between 1:15 p.m. and 10:30 p.m. appeared to have been missed. ▪ Sample #C7.2: the individual's name did not appear on the Restraint Checklist; the Restraint Monitor and the Psychologist did not check and document the condition of the restraint; checks for circulation were not completed every 15 minutes; and releases for toileting and meals were not documented. ▪ Sample #C7.3: no physician's order was available, and no circulation checks were documented between noon and 7 p.m.	

#	Provision	Assessment of Status	Compliance
		As noted above, based on this limited review, the Facility remained in noncompliance.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the 19 individuals in Sample #C.1 were reviewed. Of these, four of the individuals had Crisis Intervention Plans that defined the use of restraint. Two of the restraints (#C1.8 and #C1.18) were chemical restraints and removed from the sample for this provision. Of the 17 restraint records, five (Sample #C1.4, C1.6, C1.10, C1.11, and C1.19) were eliminated from the following metrics because the restraints were released when staff could not maintain the restraint or when the individual was released prematurely due to his arm hurting. One (Sample #C1.15) was released due to medical distress. The following metrics were applied to the remaining 11 restraints. a. For five of these 11 restraints where individuals had CIPs, three (60%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. Those that did not included: ▪ Sample #C1.14, where the individual was released after 15 minutes when calm. There was no documentation to indicate she had been calm for the three minutes prior to release as required by the CIP. ▪ Sample #C1.16, where the restraint was a Kevlar vest and was released after seven minutes when the individual fell asleep. The CIP called for 55 minutes prior to release. b. For the six individuals who did not have CIPs, five (83%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. The one that did not was: • Sample #C1.17, where the individual was placed in a Kevlar shirt to prevent self-injury (biting). The restraint code on the Restraint Checklist indicated he was quiet, but attempting to bite himself when the restraint was applied. There was no attempt to release and no code entry after 15 minutes. He was released at 30 minutes, with the code entry of quiet. Based on this review, the Facility was not in compliance with this provision.	Noncompliance
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	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:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	▪ 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. For the 24 current staff in the sample, 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. This was not reviewed during this site visit due to influenza issues at the Facility. It should be noted that the responses were at 100% on the last visit. • Based on responses to questions, ____ direct support professionals answered the following questions correctly: o What policies govern the use of restraint; o Describe two verbal or redirection techniques; o Describe two approved restraint techniques; and o How would you supervise an individual in restraint? d. In 17 of 19 records (89%), 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 were sample #C1.9 (as described related to C1.h above), and #C1.14 where no boxes were checked on the Restraint Checklist and no further explanation was provided in the Face-to-face or Debriefing sheets. Based on this review the Facility was in substantial compliance, since staff had received the required training and only two of nineteen records lacked sufficient explanation of less restrictive measures that had been tried prior to restraint.	
C4	Commencing within six months of	a. Based on a review of 19 restraint records in the sample used for this review (Sample	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	#C.1), in 18 (95%) there was evidence that documented that restraint was used as a crisis intervention. The one that did not was Sample #C1.19 where it was not clear that anyone was in immediate danger. The individual was pulling things off shelves at the workshop, but it was not clear how those things posed a danger to him. In fact, in the debriefing, it was noted that monitoring from a safe distance could have been attempted. b. In a review of 19 PBSPs (16 for Section K.9 and three for Section C.7), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). The plan for Individual #199 did instruct staff to apply wristlet restraint and follow her Crisis Intervention Plan if she attempted to touch the wound on her head. This was a crisis situation, however, the plan should be revised when the wound is healed. 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 of 19 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the Facility. Based on a subsample of three records for this review (as identified in the Documents Reviewed list: subsample of Sample C.1): e. In two of three restraint records reviewed (67%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form used by the Facility to document restraint considerations/ restrictions. For one, Sample #C1.1, no medical problem list was provided. f. In two of three restraint records reviewed (67%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. For the third (Sample #C1.19, no ISP was provided.) The Facility provided copies of Dental Desensitization Assessments completed for 30 individuals. These reflected thoughtful work by two Registered Dental Hygienists. Some positive elements included the following: ▪ If the individual displayed behaviors that suggested he/she was possibly agitated or uncomfortable, the hygienist delayed her assessment to another time. Throughout, the described assessment activities the hygienists displayed a great deal of respect and consideration for the individual. ▪ If a strategy appeared to hold promise for improved involvement in oral hygiene, the hygienist occasionally returned to the individual's residence to further explore its effectiveness.	

#	Provision	Assessment of Status	Compliance
		▪ When sensitivity was observed, the hygienist recommended a consult from the Occupational Therapist as appropriate. ▪ When appropriate, the hygienist recommended a consult from the Behavioral Health Specialist. ▪ Strategies employed included using different toothbrushes, applying different flavored toothpastes, encouraging the individual to become familiar with the utensil by placing it on his/her hand, providing preferred objects for the individual to hold, or modeling appropriate brushing techniques. ▪ Recommendations were included in all of the assessments. As indicated by a master list the Facility provided, a total of 45 individuals had either a desensitization plan or strategy. The Monitoring Team was provided copies of nine of these plans/strategies. A summary of findings is provided below. ▪ A dental strategy had been developed for five of the individuals in the sample. As a result of staff observations or experiences, the individual's team developed these with the individual. o Individual #65 has been very resistant to any oral hygiene care and dental procedures. The Occupational Therapist recommended expanding his sensory diet to include joint compression to his jaw and mouth. The team also agreed to try small ear buds or earplugs to help dampen the sound of the vacuum toothbrush. o Individual #422 was to be reinforced with cheese and crackers upon successful completion of a dental cleaning. This reinforcer was reserved for the dental office only. o Individual #239 was to be reinforced with sugar free pudding for cooperating with dental and medical procedures. o Individual #49 was to be assigned female providers and he was to receive a foot massage during all dental procedures. o Individual #40 was noted to have tight cheek muscles that affected tooth brushing. He was to begin an oral motor program designed by the Occupational Therapist. He was also to utilize a chewy tube prior to tooth brushing. ▪ A formal desensitization program was designed for four individuals in the sample. Behavior Health Specialists designed these programs. o Individual #65 was to visit the dental office once per week to learn to tolerate tooth brushing. This was a shaping program designed to increase the length of time she tolerated this activity. Reinforcement for cooperative behavior was praise and the provision of a bead. o Individual #455 was to visit the 7th Street Dental Clinic twice weekly. This program began with his sitting in the lobby of the office and progressed through increasingly intrusive dental procedures. Successful	

#	Provision	Assessment of Status	Compliance
		completion of steps of the program was reinforced with praise, food, and items to hold. o Individual #127 was to visit the dental office once per week to tolerate increasingly longer periods of tooth brushing. The identified reinforcer was the flavored toothpaste. o Individual #363 was to visit the 7th Street Dental Clinic once per week. She was to learn to tolerate increasingly intrusive dental procedures. The identified reinforcer was praise. Behavioral Health Services staff should follow the lead of the dental hygienist when designing formal desensitization programs. Ms. Acevedo had taken the lead in completing assessments and introducing different strategies to help individuals improve their oral hygiene and tolerate dental procedures. She was a skilled observer and had designed some very creative plans to improve behavior. When problems with data collection are identified, behavioral staff should work with the dental staff to ensure ease and accuracy of documentation. Technical support (i.e., a laptop computer) would also be helpful, particularly at the 7th Street Dental Clinic. Behavioral staff also should incorporate identified preferences to help motivate the individual to participate in any dental program. It is suggested that praise alone or the use of flavored toothpaste might not be sufficient when introducing an activity that historically has been aversive to the individual. As of 10/1/13, the Facility had begun developing Medical Restraint Plans for identified individuals. Five plans for medical care/procedures and four plans for dental care/procedures were reviewed. A summary of findings is provided below. ▪ The plans began with an outline of preventive actions to avoid restraint. These included involvement of familiar and/or preferred staff; identification of the best time of day, if applicable; transportation needs; and other strategies including preferred providers and guidelines for effective communication. ▪ A rationale for the need for restraint and/or sedation was provided. This included a description of the observed behaviors during medical or dental care/procedures. ▪ The plans also provided criteria for release from restraint, instructions for direct support professionals, and required documentation. ▪ The last section outlined procedures to reduce the need for future restraint. These included continued training, informal counseling, and consideration for a desensitization plan. ▪ The Human Rights Officer had signed all of the plans. Five had been approved and four had been approved pending guardian consent. The Facility had put forth a good effort in addressing the use of restraint and/or sedation	

#	Provision	Assessment of Status	Compliance
		for medical and dental procedures. The dental staff, in particular, are commended for the work that had been accomplished in completing assessments and designing programs. As noted in the Facility's Self-Assessment, however, Individual Support Plans did not consistently include plans or strategies to address routine restraint required for medical and dental care. The initiative to develop desensitization plans and other strategies for medical procedures was less well developed than those for dental procedures, even though there were many more individuals who required pretreatment sedation for medical procedures. The Facility should expand the assessment of the need for, as well as the development of, Pretreatment Sedation Desensitization Plans for medical procedures in the near future. For this reason, the Facility remains out of compliance with this provision of the Settlement Agreement.	
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 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. At the last review, the review of Facility training documentation showed the Facility did not have 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. The modification to the curriculum needs to clarify this distinction and the new version of the curriculum needs to include the effective date of the modified version. At the time of this most recent review, no additional language was evident in the training curriculum, though it was clear in interview with the Director of Behavior Supports that restraint monitors were being cautioned not to monitor restraints in which they participated. b. This training was competency-based. c. Based on review of training records, five of the six staff at the Facility who performed the duties of a restraint monitor in the reduced sample (83%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. The one that was not was listed was the restraint monitor for Samples #C1.7 and C1.8. Based on a review of 10 restraint records (reduced Sample #C.1), a face-to-face assessment was conducted:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	▪ d. In eight out of ten incidents of restraint (80%) by an adequately trained staff member. Records that did not contain documentation of this included: Samples #C1.7 and C1.8, because the name of the Restraint Monitor on the Restraint Checklist and on the Face-to-Face form did not appear on the list of restraint monitors provided by the Facility. ▪ e. In ten out of ten instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. ▪ f. In ten instances (100%), the documentation showed that an assessment was completed of the application of the restraint. ▪ g. In ten instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint. 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 11 restraint records for eight individuals for restraints that occurred at the Facility (i.e., Individual #318, Individual #379, Individual #299, Individual #231, Individual #8, Individual #199, Individual #354, and Individual #530) (i.e., chemical and mechanical 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 10 (91%) of the instances of restraint. Records that did not contain documentation of this included: Individual #354 on 3/9/14 at 2:59 p.m. ▪ k. Monitored and documented vital signs in 11 (100%) episodes. ▪ l. Monitored and documented mental status in 11 (100%) episodes. Based on initial documentation the Facility provided, four restraints had occurred off the grounds of the Facility in the last six months. The Monitoring Team requested documentation for the four instances (Sample #C.5). However, in reviewing the documentation submitted, one restraint did not occur off-grounds, and although requested, no IPNs were submitted for any of the restraints in the sample. As a result, the following could not be completed: A licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the Facility in __ out of ___ (__%). ▪ n. Monitored and documented vital signs in ___ (___%). ▪ o. Monitored and documented mental status in ___ (___%).	

#	Provision	Assessment of Status	Compliance
		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 (#C3.1-#C3.6) was selected for this limited review. For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. A review of the procedures for medical restraints revealed that the physician or dentist was required to order restraints for medical or dental purposes. If the restraint was chemical, a nurse was to complete the monitoring following the nursing protocol. Since that was the accepted practice, the physician's order did not include a schedule or type of monitoring. If the medical restraint was mechanical or physical, the physician's ordered the restraint, and specified the type and schedule of monitoring. As of August 2013, a Medical Restraint Plan format was available that provided specifics on the use of restraint for medical purposes for the individual as well as ways to prevent use of restraint. The Medical Restraint Plan included directions for nurses and direct support professionals on the use of any restraint, and was approved by the IDT and the HRC. Based on this: ▪ p. In three out of six (50%) (i.e., #C3.1, #C.3.4, and #C.3.6), the physician specified the schedule of monitoring required or specified Facility policy regarding this was followed. o Samples #C3.1 and C3.4 were chemical restraints, and the individuals had Medical Restraint Plans or Medical Sedation Plans in place, which specified the schedule of monitoring. o Sample #C3.6 was for chemical restraint, did not include a Medical Restraint Plan, or reference a schedule of restraint, but based on policy and practice the expectation was that the monitoring would follow the schedule on the Restraint Checklist. o Sample #C3.2 was a mechanical restraint. A plan for PMR-SIB was provided, but not for medical restraint. o Sample #C3.3 and C3.5 were mechanical restraints, and no plan or schedule for monitoring was provided. ▪ q. In three out of six (50%), the physician specified the type of monitoring required as the Facility standard or a different schedule. This followed the same pattern as the findings in "p". ▪ r. In two out of six of the medical restraints (33%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as the physician prescribed. The two that did were Sample #C3.4, where a medical restraint plan was in place, and C3.5 where no plan was in place, but the routine schedule of circulation checks was conducted. Those that did not were: o Sample #C3.1 and C3.3, where there were no Restraint Checklist with	

#	Provision	Assessment of Status	Compliance
		the monitoring recorded; o Sample #C3.2, where the Restraint Checklist recorded circulation checks on the abdominal binder every 30 minutes for 7.5 hours, but there was no release recorded and no checks after that time. o Sample #C3.6 where the Restraint Checklist included monitoring, but the schedule required was not followed. Based on this review, the Facility was not in substantial compliance. The Process for Medical Restraint Plans (for Medical and Dental) was available and in use for some, but not all of the restraints sampled. There appeared to be confusion about what restraint plan format to use (some were Sedation plans), and some confusion about how to monitor according to the chart provided in the Restraint Checklist.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 19 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 19 (100%), continuous one-to-one supervision was provided; ▪ b. In 19 (100%), the date and time restraint was begun; ▪ c. In 19 (100%), the location of the restraint; ▪ d. In 19 (100%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. ▪ e. In 16 (84%), the actions taken by staff prior to the use of restraint to prevent the use of restraint were adequate to permit review per C.8. Those that were not: o Sample #C1.9: aggression toward staff occurred during the wait before dinner. The Restraint Checklist indicated that PMAB protection skills were used and PBSP was followed. However, the PBSP indicated that the individual should receive staff attention at least every 10 minutes. It was not clear that he was getting that regular attention in the wait before dinner. o Sample #C1.14: involved a restraint after the individual punched her staff and began engaging in self-injurious behavior, and after staff told her she did not have enough money for ice cream. No information was provided about steps taken to prevent use of restraint. o Sample #C1.16: The check-box on the Restraint Checklist indicated that staff had changed the environment, but the Debriefing indicated it had not been possible to change environment. Such inconsistencies need to be addressed and/or explained before the restraint documents are finalized. While it would be best if either the restraint checklist or the debriefing included some indications of the order and results of actions taken, that is not always	Noncompliance

#	Provision	Assessment of Status	Compliance
		practical or possible due to the rapid changes in the individual's behavior and the inability of staff to accurately record While none of the restraint documentation included a clear delineation of the order and results of efforts to prevent use of restraint, most provided a general sense of what had happened such that reasonable discussions could take place about whether the restraint was needed. ▪ f. In 19 (100%), the specific reasons for the use of the restraint; ▪ g. In 19 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In 19 (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 (excluding two chemical), including: o i. In 16 of 16 that lasted 15 minutes or less (100%), the observations documented every 15 minutes (if 15 minutes or longer) and at release; o j. In the one restraint that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint were not recorded every 15 minutes (0%), but only at the beginning and at the end of the restraint (Sample #C1.17); and o k. There were no restraints lasting more than 30 minutes, so it was not necessary to measure 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 18 (95%), 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. ▪ m. In all (100%), the date and time the individual was released from restraint; and ▪ Based on a review of 11 restraint records for eight individuals for restraints that occurred at the Facility (i.e., Individual #318, Individual #379, Individual #299, Individual #231, Individual #8, Individual #199, Individual #354, and Individual #530) (i.e., chemical and mechanical 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 11 (100%), 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. o. In a sample of 19 records, restraint-debriefing forms had been completed for 18 (95%). The one that did not was Sample #C1.14 where no debriefing form was provided. The 21 records reviewed for Sample #C.3 revealed considerable confusion over how to	

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		document and record medical restraints. As noted in the reduced sample used for metrics C.5.p and q above, about half of the restraints contained a physician's order with indications of schedule and method of monitoring. For some, the records did include a Medical Restraint Plan (Sample #C3.1 and C3.4), or based on policy and practice, the physician appeared to intend for the nursing protocol or the monitoring plan that was part of the Restraint Checklist to be followed (Sample #C3.6). The remaining three were mechanical restraints. One of the three, Sample #C3.2, included a plan for PMR-SIB which was not a medical restraint, and the remaining two did not include plans or directions from the physician. In the full sample of 21 records for this metric, the proportion of chemical restraints was higher and more of the records for chemical restraints contained Medical Restraint Plans and/or Medical Sedation Plans that provided more information about the use of the restraint, particularly about the monitoring. p. A sample of 21 records of individuals subject to medical restraint was reviewed (Sample #C.3), and in seven (33%), there was evidence that the monitoring had been completed as required by the physician's order. Those that did included: ▪ Sample #C3.4, #C3.11, #C3.14, #C3.15, #C3.16, and #C3.17. Sample #C3.5 was monitored per the standard for circulation checks without a specific order. Those that did not included: ▪ For some restraints, the protocol was not followed (Sample #C3.6, #C3.10) or (Sample #C3.12) not followed completely. ▪ In one (Sample C3.7), the order indicated a wheelchair seat belt was to be used for two weeks, but it was discontinued after three hours with no explanation. ▪ For two restraints, there appeared to be confusion as to whether they were Protective Mechanical Restraints for Self-Injurious Behavior or medical restraints (Sample #C3.8 and #C3.2). ▪ Sample #C3.9 had no plan, but had monitoring for circulation: for the first 2.5 hours every 15 minutes, and then stopped with no explanation. ▪ For five records (Sample #C3.1, #C3.3, #C3.13, #C3.18, #C3.19, #C3.20 and #C3.21) there was no documentation at all of the restraint or the monitoring of the restraint (no Restraint Checklist). Use of the Medical Restraint Plan together with the Nursing Protocols appeared to be key to correctly ordering and monitoring both chemical and mechanical restraints for medical purposes. It was encouraging to see more Medical Restraint Plans in place, but much more needs to be done to ensure the plans are written, followed, and correctly documented. Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last onsite review. This sample of two individuals was reviewed.	

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		q. In two (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review, the Facility was not in substantial compliance with this provision.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	A review of the master list of crisis restraints applied between 10/1/13 and 3/15/14 revealed a total of seven individuals who had been restrained more than three times in a rolling 30-day period. (The Facility had reported only four individuals.) A sample of three individuals was chosen for review. The individuals were Individual #199, Individual #318, and Individual #379. Although a request was made for a number of documents, these were not consistently provided. Below is a list of requested documents and the individuals for whom these were provided. ▪ The restraint checklist and face-to-face debriefing report for all identified restraints (Individual #199, missing two incidents; Individual #318; and Individual #379, missing one incident); ▪ The Positive Behavior Support Plan that was in place at the time of the restraints (individual #199 and Individual #379); ▪ The functional assessment that was in place at the time of the restraints (Individual #379); ▪ The Crisis Intervention Plan that was in place at the time of the restraints (Individual #199); ▪ Psychology Monthly Progress Notes for the months of the identified restraints (Individual #199, Individual #318, and Individual #379); ▪ The most recent Individual Support Plan (Individual #199 and Individual #379); and ▪ Any Individual Support Plan Addenda minutes or other reviews of the use of restraint in the identified time period (Individual #379). It should be noted that additional plans that were developed before or after the specified time frames were provided. These are identified in the review below.	Noncompliance

#	Provision	Assessment of Status	Compliance
		For zero of three incidents (0%), 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 failed to meet: ▪ Individual #199 had been restrained six times between 1/2/14 and 1/6/14. There was no evidence that her team met to review these restraints. ▪ Similarly, Individual #318 had been restrained four times between 10/25/13 and 11/16/13. His team failed to meet regarding these restraints, although it was noted in his November Psychology Monthly Progress Note, signed on 12/10/13, that the team needed to complete the review of more than three restraints in a 30-day period. ▪ While there was evidence of the team meeting to discuss restraint for Individual #379, this meeting occurred before he had been restrained three times in a rolling 30-day period. This young man had been restrained six times between 10/19/13 and 10/27/13. Although his team met on 10/22/13 to review the restraint that had occurred on 10/19/13, they did not meet again after the sixth restraint on 10/27/13. When reviewing the documents that were provided, there were several concerns regarding habilitation planning as it related to adaptive behavior. These are reviewed below. ▪ The ISP for Individual #199 included five skill acquisition plans, four of which were scheduled for weekly implementation. One of these weekly skills involved her doing her laundry, although other documents noted that she could complete this task independently. Her interest in learning to use the computer was not specifically addressed. As four of the restraints that were reviewed occurred in her bedroom between the hours of 2:38 p.m., and 7:09 p.m., it is suggested that a focus on skill expansion and active engagement would be appropriate. ▪ The ISP provided for Individual #318 was from 2012. Only four skill acquisition plans were identified for a young man who was not working at the time and was not scheduled to attend the activity center. Schedules of training were not identified. ▪ The ISP for Individual #379 included five skill acquisition plans, all scheduled for weekly implementation. One of these plans addressed informal training on skills he already could complete independently. Evidence of review of possible medical factors was found in documentation for two individuals. ▪ Due to reports of increased aggression in October, the team for Individual #318 contacted his prescribing psychiatrist. As a result, one medication was discontinued, one was tapered and then discontinued, and a new medication was introduced. Staff reported no change in his aggression, but did note that the	

#	Provision	Assessment of Status	Compliance
		changes had resulted in loss of an observed tremor and less sedation. ▪ Due to an increase in problem behaviors, the dosage of one prescribed medication was increased for Individual #379. Document review also raised concerns regarding biological, medical, and psychosocial factors. These are reviewed below. ▪ Individual #199 was supposed to be involved in counseling to develop anger management skills. In the January Monthly Progress Note, data indicated that she had not attended any sessions for four months. There were no identified action plans or recommendations to address this issue. ▪ Individual #318 was noted to have repeated difficulties with one of his housemates. In fact during one debriefing, staff stated that problems arose with this housemate at the same time each day. There was no evidence that the team had considered a change of residences for either one of these men so that they no longer lived together. ▪ Individual #379 had been recently admitted to the Facility. At the time of admission, it was noted that he was prescribed glasses although he did not arrive with these. There was no indication that this matter had been addressed. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely reviews of more than three restraints in a 30-day period, a comprehensive analysis of adaptive skills, along with biological, medical, and psychosocial factors is required.	
	(b) review possibly contributing environmental conditions;	For zero of three incidents (0%), the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. There was not evidence that teams had reviewed possible environmental conditions that contributed to problem behavior. For these reasons the Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For zero of three incidents (0%), the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. For two of the three individuals (67%), there was evidence that an assessment had been completed to identify possible antecedent conditions that set the occasion for problem behavior. The Functional Assessment had been provided for Individual #379 and an assessment was referenced in the PBSP for Individual #318. In the PBSP for all three individuals, antecedent variables were identified. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely and comprehensive reviews of more than three	Noncompliance

#	Provision	Assessment of Status	Compliance
		restraints in a 30-day period, structural assessments should be updated annually or more frequently in response to worsening behavior.	
	(d) review or perform functional assessments of the behavior provoking restraints;	For zero of three incidents (0%), the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. For two of the three individuals (67%), there was evidence that an assessment had been completed to identify possible consequent conditions that maintained the problem behavior. The Functional Assessment was provided for Individual #379 and an assessment was referenced in the PBSP for Individual #318. In the PBSP for all three individuals, antecedent variables were identified. The Functional Assessment for Individual #379 was comprehensive and clearly written. Methodology included both indirect and descriptive assessment, including an observation in his school environment. The individual was interviewed regarding his preferences and these were validated with a review of the choices he made during token exchange. Antecedent-Behavior-Consequences data sheets were reviewed and analyzed with regard to location, activity, immediate antecedent, and immediate consequence to problem behavior. The report concluded with a succinct summary of motivating operations, setting events, and consequences likely maintaining the problem behavior. The Facility remained out of compliance with this provision of the Settlement Agreement. In addition to the need for timely and comprehensive reviews of more than three restraints in a 30-day period, functional assessments should be updated annually or more frequently in response to worsening behavior.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint	Each of the three individuals reviewed (100%) had a Positive Behavior Support Plan (PBSP) in place at the time of repeated restraint. (It should be noted that the PBSP provided to the Monitoring Team for Individual #318 was implemented after the date of repeated restraints.) The review of these PBSPs is summarized below: ▪ In the PBSPs provided for three individuals (100%), there was evidence of operationally defined problem behaviors. ▪ In the PBSPs for three individuals (100%), there was evidence of functionally equivalent and operationally defined replacement and/or alternative behaviors. o Individual #199 was learning to problem solve and wait for attention. o Individual #318 was learning to consistently keep his communication book with him so that he could ask for things he wanted. o Individual #379 was learning to request a delay when he was asked to engage in a non-preferred activity. • In the PBSPs for three individuals (100%), there was evidence of other programs	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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;	designed to reduce or eliminate the problem behaviors that led to restraint. o Individual #199 was to be provided attention every 15 minutes. She also participated in a home-based token reinforcement system. o Individual #318 was to be encouraged to go to a quiet area when he first became upset. Staff were also to try to help him find appropriate solutions when he began to get upset. o Individual #379 was learning to apply self-management strategies, he was given a choice of tasks to complete, he was given attention every 10-15 minutes, and he was involved in a token reinforcement system. ▪ In the PBSPs for three individuals (100%), there were clearly specified interventions designed to reduce or eliminate the behaviors that led to restraint. ▪ While not a requirement for substantial compliance with this provision, staff should ensure timely approval of new or revised PBSPs so that improved plans can be implemented as soon as possible. For example, the plan for Individual #318 was implemented over six months after his ISP, in spite of a recommendation in his progress notes three months earlier that training on his plan should begin as soon as possible. This improved plan might have had a positive impact on his behavior, possibly reducing the need for restraint. It should be noted that the Facility had initiated a process to improve timely submission of PBSPs. All three of the individuals (100%) had a plan for use in a crisis. Individual #318 and Individual #379 had a Crisis Intervention Plan, while Individual #199 had both a Crisis Intervention Plan and a Protective Mechanical Restraint for Self-Injurious Behavior Plan. The CIP for Individual #199 had been implemented before the repeated restraints, while all other plans had been implemented after the first of the identified restraints. A summary of the review of these plans is provided below: ▪ All of the plans (100%) delineated the type of restraint authorized. The CIPs for Individual #318 and Individual #379 utilized a PMAB-approved bear hug/baskethold or two-person horizontal restraint. The plans for Individual #199 involved the use of wristlets. ▪ All of the plans (100%) specified the maximum duration of restraint authorized. The maximum duration of the restraint prior to an attempted release was 15 minutes in the CIP for Individual #318 and Individual #379. For Individual #199, release from restraints was required after 55 minutes and for all meals. ▪ In all of the plans (100%), the observed behaviors that constituted a crisis situation were clearly described. ▪ All of the plans (100%) specified the criteria for terminating the use of the restraint. Restraint duration was time-based in the plan for Individual #199. In the plans for Individual #318 and Individual #379, restraint was to cease when the individual was no longer struggling or displayed aggression or yelling,	

#	Provision	Assessment of Status	Compliance
		respectively. Each of the individuals in the sample had a PBSP and a CIP, developed in response to repeated restraints. The Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	The progress notes for all three individuals reflected monitoring of plan implementation. Individual specific reviews are provided below. ▪ The monthly progress notes for Individual #199 reflected two interviews and two observations during a two-month period. Interview scores were 70% and 100% with a mean of 85%, while observations were reported to indicate 0% correct plan implementation. ▪ Over two consecutive months, the monthly progress notes for Individual #318 included reports of two staff interviews and two recorded observations. Interview scores were 60% and 90% for a mean of 75%, while observations noted 100% correct plan implementation. ▪ Three consecutive monthly progress reports for Individual #379 reflected multiple occasions where staff were interviewed or observed. A total of 11 interviews, involving eight different staff, were conducted. Staff correctly answered questions correctly between 60% and 100%, with an average score of 90%. Staff were observed via video recording eight times. They demonstrated correct plan implementation between 33% and 100%, with an average of 75%. Continued training and/or supervision will be necessary for staff to demonstrate implementation of PBSPs with a high degree of treatment integrity. Until that time, the Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	For zero of three incidents (0%), the team met within 10 business days following each occurrence of more than three restraints in a rolling 30-day period. None of the progress notes that were reviewed for Section C.7 included recommendations for revisions to the PBSP. The Facility remained out of compliance with this provision of the Settlement Agreement, as timely reviews had not been conducted of the plans for individuals who had experienced more than three restraints in a rolling 30-day period to determine whether or not the PBSPs should be modified.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the	A sample of documentation related to five incidents of crisis intervention restraint was reviewed (Sample #C1.1, #C1.14, #C1.8, #C1.12, and #C1.16) including the Unit Team meeting minutes, IMRT meeting minutes, Restraint Reduction Committee minutes, and	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	any related ISP addenda. This documentation showed that: ▪ a. In five (100%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist. ▪ b. In four (80%), 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 in sample #C1.14. ▪ c. In three (60%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. Those that did not were: o Sample #C1.14, where there was no explanation of the graduated range of steps used to avoid restraint, no level of supervision was checked, and there was no debriefing form. o Sample #C1.16, where there was a conflict between the Restraint Checklist and the Debriefing form. ▪ 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 meeting were provided. ▪ e. In none (0%), referrals were made to the team, as appropriate. ▪ f. Since none were referred to the team, no appropriate changes were made to the individuals' ISPs and/or PBSPs as a result of a referral to the IDT. Based on this review the Facility was not in substantial compliance with this provision, since the minutes of the Unit IDT and the IMRT did not contain evidence of review of restraints in sufficient scope and depth, nor document whether referrals to the IDTs were needed.	

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 #021.3: Abuse/Neglect/Exploitation (A/N/E) Policy, dated 11/5/13, revised 3/26/13; o ABSSLC Policy/Procedure: Spurious Allegations of Abuse/Neglect/Exploitation, dated April 18, 2012; o ABSSLC Policy: Injury Audits, revised 12/16/13; o Self-Assessment, updated 4/28/14; o ABSSLC Action Plans, updated 4/28/14; 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 Abuse/Neglect Trend Analysis Report 1st Quarter Fiscal Year (FY) 2014, dated 12/9/13; o Abuse/Neglect Trend Analysis Report 2nd Quarter FY 2014, dated 3/10/14; o Trend Analysis Report 1st Quarter FY 2014 for Unusual Incidents, dated 12/9/13; o Unusual Incident Trend Report: 12/1/13 to 2/28/14, dated 3/10/14; o All Injuries Between Dates of 10/1/13 and 3/31/14, dated 5/13/14; o List of individuals for whom DFPS conducts streamlined investigations, undated; o ABSSLC Staff Status Tracking – by Date, undated; o Monthly Meeting Notes: Section D, dated 1/15/14, 2/26/14, and 3/31/14; o Self Advocates meeting minutes, dated 4/8/14; o Semi-Annual Injury History Review for 9/1/13 to 2/28/14, dated 4/22/14; o QA/QI Data Summary Section D for 12/1/13 to 2/28/14, dated 4/7/14; 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 OIG or law enforcement agencies; • Documentation of supervisory review of the investigative report; and • Any checklist maintained by the Facility or DFPS.

Sample #	Date	Facility #	DFPS #
D1.1	10/8/13	1393	42894447
D1.2	10/18/13	1463	42904950
D1.3	10/23/13	1700	42913730
D1.4	10/27/13	1707	42914559
D1.5	11/3/13	1721	42922504
D1.6	11/11/13	1728	42931089
D1.7	11/23/13	1743	42945646
D1.8	12/6/13	1757	42958195
D1.9	12/17/13	1814	42967165
D1.10	12/9/13	1826	42974330
D1.11	1/2/14	1831	42980643
D1.12	1/11/14	1842	42989591
D1.13	1/11/14	1847	42989586
D1.14	1/21/14	1855	43000781
D1.15	1/30/14	1862	43010215
D1.16	2/7/14	1870	43019951
D1.17	2/22/14	1881	43037953
D1.18	3/2/14	1889	43047049
D1.19	3/11/14	1906	43057349
D1.20	3/25/14	1915	43072537

- **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.

Sample #	Date	Facility #
D2.1	10/31/13	1712
D2.2	11/10/13	1727
D2.3	11/18/13	1737
D2.4	12/19/13	1819
D2.5	1/12/14	1848

D2.6	1/26/14	1860
D2.7	2/15/14	1878
D2.8	2/22/14	1882

- **Sample #D.3**: No additional reports.
- **Sample #D.4:** the sample of ISPs reviewed included ISPs for the following individuals: Individual #64, Individual #78, Individual #307, Individual #296, Individual #348, Individual #88, Individual #263, Individual #521, Individual #212, Individual #92, Individual #255, Individual #334, Individual #447, Individual #489, Individual #182, Individual #430, Individual #517, Individual #374, Individual #59, and Individual #300;
- **Sample #D.5:** a subsample of five of the investigations included in Samples #D.1 and #D.2 which included programmatic or disciplinary recommendations:

Sample ID#	Facility #	DFPS #
D1.1	1393	42894447
D1.3	1707	42914559
D1.6	1728	42931089
D1.7	1743	42945646
D2.1	1712	None

- **Sample #D.6:** a sample of 15 completed Injury Audit Record Reviews, including:

Individual Identification #	Audit Date
Individual #276	4/30/14
Individual #16	3/27/14
Individual #88	4/29/14
Individual #486	4/29/14
Individual #466	4/29/14
Individual #97	4/29/14
Individual #397	2/24/14
Individual #61	2/25/14
Individual #162	1/25/14
Individual #476	1/24/14
Individual #167	3/27/14
Individual #343	3/31/14
Individual #177	3/31/14
Individual #488	3/31/14
Individual #472	3/20/14

- **Sample #D.7**: A sample of CAPs developed as a result of trend analysis, including: CAP #21 and CAP #26.

- **Interviews with**:
  - Linda Hinshaw, Facility Director;
  - Jolene Willis, Assistant Director of Programs;
  - David Daniel, Director for Quality Assurance;
  - Luee McCreary, Incident Management Coordinator (IMC); and
  - Renay Kellum, Program Compliance Monitor (PCM).
- **Observations of**:
  - Quality Assurance/Quality Improvement Council Meeting, on 5/12/14;
  - Unit IV Team Meeting, on 5/13/14;
  - IMRT meeting, on 5/13/14.

Facility Self-Assessment: The ABSSLC Self-Assessment indicated the Facility was in substantial compliance with 21 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 17 of the 22. 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 Finding
D.2.a	Substantial compliance	Noncompliance
D.3.e	Substantial compliance	Noncompliance
D.3.g	Substantial compliance	Noncompliance
D.4	Substantial Compliance	Noncompliance

The Facility submitted a Self-Assessment for Section D, dated 4/28/14. 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 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.
  - This monitoring/audit tool 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. 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. o According to the information provided, inter-rater reliability was reviewed, but had not been consistently established between the various Facility staff responsible for the completion of the tools. This remained a priority issue for the Facility. ▪ 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. The Facility did not present data on key indicators and outcome measures in its Self-Assessment, although work had been done towards establishing a set of key indicators for this section. ▪ The Facility presented some data in a useful way, but not always. Specifically, the Facility's Self-Assessment: o Presented its findings as specific, measurable indicators. o Did not measure the quality as well as presence of items. ▪ The Facility rated itself as being in substantial compliance with all provisions of Section D, except for D.3.i. The Monitoring Team found the Facility to be noncompliant with D.2.a, D.3.g, D.3.i and D.4. The inconsistences in the findings could have resulted from different sample sizes or from the use of different standards. 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. ▪ The Facility data 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 connecting the findings to the Facility's Action Plans/Corrective 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 compliance with 17 out of 22 provisions of Section D, as opposed to 19 provisions that were in compliance during the last review.

	Progress was noted in a number of areas. Highlights of progress included: ▪ The injury audit process was well underway. ▪ A log of recommendations and concerns from investigation reports had been established to track concerns to completion and to verify with a Program Compliance Monitor (PCM) quality check. ▪ Some of the issues with extracting data from the system seemed to have been resolved, though there was still room for progress. The new Data Analyst should prove helpful in moving forward. ▪ There was some additional analysis of trend reports, which should help to identify where corrective action plans might be needed. However, to make this process complete and useful, more work will be needed to assure that analysis includes comparisons of the trended data across the several databases. For example, it can be useful to compare data on injuries, peer-to-peer aggression, unusual incidents, abuse/neglect allegations, and restraints to see whether some individuals are experiencing high numbers within each category, or whether some homes are experiencing high numbers within each category as a method for identifying where corrective action might be productively directed. ▪ The injury audit process was well underway, including review of trends identified in the audit process. The Facility's plans to supplement that process with a review of the general trend data on injuries to determine if there are any patterns or numbers of injuries for some individuals that should be investigated was underway and to determine the cause and to institute action to reduce injuries to those individuals, particularly when injuries were caused by peer-to-peer altercations. Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included: ▪ When it is clear in an investigation that staff did not report abuse, neglect, and exploitation, recommendations in the DFPS report and the UIR need to address that failure to report. ▪ It will be important to continue to work complete all recommendations timely, and monitor results to assure that the actions achieved the desired results. ▪ Trend data needs to be analyzed across incident and allegation data to determine if individuals or homes are in need of additional supports. Corrective Action Plans need to be developed when that analysis indicates supports are needed.

#	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 more than three consecutive reviews. The substantial compliance finding from the last review 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>4/1/13 to 9/30/13</th><th>10/1/13 to 3/31/14</th></tr>
<tr><td>Total abuse allegations</td><td>167</td><td>105</td></tr>
<tr><td>Physical</td><td>87</td><td>57</td></tr>
<tr><td>Verbal</td><td>39</td><td>19</td></tr>
<tr><td>Sexual</td><td>41</td><td>29</td></tr>
<tr><td>Abuse substantiated</td><td>14</td><td>7</td></tr>
<tr><td>Physical</td><td>12</td><td>4</td></tr>
<tr><td>Verbal</td><td>2</td><td>3</td></tr>
<tr><td>Sexual</td><td>0</td><td>0</td></tr>
<tr><td>Total neglect allegations</td><td>87</td><td>61</td></tr>
<tr><td>Neglect substantiated</td><td>17</td><td>8</td></tr>
<tr><td>Total exploitation allegations</td><td>1</td><td>2</td></tr>
<tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		According to Facility data provided: **4/1/13 to 9/30/13** / **10/1/13 to 3/31/14** Deaths: 4 / 5 Serious Injuries: 25 / 24 Sexual Incidents: 1 / 7 Suicide Threat (credible): 2 / 0 Unauthorized Departure: 1 / 2 Choking: 4 / 1 Other: 0 / 0 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**.** 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. Based on a review of the 20 investigation reports included in Sample #D.1, 11 were reported timely. Two resulted in Information and Referrals (in other words were not determined to be incidents reportable to DFPS) and five were unconfirmed, and there was no information to suggest that staff should have reported. The remaining two were not reported timely. In summary: ▪ 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: o Sample #D1.11 involved an allegation of neglect that was confirmed. It was reported the day after the event. However, there were several witnesses who should have reported it sooner. o In Sample #D1.8, the Facility received a report alleging neglect in allowing an individual to remain outdoors on the patio in 25 degree weather. The Facility immediately took action to protect the individual	

#	Provision	Assessment of Status	Compliance
		and secure evidence. Three days later when no call came from DFPS to start the investigation, the Facility contacted DFPS to inquire and found that DFPS had not received or had not recorded the initial phone call. The investigation started immediately and confirmed neglect. However, there was no information in the reports about why the initial report did not reach DFPS. ▪ Metric 2.a.7: 19 (95%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. The one that did not was Sample #D1.8, which either did not reach DFPS or was not recorded by DFPS within the policy guidelines. ▪ 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. Based on a review of eight investigation reports included in Sample #D.2: ▪ Metric 2.a.9: six (75%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. Those that did not included: o Sample #D2.1: Two individuals were observed on the video surveillance as engaging in inappropriate touching that stopped immediately when the aggressor was rebuffed by his peer. It was not clear in the UIR whether the video surveillance monitor observed this action as it was happening, or upon review of a tape two days later. If the observation was live, the report was two days late. If the observation was made after the fact, it might have been reported timely, but there was no way to tell from the UIR. o Sample #D2.8: An individual was seriously injured, likely by a fall, causing a subdural hematoma. The UIR indicated that this individual had fallen or dropped to the ground 23 times in five days. After the last fall, she became unresponsive leading to hospitalization and discovery of the hematoma. It was not clear why, after the hospitalization, the serious injury was not reported for four days. ▪ Metric 2.a.10: all (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.11: For the two unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, no UIR investigation folders (0%) included recommendations for corrective actions. o Sample #D2.1: the UIR did not contain any information about why the report was late. Since there was no information about when the sexual activity between two peers was first observed, it was not clear whether	

#	Provision	Assessment of Status	Compliance
		corrective action was needed. o Sample #D2.8: the UIR did not contain any information about why the report was late or recommend any corrective action to prevent late reporting in the future. Metric 2.a.12: The Facility had a standardized reporting format. Metric 2.a.13: Based on a review of 28 investigation reports included in Samples #D.1 and #D.2, 26 (93%) contained a copy of the report utilizing the required standardized format and were completed fully. The two that this not were the two allegations that were returned as Information and Referrals (I and Rs), but where the file did not include copies of the I and Rs. Based on this review, based on late reporting of both allegations of neglect and serious incidents and the lack of any recommendations in the UIRs to correct the late reporting in the future, the Facility did not achieve substantial compliance.	
	(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 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
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating	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

#	Provision	Assessment of Status	Compliance
	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 from the last review 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. The Incident Management Unit was checking ISPs monthly to assure that the brochures were distributed, that education on reporting occurred at the annual IDT meeting, and that distribution was documented in the ISP. Based on a review of twenty individuals' ISPs (Sample #D.4), 17 individuals (85%), or their LAR and/or other significantly involved individual had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. One report had not followed the process, however, the circumstances were unusual and steps were in place to assure compliance. ▪ Individual #88: Upon interview with the Facilitator QIDP, it was learned that the LARs were new guardians who called in to the ISP meeting. The QIDP noted some reluctance to discuss abuse, so she asked it they knew how to report. They	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		indicated they did and the documentation reflected that. However, the materials on abuse should have been mailed to the LARs and some discussion should have taken place, perhaps on a separate phone call, to understand their reluctance to talk about the subject. Fortunately, a follow-up IDT meeting was scheduled for early June so that the LARs could participate in the discussion in person. At that time, the Facilitator QIDP reported that the brochure will be made available and further discussion will be conducted to assure that the LARs are familiar with the process and that they do not have concerns about the individual's care. Since this was an unusual case and plans were already in place to rectify the problem, this was determined to be an acceptable deviation from the requirement. In two other ISPs, the documentation did not clearly record that the materials had been shared and the individual informed about reporting abuse and neglect. ▪ Individual #92: The ISP dated 3/12/14 indicated that the IDT had been asked if they were willing to assist with reporting any abuse on the individual's behalf and the documentation reflected that they were willing. While it was clear why the team did not include a guardian or other involved party, it was not clear why the brochure was not at least provided to the individual along with some discussion about its meaning. ▪ Individual #430: This individual's LAR was his grandmother who had died, leaving him without an LAR or family members. The brochure was not provided to the individual, but the IDT was asked and agreed to assist him should he need to make a report of abuse or neglect and this was documented. However, the brochure should have been provided and an effort should have been made to identify a person close to him to help assure that someone would be paying special attention to his needs for assistance. In the log kept by Incident Management, this individual was checked as having received the materials. While the metric fell short of the 90% benchmark, the Facility remained in substantial compliance since in the one unusual situation, the lack of distribution of materials and discussion with the guardian will be remedied in June. However, the expectation is that every effort will be made to educate the individual, the family, the LAR or a next friend to assist with reporting of abuse/neglect and that whatever action is needed will be accomplished at the IDT meeting or documentation of a plan for educating about abuse/neglect will be documented in the ISP.	
	(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	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

#	Provision	Assessment of Status	Compliance
	report violations of such rights.		
	(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 from the last review 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 from the last review 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 procedures did define sufficient procedures to audit whether significant injuries were reported for investigation. The policy provided for review of client injury data for trends and causes of injuries within the audited samples. The policy went further to indicate that ASSLC "may" also assign a committee to review client injury data for system causes and trends of injuries and make recommendations to prevent future injuries from occurring. The policy would be stronger if it indicated such a committee "will" be formed and that the committee will generate and review all injury data for system causes and trends semi-annually. In fact, the Action Plan for Section D included the steps to implement a plan to review injury reports for injuries that raise suspicion of possible A/N/E and report them for investigation 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 15 recently completed Injury Audit Record Reviews (As defined in Sample #D.6 in the Documents Reviewed section above.) The audits followed a standard format, documented review of injuries that had been reported, integrated progress notes related to those injuries, direct support staff observation notes	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 IMC reported on the semi-annual review for the months of September, October, November, and December 2013, and January and February 2014, in a report dated 4/22/14. The report described the methodology, provided a summary graph and narrative analysis of results and outlined corrective actions to be taken, based on findings. The audit samples were 12 per month for a total of 72 for each half-year, or 20% of the census of 363. 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 audits that had not previously been investigated. The Facility was in substantial compliance with this provision.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of	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

#	Provision	Assessment of Status	Compliance
	supervision of the alleged perpetrator.		
	(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 from the last review 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 from the last review 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 from the last review 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, findings and, as appropriate, recommendations for corrective action.	Based on Facility Policy #002.4, investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ 18 out of 20 (90%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. For Sample #D1.10 and #D1.20, there were no copies of the Information and Referral that was made by DFPS to	Noncompliance

#	Provision	Assessment of Status	Compliance
		the Facility. There was information in the Facility's records documenting the referral, but there should have been properly completed Information and Referral Forms on file. ▪ 16 out of 20 were completed within 10 calendar days of the incident, including sign-off by the supervisor. Two of those 16 were Information and Referrals from DFPS, documented in the UIRs by the Facility. Those that were not were: Sample #D1.12, #D1.14, #D1.16, and #D1.18. o For the four that were not completed within 10 days, four (100%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ 19 (95%) 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 #D1.20 was an Information and Referral. There was no written report on file to indicate why it was being returned. However, the UIR referenced receipt of the Information and Referrals. ▪ In 10 of the investigations reviewed, recommendations for corrective action were included. In eight of these investigations (80%), the recommendations were adequate to address the findings of the investigation. Those that did not included: o Sample #D1.8, a report of possible neglect was received by the Facility and steps were taken to protect the individual. When no notification of DFPS intake was received by the Facility, inquiry was made and it was learned that DFPS never registered a call on this report. While the UIR was clear in its description of the late report, there were no recommendations about how to assure this did not happen again. o Sample #D1.11 contained no recommendations concerning the late reporting of the allegation, which was one day late. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Eight out of eight (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ Seven out of eight (88%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The one that did not was sample #D2.6 which involved a death.	

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		○ For the one that was not completed within 10 days, there was no documentation (0%) of a written extension request that had been approved by the Facility Director, nor was there documentation of the extraordinary circumstances that necessitated the extension. That one was Sample #D2.6. ▪ Eight (100%) resulted in a written report that included a summary of the investigation findings. ▪ In seven of the investigations reviewed, recommendations for corrective action were included or needed. In four of the seven investigations (57%), where recommendations were needed, the recommendations were adequate to address the findings of the investigation. While recommendations were generally comprehensive and specific the following issues were identified: ○ Sample #D2.1: the incident was reported late and there was no recommendation to correct in the UIR. ○ Sample #D2.6: in this investigation of the death of an individual, the UIR noted that he had been scheduled for a battery replacement for the Vagus Nerve Stimulator that had been implanted for seizure control. While there was no evidence that a failed battery had contributed to his death, the battery had been scheduled for replacement raising the possibility that it had failed. The investigation should have included a recommendation to the Medical Department to review such devices in use by individuals to determine if replacements were routinely being done on time. ○ Sample #D2.8: the incident was reported late and there was no recommendation to address this in the UIR. The investigation uncovered a series of 23 falls in five days, but did not raise any issues about why the individual was not wearing a protective helmet or not otherwise being monitored for falling, or recommend further follow-up to address the individual's risk. The Facility was in noncompliance with this provision.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of	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

#	Provision	Assessment of Status	Compliance
	wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.		
	(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. DFPS Investigations The parties have agreed that due to concerns related to the confidentiality of the DFPS supervisory process, the Monitoring Teams will not review it. As a result, the Monitoring Teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. To determine compliance with this requirement of the Settlement Agreement, full samples of investigations the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ Metric 3.g.8: Eight of eight (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. ▪ Metric 3.g.9: In eight out of eight 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 three investigations noted above for which the Monitoring Team identified deficiencies and the supervisory review did not appear to address these deficiencies. Those were: o Sample #D2.1: the incident was reported late and there was no recommendation to correct in the UIR. o Sample #D2.6: in this investigation of the death of an individual, the UIR noted that he had been scheduled for a battery replacement for the Vagus Nerve Stimulator that had been implanted for seizure control. No questions were raised in the UIR about whether a failed battery contributed to his death. o Sample #D2.8: the incident was reported late and there was no recommendation to address this issue in the UIR. The investigation uncovered a series of 23 falls in five days, but did not raise any issues about why the individual was not wearing a protective helmet or not otherwise being monitored for falling. These issues should have been caught and addressed via the supervisory review. At the last review, the Facility was determined to have achieved substantial compliance with this provision, but the Monitoring Team noted that the Facility had found noncompliance and might not be able to sustain compliance on future reviews unless it addressed the issues identified in its own self-assessment. On this review, the Facility found substantial compliance in its self-assessment, based on its monitoring sample, but noted that the inter-rater agreement between QA and Incident Management Investigators was less that 70%. Since the Monitoring Team noted issues with the Facility's compliance with this provision, the Facility should review its self-assessment process. The Facility was not in compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of	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

#	Provision	Assessment of Status	Compliance
	subparagraph g, for each unusual incident.		
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	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 outcomes. ABSSLC was recording recommendations (often expressed as "concerns" in the DFPS reports), whether offered by DFPS investigators or by the Facility investigators, in the UIR with the person assigned responsibility and the date due. The IMC followed up by sending a memo to responsible people with the request for action and space for the response. Responses were sent together with evidence of completion, such as disciplinary letters, or training rosters to assure that the requested action had been completed. A log was kept of recommendations and follow-up dates to track completion, as well as a description of follow-up by the PCM. A subsample of five of the investigations included in Samples #D.1 and #D.2 was drawn to review 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 one out of one of the investigations reviewed in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented. ▪ Sample #D1.2 involved a confirmation of abuse. The perpetrator was terminated, Abuse/Neglect training was provided to all staff who were present, and two staff who failed to intervene in the neglect had their job descriptions reviewed with them. 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 five of the investigations reviewed (60%), prompt and thorough programmatic action had been taken and documented. The two that did not included: ▪ Sample #D1.1: A prohibited supine restraint was used by a staff member who found himself alone, outdoors at night with an individual who assaulted him with a lawn chair. After being hit in the head, the staff member restrained the individual on his back, pinning his arms to the ground. (After the event, the staff member required a trip to the Emergency Room). The DFPS report did not confirm abuse or neglect, but did recommend that the individual's PBSP be	Noncompliance

#	Provision	Assessment of Status	Compliance
		adjusted to instruct staff on what to do in a similar circumstance. The response from Behavior Health Services indicated that the PBSP and Crisis Intervention Plan did provide for such circumstances: staff could back away, maintain a safe distance, and call for help. This response did not appear to address the circumstances where there was not help immediately available, or when staff had been injured. ▪ Sample #D1.2 had three programmatic recommendations. The one that was addressed was to either find a way to provide male staff to prompt the individual as called for in the BSP or find an alternative. In his response, the Unit Director denied the second recommendation was a problem. The recommendation was to address the overall noisy environment in which inappropriate communication was used. A third recommendation addressed the failure of staff to intervene or report the abuse that was taking place by calling for a review of 24 hours of video of the residence and documentation of the small departures from policy. The Unit Director rejected this recommendation, indicating such reviews were already done in the context of reviewing meals and other activities. The IMRT and/or Facility Administration needed to reinforce both recommendations that the Unit Director rejected, and make it clear that the recommendations from an investigative report should be addressed, not denied. Metric D.3.i.5: For one of five investigations (20%), 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. That one was Sample #D2.1, where the Program Compliance Monitor had checked on the outcome and documented completion of the recommendation. In three of the remaining four reports, there was no evident follow-up to determine if the actions taken on the recommendations had the desired results (i.e., Sample #D1.1, #D1.6 and #D1.7). No PCM monitoring sheets were found in these files. In the remaining one (Sample #D1.1), the file did contain a PCM monitoring report that showed all programmatic recommendations completed. However, there was nothing to clarify the inconsistency between what the PCM monitored, which looked like the original recommendations, two of which the Unit Director had rejected. It was noteworthy that the PCM had questioned staff about the environment and reported that staff knew the home should be quiet and comfortable and that individuals should not be rushed. The Facility was not in substantial compliance with this provision. To move towards substantial compliance, the Facility will need to focus on providing documentation of follow-up on the actions taken to address programmatic recommendations.	

#	Provision	Assessment of Status	Compliance
	(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 from the last review 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 incident; and outcome of investigation.	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. 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; ▪ Metric D.4.4: Did use some appropriate trend analysis procedures to show how data changed over a rolling one-year period. There were charts showing total ANE per 100 residents by disposition and trend lines were calculated, showing a steady decline in confirmation rates and an upward trend in numbers of cases determined to be unfounded. However, to make this process complete and useful, more work will be needed to assure that analysis includes comparisons of the trended data across the several databases. For example, it can be useful to compare data on injuries, peer-to-peer aggression, unusual incidents, abuse/neglect allegations, and restraints to see whether some individuals are experiencing high numbers within each category, or whether some homes are experiencing high numbers within each category as a method for identifying where corrective action might be productively directed. ▪ Metric D.4.5: Did provide a narrative description/explanation of the results and conclusions. However, the narrative in the Unusual Incident and A/N/E Trend reports was sparse and did not point out the significance of all the data.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Metric D.4.6: Did not**,** as appropriate, contain recommendations for corrective actions. For example: There was an upward trend in the rate of unfounded results in ANE investigations. There was no analysis of this trend and no recommendations for further investigation or corrective action. 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. Although as noted below, the QA/QI Council had approved some CAPs related to trends found, this was not the case for some significant trends. For example: ▪ The trend analysis reports identified homes and individuals with high numbers of allegations, yet no corrective action plans were developed to address these high numbers. ▪ The QA/QI Quarterly Section Review of Settlement Agreement Progress in April 2014 identified 10 indicators that monitoring showed a score of less than 70%, yet no action plan was put in place to address the issues. Metric D.4.8: Corrective action plans were not developed both for specific individuals and for systemic level issues. However, investigations of serious incidents/injuries or investigations of abuse/neglect/exploitation did result in referrals to IDTs to take action in individual situations. Similarly, though, when trends are identified as a result of review of aggregate data, Facility staff need to identify appropriate actions and taken them. Metric D.4.9: The trend reports and/or minutes did show that corrective action plans were implemented and tracked to completion. Two corrective action plans were developed and implemented between October 1, 2013 and March 31, 2014. CAP #21 (10/3/13) addressed the number of injuries, not usually vulnerable to trauma. CAP #26 (1/6/14) addressed the high number of unusual incidents occurring with an unknown location. Both arose from data analysis and review. It was positive that the Facility was beginning to use its data and analyses of data to develop and implement corrective actions. As noted above, when significant trends are identified, the QA/QI Council and/or IMRT should discuss and develop, as appropriate, CAPs or other corrective actions. If decisions are made not to take corrective action related to an identified trend, meeting minutes should include clear rationale for the decisions. Metric D.4.10: The report/minutes did review, as appropriate, the effectiveness of previous corrective action plans. Metric D.4.11: Two out of two action plans (100%) 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.	

#	Provision	Assessment of Status	Compliance
		Metric D.4.12: For two out of two of the action plans reviewed (100%), the plan had been timely and thoroughly implemented. Metric D.4.13: For none out of two action plans (0%), 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. There was no indication on the CAPs tracking sheet to show that the objectives of these CAPs had been achieved and/or the CAPs been reviewed to assure the desired outcomes were in place. The QA/QI review of CAP #21 on 1/13/14 indicated that it was too early to determine if progress had been made. The QA/QI minutes of 4/23/14 indicated that the desired outcome had not been achieved and discussion of the reasons resulted in assignment of a group to develop a new CAP to address problems with documenting injuries in all records required by policy. However, since the CAPs were not always identified in the minutes by CAP number, it was not easy to determine which CAP was being reviewed. The Facility remained in noncompliance with this provision. The Facility had established trend reports for abuse/neglect/exploitation and for unusual incidents for presentation to both to IMRT and QA/QI Council at least quarterly. However, the analyses as well as the narrative explaining trends and issues needed to be expanded to analyze data across incidents and allegations and extract and explain information in the reports that could lead to actions for improvement, such as corrective action plans. The Facility should consider the use of graphs of trends over time to more easily identify progress. In addition, CAPs needed to be developed for significant trends on an individual as well as systemic level, or rationale for not doing so provided. Clear follow-up to ensure expected outcomes were achieved also was needed.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall	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

#	Provision	Assessment of Status	Compliance
	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.		

<table>
<tr><th>SECTION E: Quality Assurance</th><th></th></tr>
<tr><td>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:</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

DADS Policy #003.1: Quality Assurance (QA), dated 1/26/12;
ABSSLC Policy: Quality Assurance, dated 2/20/14;
ABSSLC Quality Assurance Plan, dated 3/7/14;
ABSSLC QA Plan/Matrix, undated;
QA Monitoring Tool Matrix, dated 4/3/14;
Master Inventory of Data, undated;
Presentation Book for Section E;
ABSSLC Self-Assessment, dated 4/28/14;
Results from CAP Audit Tool for April 2014;
Unusual Incident Trend Analysis Report for 9/1/13 to 11/30/14;
Unusual Incident Trend Analysis Report for 12/1/13 to 2/28/14;
A/N/E Trend Report for 12/1/13 to 2/28/14;
A/N/E Trend Report for 9/1/13 to 11/30/13;
Injury Trend Analysis Report Quarter 1 FY14 and Q2 FY14, undated;
Emergency Response Trend Report Quarter 1 FY 14;
ABSSLC Restraints Trend Analysis Reports: March 2014;
ABSSLC 2013: Quarterly Dental Presentation, dated 11/20/13;
Section Q Review of Progress and Quarterly Dental Trend Report, dated 2/10/14;
ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting notes, for the months of November 2013 to April 2014;
ABSSLC Leadership Council/Quality Assurance/Quality Improvement Council meeting agenda and handouts for meeting on 5/11/14;
Monitoring tools associated with the Quality Assurance Plan;
Quality Assurance Monitoring Tool Matrix, undated;
Corrective Action Plan List, undated (a listing of 38 CAPs with status of open/closed) Note: at the time of the document request, the Facility had 38 CAPs;
List of dissemination dates of CAPs #1 through #43. Note: 43 was the number of CAPs at the time of the site visit;
Corrective Action Plans (open): numbers assigned by the Facility to 15 CAPs used as sample for Section E.2:

<table>
<tr><th>CAP #</th><th>Section</th></tr>
<tr><td>3</td><td>J</td></tr>
<tr><td>5</td><td>K</td></tr>
<tr><td>7</td><td>V</td></tr>
<tr><td>11</td><td>C</td></tr>
<tr><td>16</td><td>F</td></tr>
</table>
</td></tr>
</table>

20	S
21	D
22	L
29	M
31	T
32	Q
33	I
35	O
37	P
38	R

- Corrective Action Plans (open and closed): numbers assigned by the Facility to 15 CAPs used as sample of closed and open CAPs for Sections E.4 and E.5.

CAP #	Section	Status
1	M	Closed
3	J	Open
6	C	Closed
7	V	Open
8	L	Closed
16	F	Open
17	F	Closed
21	D	Open
24	E	Closed
25	U	Closed
26	D	Closed
29	M	Open
32	Q	Open
35	O	Open
38	R	Open

- **Interviews with**:
  - Linda Hinshaw, Facility Director;
  - Jolene Willis, Assistant Director of Programs;
  - David Daniel, Director for Quality Assurance; and
  - Tracyl Gandee, Settlement Agreement Coordinator.
- **Observations of**:
  - Quality Assurance/Quality Improvement Council Meeting, on 5/12/14;
  - Restraint Reduction Committee, on 5/14/14;
  - Unit IV Team Meeting, on 5/13/14; and
  - IMRT meeting, on 5/13/14.

	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 4/28/14. 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 E, in conducting its self-assessment: ▪ The Facility used a locally designed CAP Audit Tool and relied on other work products to conduct the self-assessment. A previously used monitoring tool for the section had been discontinued, because it did not provide a useful basis for determining compliance with the Settlement Agreement. ▪ The Facility used other relevant data sources, such as reviews of notes, minutes of meetings, and documents such as the CAPs list and tracking sheets. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did present findings consistently based on specific, measurable indicators. o Did include measurement of the quality as well as presence of items. For example, for Section E.1, the review of monthly Council meeting notes did not just indicate that the meetings had occurred, but listed seven separate elements, such as having relevant agendas and trending data from the QA plan matrix. ▪ The Facility data identified areas in need of improvement. For example, for Section E.1, the Self-Assessment noted the need for improvements to the QA Matrix, and to the QA or Department data summaries to identify recommendations for systemic improvements or CAPs.
	Summary of Monitor's Assessment: Since the Monitoring Team's last visit, the Facility had made progress with regard to Section E: ▪ At the last visit, it appeared that the Quality Assurance (QA) system had matured to a point where many Settlement Agreement section leads were commenting on monitoring and CAP development in their section presentations. This time all sections were taking responsibility for quality and were including comments, indicating that quality improvement had become an integral part of the work of each discipline. ▪ The QA Plan had been revised to separate the QA Plan and the QA policy, creating a more defined process for monitoring quality. ▪ Work had continued on the QA Plan matrix to include measurement through the use of key indicators as well as the Quality Monitoring Tools. Work on key indicators was proceeding with careful thought and consideration, and it was good the Facility was delaying the collection of data until the set of indicators was clearly in place. ▪ The data inventory had progressed to include a column for the source of each entry and to create a searchable field allowing searches by source of data. ▪ A matrix for the monitoring tools had been added to track tools in use as they were revised. ▪ The number of CAPs increased from 21 to 43 at the time of the site visit, and nearly all 20 sections of the Settlement Agreement had at least one CAP in place. ▪ The process for regularly reviewing progress on CAPs at QA/QI Council meetings was in place and being followed. ▪ A CAP audit process had replaced the Section E monitoring tool, which had not proven useful in

	determining substantial compliance. While the CAP audit tool needed further development, it was already proving more useful than the old tool in determining compliance at least with regard to CAPs. Some of the areas that will need to continue to improve for the Facility to progress towards substantial compliance with the Settlement Agreement included the need for the Facility to: ▪ Develop and refine the draft Data Matrix to define how the key indicators will be measured as well as to set goals for the progress identified through the key indicators as well as the Quality Monitoring tools. ▪ Improve the CAP tracking sheet by including additional detail on when steps were completed and the date the CAP was considered complete. ▪ Add descriptors of the desired outcome of each CAP and the baseline from which that outcome was being measured.

#	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> Metric E.1.1: 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> Metric E.1.2: There were Facility policies that supported the State Office policy for quality assurance. ABSSLC -Quality Assurance Policy, revised 2/20/14 to separate the policy from the QA Plan. <u>QA inventory of data</u> Metric E.1.3: There was not a complete and adequate data inventory at the Facility, though it had been improved since the last. Metric E.1.4: The data inventory was current, though it remained in draft. The Facility produced a draft of a data inventory that identified data for many sections of the Settlement Agreement that could be used to identify trends related to the requirements of those provisions. The draft data inventory did not include data on key indicators (outcome and process) of	Noncompliance

#	Provision	Protocol	Compliance
		performance, selected by the QA/QI Council to track priorities. The list of key indicators remained under development. 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, although progress had been made in both descriptions of data and in indicating the source or data location. <u>QA Plan Narrative</u> Metric E.1.5: 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. Metric E.1.6: The QA plan narrative coupled with the QA Policy was complete, though work remained to be done of the attachments, such as the QA Plan Matrix and the Data Inventory. The QA Plan and policy together 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 not complete, but considerable work had been done to establish a comprehensive inventory; ▪ A comprehensive 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; and ▪ Descriptions of how CAPs were to be tracked. <u>QA Plan Matrix</u>: The QA Plan Matrix 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	

#	Provision	Protocol	Compliance
		section provisions of the Settlement Agreement as one indicator. This document resulted from a major, system-wide effort to connect key indicators of performance to the quality outcomes for people, and had been improved since the Monitoring Team's last by: ▪ Adding a QA Monitoring Tool Matrix to track the monitoring tools for each section of the Settlement Agreement, the most recent revision dates and any changes to sample size. Areas still in need of improvement included: ▪ There was no crosswalk or chart showing how the matrix contents related to the sections of the Settlement Agreement. ▪ 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. The latter is about how individuals will benefit. Both need to be measured as part of a good quality assurance system. However, the outcomes for the individuals should be the ultimate measure. Metric E.1.7: For the 20 sections of the Settlement Agreement, a set of key indicators was included for 20 of the 20 sections (100%), according to the Facility Self-Assessment. The QA Plan Matrix appeared to list key indicators for all, including Section T, which had been missing at the last review. The key indicators were primarily process indicators. The format of the QA Plan/Matrix included a space for indicating the indicator type, however, those spaces had not been completed. As a result the following metrics were not rated. ▪ Metric E.1.7.a: Of these ___, both process and outcome indicators were identified for (%) of the sections. ▪ Metric E.1.7.b: 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>: Metric E.1.8: the QA Monitoring Tool Matrix did not include self-monitoring tools/self-monitoring procedures for the 20 sections of the Settlement Agreement. Tools were not listed for Sections P, O, R, and U in the QA Monitoring Tool Matrix. Tools were not found in the document submission for Sections G, H, I, K, O, P, R and U. The QA Monitoring Tools Matrix did identify the frequency of monitoring, and the persons responsible for monitoring for each tool listed.	

#	Provision	Protocol	Compliance
		All Data Collected by QA Department Metric E.1.9: All data that QA staff members collected, based on monitoring tools were listed on the QA Plan matrix. All Items in QA Plan Matrix Also Appear in the QA Data List/Inventory Metric E.1.10: 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 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. All data in QA plan matrix were submitted and reviewed Submitted/Received: Metric E.1.11: Of the 19 items in the QA plan matrix (excluding Section E), 11 (58%) 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, H, I, K, O, P, R and U. did not have monitoring tools. Reviewed/Analyzed: Metric E.1.12: Of the 19 items in the QA plan matrix, for 11 (58%), documentation showed 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 those without monitoring tools as noted above. Some sections did not have tools in place, but did analyze data from internal monitoring tools/activities or data collected as part of ongoing operations. These included: ▪ Sections I, K and P did not have tools, but did have review and analysis of other data by the section lead; ▪ Sections H and G did not have tools in place, but may have been covered to some extent by the monitoring that was done for Section L. Implemented the QA Plan as Written Metric E.1.13: Of the 19 sections of the QA Plan narrative and matrix, the Facility implemented 11 (58%). Those that were not included the sections that did not have established tools as noted in the metrics above. QA Staff Assist Disciplines/Departments in Analysis of Data Metric E.1.14: Documentation and observation did not indicate that the QA staff assisted all disciplines in the analysis of data, or if there was no assistance provided, there was documentation that it was not needed.	

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		For the 19 sections of the Settlement Agreement (Section E excluded), for nine there was documentation indicating that QA staff had provided some assistance to the section leads with analysis either by participating in meetings or providing summaries. For those sections without documentation of assistance by QA staff (i.e., Sections G, H, I, K, L, N, O, P, R and U), 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. There was other data analysis, including work by committees, such as infection control and risk management, that did offer analysis as did trend reports analyzing data on topics such as incidents, allegations of ANE, injuries, and peer-to-peer aggression. As the QA Director and the Department section leaders work towards improving the self-monitoring tools, the Facility should be prepared to present to the Monitoring Team the following information on aspects of the self-monitoring tools: ▪ Metric E.1.15: 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.) ▪ Metric E.1.16: 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.) ▪ Metric E.1.17: 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).] ▪ Metric E.1.18: 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.)	

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		There had been significant progress in the development of the QA Plan, the QA Plan Matrix, the Data Inventory, and the addition of a QA Monitoring Tool Matrix, though they were still in need of additional work to achieve compliance. Not all sections of the Settlement Agreement had current monitoring tools, nor was there sufficient analysis of data to guide development of corrective actions. Therefore, 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 anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	<u>All data in the QA Plan Matrix are summarized, graphed and analyzed</u> Metric E.2.1: 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 and also associated trend reports that displayed data over time, and across the a-g categories included: Sections C, D, and F. ▪ Sections that had quarterly summaries, with some 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 J, K, L, M, Q, S, T, and V. ▪ Sections that 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 G, H, I, and N. ▪ Sections that had no summaries and no quality assurance data at all included Sections O, P, 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> In discussion with the QA Director it was learned that the method for documenting minutes of meetings between QA staff and discipline heads had changed in March 2014. The protocol or shell for the monthly meeting notes was presented and appeared to include prompts for the important elements of such meetings as listed in E.2.2. However, meeting notes in the new format were not available for most sections for both of the last two quarters. Since meeting notes were not available for this review, the following was based on a review of a sample of the data summaries and information included in the quarterly updates to the	Noncompliance

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		QA/QI Council. The sample included Sections D, F, Q, T, and V, where the quarterly updates referenced meetings between QA staff and discipline heads for the last two quarters: ▪ Metric E.2.2: Since the last onsite review, a meeting was reported at least twice for five of the sampled sections (100%) of the Settlement Agreement. Summaries prepared by the Program Compliance Monitors were included in the quarterly updates presentation in nine (90%). The one missing was for Section Q on 2/10/14. The following five topics were addressed in nine of the 10 (90%) summaries, though not always in the form of comprehensive and in-depth analysis: 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> ▪ Metric E.2.3: Since the last onsite review, during ten of the ten (100%) meetings, data were available to facilitate department/discipline analysis of data. This determination was based on the data presented at the quarterly review. <u>Data Were Reviewed/Analyzed</u> ▪ Metric E.2.4: Since the last onsite review, during ten of the ten (100%) meetings, data were reviewed and analyzed, though the depth of the analysis was questionable for some (e.g., Section V). ▪ Metric E.2.5: Since the last onsite review, during nine of the ten (90%) meetings, action plans (and/or CAPs) were created for systemic or individual problems as identified. The one that did not was Section T (reported in the 12/9/13 minutes). 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. In fact, often the meeting minutes did not clearly show analysis of the data, and the connection between the data and decisions about the need for corrective action. While there were CAPs or other action plans in evidence, they all addressed systemic, not individual issues. Generally whenever individual issues were encountered, they were referred to the individual's IDT. While referral to an IDT often makes sense, if a serious issue persists for an individual in spite of IDT efforts, a CAP should be considered to bring additional efforts to solving the problem. <u>QA Reports</u> Metric E.2.6: 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 reports were in conjunction with the department reports by section	

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		according to a schedule set forth by the QA/QI Council. In addition, at each council meeting, outstanding CAPs were reviewed. Metric E.2.7: Of the 20 sections of the Settlement Agreement, 20 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Metric E.2.8: Of the sections of the Settlement Agreement that were presented, none of 20 (0%) contained all of 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> Metric E.2.9: There was an adequate description of the QA/QI Council in the QA plan narrative. The narrative listed the Facility Director as chairing the QA/QI Council and listed the discipline heads and other key members, such as the Settlement Agreement Coordinator, as members. The narrative provided for additional department staff as necessary to attend or facilitate a discussion. <u>Schedule, Agenda, Attendance</u> Metric E.2.10: Since the last onsite review, the QA/QI Council met at least once each month. Metric E.2.11: Minutes from 10 of the 10 (100%) QA/QI Council meetings between 11/20/13 and 5/5/14 indicated that meetings occurred according to schedule or reasons for changes were documented. Metric E.2.12: Minutes from 10 of the 10 (100%) QA/QI Council meetings between 11/20/13 and 5/5/14 indicated that the agenda included relevant and appropriate topics. Metric E.2.13: Minutes from none of the 10 (0%) QA/QI Council meetings between 11/20/13 and 5/5/14 indicated that there was appropriate attendance/representation from all departments. The meeting rosters contained 38 names. From 20 to 30 of those staff attended the meetings. <u>Data and Analysis Presented</u>: Metric E.2.14: Minutes from none of the 10 (0%) QA/QI Council meetings since the last review documented that:	

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		▪ Data from QA plan matrix were presented. In general, data from self-monitoring tools were presented, as were trend analysis data in 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. <u>Recommendations and Action Plans</u>: Metric E.2.15: In 10 of the 10 QA/QI Council meetings (100%), recommendations and action plans were selected when appropriate to do so and were based on the data presented. Most discipline presentations included recommendations for or review of action plans or CAPs. In addition, committees reporting to the Council included recommendations for CAPs, and sometimes a recommendation came from a participant in the meeting. However, CAPs were not generated in every instance where data indicated an issue, particularly when a specific individual or home surfaced in trend reports as having a high number of incidents, and rationales for not addressing these identified issues were not provided. **Corrective Action Plans (CAPs)** <u>System for generating CAPs:</u> Metric E.2.16: A written description existed, indicating how CAPs would be generated, but it did not include all it should have incorporated. 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 otherwise need the oversight of the QA/QI Council. <u>CAP development</u>: Metric E.2.17: When considering the full set of 25 "open" CAPs, 25 (100%) appeared to have been chosen following the written description policy or procedure. <u>Content of each CAP:</u> Metric E.2.18: Of the sample of 15 CAPs reviewed by the Monitoring Team, 14 (93%)	

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		appeared to address the specific problem for which they were created. The one that did not was CAP #29, where the issue was not included on the tracking sheet. <u>CAPs contain all necessary components:</u> Metric E.2.19: Based on a sample of 15 CAPs, which represented 39% of the total of 38 CAPs: ▪ 15 (100%) included the actions to be taken to remedy and/or prevent the reoccurrence; ▪ None (0%) included the anticipated outcome of each action step; ▪ 15 (100%) included the person(s) responsible; and ▪ 15 (100%) included the time frame in which each action step must occur. Substantial improvements had been made in the adoption of a format for meeting notes between PCMs and discipline heads. The conduct and minutes of QA/QI Council meetings contained substantive data, graphs and analysis in most reports, and CAPs were more numerous, discussed at Council meetings, and addressed the identified issues. However, attendance at Council meetings was inconsistent; it was not clear that data was trended across time and across specified categories; the new system for completing meeting notes had not been fully established; and CAPs did not list a projected outcome for each step, an outcome for the CAP, and/or the baseline performance at the start of the CAP, making it difficult to determine whether progress was being made and whether the desired outcome had been achieved.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	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. A copy of the email was placed in the CAP notebook that was kept by the person in charge of the CAP. The date of dissemination was recorded in the CAP database. For purposes of scoring the following metric, a list of CAPs with dates as found on the emails used to disseminate the CAPs was provided: Metric E.3.1: Based on a sample of 15 CAPs, which represented 35% of the total of 43 CAPs: there was documentation that indicated: ▪ 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 since CAPs were disseminated as required. The Facility Self-Assessment found the same.	Substantial Compliance

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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: The Facility provided a list of 38 CAPs arranged by their assigned numbers with indications of which were open and which had been closed. A tracking list arranged the CAPs by numbers with the start date, the issue addressed, the action steps with due dates and persons responsible, and running notes on follow-up/modifications for each CAP. While the running notes were helpful in understanding when the CAPs had been discussed by the QA/QI Council and when they had been changed or had dates extended, it was not always clear when the various steps had been completed. CAPs were being discussed and reviewed at QA/QI Council meetings, particularly when a change was contemplated or the CAP was completed. Both the QA Director, during his regular CAP updates, and the discipline heads, during their quarterly presentations, addressed questions about implementation and progress. Metric E.4.1: Based on a sample of seven completed CAPs and eight in process CAPs, 11 (73%) were implemented and two (13%) were implemented in a timely manner. Those that did not appear to have been implemented were: ▪ CAP #29 had a start date of 1/23/14 and a target date for completion of 6/1/14. There were no notes in the follow-up columns or in the completed column to indicate that steps had been completed. ▪ CAP #32 had a start date of 3/10/14, with no notes to indicate whether or not implementation was underway, although at the time of the request for documents for this report, little time had passed. ▪ CAP #35 and #36 both had start dates of 1/6/14 and had been revised, but it was not clear from the tracking sheet that they had been implemented. Those that appeared to have been implemented timely were CAP #26 and #21, though it was not clear why CAP #21 had not been closed. Tracking CAP status: Metric E.4.2: There was a system for tracking the status of CAPs. Of the 38 CAPs being tracked by the Facility, all (100%) the tracking sheet indicated the status of the CAP and any action taken if a CAP had not been implemented. However, the tracking sheet did not record the dates of completion of the steps in each CAP, making it difficult to determine the timeliness and whether the steps were being implemented as designed. CAPs are Tracked and Managed: To assess compliance with the following metric, the Monitoring team reviewed the QA/QI Council 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. The QA/QI Council minutes included updates on CAPs in nearly every meeting including changes to ongoing CAPs, additions of CAPs, and number of	Noncompliance

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		CAPs outstanding. Metric E.4.3: The Facility QA Director: ▪ Did 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 for the sample of CAPs; and ▪ Did present this information to QA/QI Council at least quarterly as determined by a review of Council minutes. Although more work was needed, there has been substantial progress. The Facility should work on documenting the implementation of the steps (perhaps by including the date of completion on the tracking sheet for each step) and a date of closure. A description of the baseline and desired outcome also should be included on the tracking sheet, along with a method for testing whether the outcome had been achieved. As of this review, the Facility was not in substantial compliance.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	<u>Evaluate effectiveness of CAPs Including Outcomes and Timely Completion</u>: Using the same sample as for Section E.4, there were seven completed CAPs reviewed out of a total of 13. ▪ Metric E.5.1.a: For none out of seven completed CAPs (0%), documentation showed review of their effectiveness (i.e., outcomes). ▪ Metric E.5.1.b: for none out of seven completed CAPs (0%), documentation showed review of their timely completion. There were few notations on the tracking sheet to indicate when or whether the CAPs had been completed, though they showed as completed on a separate summary. In reviewing the Self-Assessment and the Presentation Book, it became clear that the details about the progress of a CAP were kept in separate folders for each CAP. When the Facility monitors CAPs, using the CAP Audit Instrument, they might have been reviewing the folder rather than the tracking sheet, resulting in more favorable outcomes of those audits when compared to this review. In future, either the tracking sheet needs to include more detail, such as the dates of completion for each step, or the entire CAP file will need to be presented to the Monitoring Team for review. <u>CAPs were modified when needed</u>: The same sample was used as for Section E.4. Metric E.5.2: Of the 11 CAPs that appeared to need modification, eight (73%) had been modified. The three that were not were: ▪ CAP #29: due dates had passed with no notations as to whether the steps had been completed; ▪ CAP #3: due dates had passed with no notations as to whether the steps had been completed; and	Noncompliance

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		▪ CAP #38: due dates had passed with no notations as to whether steps had been completed, except that revisions to the plan had occurred three months after the beginning of the CAP. However, dates for steps had not been changed. <u>Modifications/results are discussed at QA/QI Council</u>. Metric E.5.3: Based on a sample of seven completed CAPs and eight in process CAPs, nine (60%) 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>. Metric E.5.4: For none of eight (0%) modified CAPs, evidence was present to show the due dates had been met or an explanation was provided for any delays. For none of the eight (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. As a result the Facility was not in substantial compliance.	

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 004.2: 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 – Annual ISP Meeting Preparation Checklist, revised January 2014; o Section F: Integrated Protections, Services, Treatments and Supports monitoring form, revised January 2014; o The last 10 monitoring tools that the QIDP Department completed and the last 10 the QA Department completed; o Monthly Meeting Notes: Sections F and S, dated 12/17/13, and 3/26/14; o Corrective Action Plan – 16: ISPs are not filed in the chart within 30 days of ISP meeting, dated 10/9/13; o Draft Facilitator QIDP Training Itinerary, updated 10/7/13; o Draft Home QIDP Training Itinerary, updated 10/7/13; o In response to request for curriculum and training materials on the development of individuals' ISPs, the following statement: "There is no information for this request as there has been no competency-based training on the implementation of individuals' plans for staff responsible for implementation of ISPs;" o Draft Facilitation Skills (Tool 1 Idea Revised), undated; o In response to request for list of QIDPs deemed competent, the following statement: "There is no information for this request as tool measuring QIDP competency of facilitation of ISPs in not finalized; and there is no tool yet to measure QIDP competency in writing ISPs;" 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 Count of Assessments Filed on Time, between 4/10/13 and 3/31/14; o Annual Assessments Filed 10 Days Prior to the ISP by Assessment, for 4/10/13 to 3/31/14, 5/1/13 to 9/1/13, 9/1/13 to 2/28/14, and 2/28/14; o ISP Required Attendance Compliance graph, for 4/10/13 to 3/31/14;

	○ ISP Attendance – All Meeting Types, from 4/10/13 to 4/1/14; ○ 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; ○ Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda (ISPAs), Preferences and Strengths Inventory (PSI), IRRF, IHCP, Community Living Options Information Process (CLOIP) worksheet, skill acquisition and teaching programs, Rights Assessment, last three monthly reviews, daily schedule, and ISP Preparation Meeting documentation for: Individual #348, Individual #521, Individual #78, Individual #296, Individual #92, Individual #300, Individual #182, Individual #64, Individual #88, and Individual #307; ○ 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; ○ Template for monthly review, dated May 2013; ○ Community Activity Satisfaction and Skill Acquisition Program Report, dated 4/8/14; ○ Updated information on number/percentage of ISPs filed within 30 days; ○ Draft ISP and assessments for Individuals #411, Individual #4, and Individual #3; ○ ABSSLC Self-Assessment, updated 4/28/14; ○ Facility Action Plans for Section F; ○ Provision Action Information for Section F; and ○ Presentation Book for Section F. ▪ **Interviews with**: ○ Yvonne Chambers, QIDP Settlement Agreement Liaison; ○ Ellen Rogers, QIDP Educator; ○ Jolene Willis, Assistant Director of Programs (ADOP); and ○ Jeff Branch, Director of Active Treatment; ▪ **Observations of**: ○ ISP meeting for Individual #411, on 5/13/14; ○ ISP meeting for Individual #4, on 5/13/14; and ○ ISP meeting for Individual #3, on 5/14/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 4/28/14. 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 was not using a monitoring/auditing tool. Based on discussion with staff from the QIDP Department, different audits were completed for the Self-Assessment for Section F than for the internal quality improvement functions. It appeared that this was due to the need to complete the indicators that State Office required for Section F for the Self-Assessment, and the Facility's recognition that different indicators would be more helpful. Based on this discussion, the Facility was using the Section F: Integrated Protections, Services, Treatments and Supports monitoring

	form, revised January 2014, for its internal quality improvement processes, but the data from these efforts were not used in conducting the self-assessment. Rather, the QIDP selected another sample of ISPs for the self-assessment process, and just collected the information needed to fill in the State Office indicators for Section F. It is not a good use of staff's time to conduct separate audits for these two purposes. The self-assessment function is one that should outlive the Settlement Agreement, and should be functional for the Facility. The Facility should work with State Office to develop an audit process the results of which can be used for both the Self-Assessment and internal quality improvement processes. ▪ The Self-Assessment identified the sample(s) sizes. Generally, this 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 following staff/positions were responsible for completing the audit for Section F of the Self-Assessment: the QIDP Coordinator. As a result, inter-rater reliability could not be established at the Facility. It was unclear if State Office had made any attempt to establish inter-rater reliability across the 13 Facilities. ▪ The staff responsible for conducting the audits/monitoring had not been formally deemed competent in the completion of the Self-Assessment activities. Although the staff responsible had experience with developing and implementing ISPs, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. ▪ The Facility used other relevant data sources. For example, the Facility maintained a database to track the timeliness of assessments, as well as spreadsheet to track attendance at ISP meetings. Some of this information was included in the Self-Assessment. ▪ The Facility presented some of the data in the Self-Assessment in a meaningful/useful way, but improvements were needed in some areas. Specifically, on a positive note, the Facility's Self Assessment for Section F: o Consistently presented findings based on specific, measurable indicators. Areas requiring improvement included: o The Self-Assessment did not include indicators that consistently measured the quality as well as presence of items. It was not consistently clear whether or not the quality of the ISPs was being assessed. For example, it was unclear if issues related to the quality of assessments (e.g., not just listing preferences, strengths, and needs, but addressing them meaningfully), or the quality of team's discussion and recommendations related to community living options had been assessed. ▪ The Facility rated itself as being in compliance with five of the subsections of Section F. This was not 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 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, as well as reference to one CAP, but generally, the Facility Self-Assessment did not reference the Facility's Action Plans, or other plans to facilitate improvements.

	Summary of Monitor's Assessment: As noted in the last report, 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 Individual Support Plan (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. This model seemed to provide some advantages, such as the ability to provide more concentrated training and supervision to the different types of QIDPs, and to utilize staff's skills and interests better. However, staff will need to guard against the weaknesses of the system, such as the need for Home QIDPs to share their knowledge of the day-to-day events that impact annual planning for individuals with the Facilitator QIDPs, who generally do not know the individuals as well. 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. Although timeliness had improved, the quality of the assessments prepared for the annual ISP meetings continued to be problematic. 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 continued to become more measurable, 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). Since the last review, a group of QIDPs had met with the goal of improving the monthly review process. Based on review of the minutes of these meetings, the group raised a number of important questions and worked to identify practical solutions. A focus was placed on improving the quality of the monthly reviews, and making them efficient to produce and usable to all team members. In the weeks prior to the Monitoring Team's onsite review, a new monthly review template was implemented.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	In 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, and ISP Preparation Meeting documentation as available. The documents the Facility provided included the most recently developed ISPs from each residence on campus. From the ISPs the Facility provided, the Monitoring Team selected a sample of 10 ISPs from different Facilitator and Home QIDPs with a full review completed of this limited number of plans. As noted in the last report, 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, and were responsible for overseeing implementation of the ISPs, including completing monthly reviews. In order to provide the relevant feedback on these various components, the Monitoring Team selected10 plans that the QIDP Facilitators had developed with different Home QIDPs. There were five QIDP Facilitators, and at least one ISP for each was included in the sample, and wherever possible based on the plans provided, two were reviewed. However, of note, some of the QIDP Facilitators had left and new ones were hired, so the sample did not necessarily represent the current Facilitators. The sample also represented various interdisciplinary teams (IDTs) across campus. This sample included plans for: Individual #348, Individual #521, Individual #78, Individual #296, Individual #92, Individual #300, Individual #182, Individual #64, Individual #88, and Individual #307.	
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 #004.2 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. ▪ As noted in the last report, in September 2013, the Facility began using Facilitator QIDPs to facilitate ISP meetings, and Home QIDPs for other duties. Since the last review, an additional Facilitator position was added, and there was now a Lead QIDP Facilitator, and four QIDP Facilitators. ▪ 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 the Facility submitted, five Facilitator QIDPs were in place, and 14 Home QIDPs. There were three vacancies. According to the document,	Noncompliance

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		the range of individuals on Home QIDP caseloads was 13 to 24 individuals, and the range for the Facilitator QIDPs was 62 to 83 individuals. ▪ During the week of the review, the Monitoring Team observed the ISP annual team meetings for Individual #411, Individual #4, and Individual #3. Based on observations of team meetings and review of documentation, progress continued to occur with regard to the facilitation of meetings. 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 At times, the teams had more comprehensive discussions 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 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 the meetings observed, some of the positives included: ▪ The team for Individual #411 reviewed the IHCPs for the high and medium risk ratings. This allowed the team to ensure that the supports discussed were included in the IHCPs. ▪ Individual #411's team celebrated some accomplishments over the last year, including his stopping his use of snuff and improving his diet. ▪ Over the 54 years that Individual #411 lived at ABSSLC, he had developed relationships with the Maintenance Department staff. A member of the Maintenance Department attended his ISP meeting, and clearly had an excellent rapport with Individual #411 and advocated on his behalf. Individual #411 had lunch in the diner each day with Maintenance Department staff, and one of the staff regularly took him to medical appointments and to get haircuts. ▪ The QIDP Facilitator for Individual #4's ISP made several good	

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		attempts during the ISP to engage the team in discussions. ▪ Although Individual #3 and his staff attended the meeting via conference call due to the flu outbreak, team members frequently spoke directly to the individual and asked his opinion regarding increasing certain activities that he appeared to like. ▪ The team for Individual #3 discussed the IHCP after each of the health categories on the IRRF was discussed and rated. ▪ Although it appeared that the Nurse Practitioner for Individual #3 was unfamiliar with the Risk Level Guidelines regarding poly-pharmacy, the team members reviewed the Guidelines and appropriately recommended a rating of "high" in alignment with the clinical data. 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 three 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, it was no longer being used to assess competence. The Facility indicated no QIDPs had been deemed competent in meeting facilitation due to the lack of a tool to measure competency. As is discussed in more detail in relation to Section F.2.e, QIDP staff were developing a list of characteristics believed to be necessary for good facilitation of meetings, and although it was a good start, further work was needed to identify a list of measurable, observable behaviors that would demonstrate that the QIDPs had and were using the necessary skills and competencies for good facilitation. ▪ 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	

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		experiences, future opportunities, etc. Although some preferences were included in ISP action plans, they generally were incorporated into steps related to community activities, and were not necessarily used effectively to expand individuals opportunities for independence or growth. 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 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 the meetings the Monitoring Team observed, the following were some of the problems noted for which the Facilitator QIDPs did not provide guidance to the IDTs to correct or clarify:	

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		○ For Individual #411, the team did not discuss measurable goals for the IHCP. As a result, it was unclear how the team would know whether or not the supports developed were benefitting the individual. In other words, it was unclear how the team would know whether Individual #411 was doing better or worse, or remaining stable. ○ The team for Individual #411 did not develop action plans for supports for his low risk areas, despite his having needs for supports. For example, for skin integrity, the team rated him as being at low risk, but the IRRF included skin-related diagnoses and a list of supports (e.g., his skin being assessed daily, and moisturizer being provided). However, the team did not discuss an action plan to ensure these supports were provided. ○ Individual #411 demonstrated a number of behaviors that either prevented his integration in the community and/or had the potential to make it difficult for him to obtain needed supports and services. For example, he regularly used language and gestures that could be perceived as inappropriate and/or offensive. He also required assistance of specific staff (i.e., maintenance staff) to complete medical appointments, and would refuse to participate in medical appointments if other staff accompanied him. In addition, in recent years, he had experienced falls and fractures, and was at high risk for osteoporosis, but refused to use a walker. At the ISP meeting, the team, including Behavioral Health Services staff, did not set forth an assertive plan to address these areas of need. As Facility staff pointed out when these issues were discussed after the ISP meeting, as he ages, Individual #411 will likely need to attend more medical appointments, and work needed to be done to attempt to use existing relationships with maintenance staff to widen the scope of staff with whom he is willing to attend medical appointments. Similarly, the knowledge and expertise of Behavioral Health Services staff as well as the lengthy list of preferences should have been used to address his use of inappropriate language that would be unaccepted in community settings, and encourage use of the walker to prevent to the extent possible falls and fractures. Based on discussions with staff after the ISP meeting, the team had evidently met on several occasions to discuss the issue related to his refusal with the walker. However, this had not been shared with the QIDP Facilitator, and was not raised in the discussion at the ISP meeting. Although at the ISP meeting, the team discussed some ideas, no action plans actually were discussed or agreed upon to address these issues. The annual ISP meeting should not be viewed as a separate meeting, but rather a continuation of other discussions and planning already occurring for the	

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		individual throughout the year. In this case, the team should have summarized efforts already tried, discussed any data collected, and revised plans in place or developed new ones. o The team for Individual #4 had very limited discussions regarding her current SAPs and offered few ideas for SAP development. In addition, there were no recommendations for any assessments when determining if a SAP for tooth brushing or use of a water pik was appropriate and functional. o Although Individual #4 had fallen during a seizure and had fractured her nose and damaged some teeth, the team removed her enhanced supervision in the shower for rights restoration noting that: "staff were always with her" during this time. o The PCP for Individual #3 did not participate or contribute to any clinical discussions during the ISP meeting. o The IHCP discussions for Individual #3 did not include the proactive implementation of nursing protocols for his existing health conditions of aspiration, falls, and fractures. In fact, all nursing/protocols/ assessments were designated for implementation only after an acute event indicating that Individual #3 would have to become ill before warranting nursing assessments. o The direct support professional for Individual #3 was not included in any of the discussions, even though she was identified as one of his favorite staff members. 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 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	In Section II.A, DADS Policy #004.2 described the interdisciplinary team as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, 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	Noncompliance

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	meetings shall be dictated by the individual's preferences and needs.	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, and the data related to attendance for each individual in the Monitoring Team's sample. Based on data the Facility provided for ISPs held between April 10, 2013 and March 31, 2014, average attendance rates were between 74% and 91%. This data was broken down by discipline, and for the same time period, showed rates ranging from 0% 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. 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. ▪ Eight individuals had strengths, preferences, or needs that potentially required additional team member participation (i.e., the only two that did not were Individual #348 and Individual #521, for whom the team had properly identified the required team members). For none of these eight individuals (0%), the team had adequately justified why such team members' participation was not necessary. Examples of concerns have been noted in previous reports, and remained the same. ▪ For one of the 10 (10%) (i.e., Individual #300), 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 in 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	

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		attendance for some disciplines. However, because the QA/QI Council did not have access to valid data, some necessary improvements likely were not being initiated. 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 not requiring assessments related to individuals' specific needs. ▪ As noted in the last report, 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. According to the QA/QI minutes for the March 10, 2014 meeting, this CAP was closed because the goal was met. ▪ The Facility was tracking the timeliness of assessments. Based on the data generated for assessments filed between 2/28/14 and 5/1/14, significant improvement was noted with regard to the timeliness of assessments. The data was presented by discipline/type of assessment, and the range of timeliness was from 70% to 100%, with many falling an average of 93%. This was an improvement from the time period between 5/1/13 and 9/1/13 (i.e., the quarter preceding the previous review), when the range was 0% to 98%, with an average of 56%. Based on the Facility's data, when looking at the one-year period between 4/10/13 and 3/31/14, the average timeliness of assessments was 77%, with a range of 52% to 99%. Unfortunately, though as discussed below, the validity of the Facility's data was questionable. Areas of concern included: ▪ 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 assessments that appeared necessary, and teams had not provided adequate justification for not requiring them. ▪ As the Facility recognized, 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	Noncompliance

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		detail throughout this report with regard to the sections of the Settlement Agreement that address, for example, psychological services (Section K), 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. Since the last review, the Assessment Workgroup continued to meet to address the quality of assessments. This was a positive initiative, but clearly more work was needed. ▪ 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 one individual (10%) 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 was the team for Individual #300. For the remaining individuals, they had needs for which assessments were not requested, and the teams did not provide adequate justification for not requesting assessments. ▪ For none of the 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 was included in the ISPs to some extent. For all of the 10 individuals in the sample, some level of review of the incidents was completed. However, at times, this 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	

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		extent possible such incidents were in place and appropriately incorporated into the ISP. For four individuals (40%) (i.e., Individual #88, Individual #348, Individual #521, and Individual #300), teams adequately analyzed the information and/or identified areas in which changes might be made to attempt to reduce the frequency of such occurrences. The remainder either provided insufficient information in the ISP to show whether sufficient review occurred, or did not provide sufficient explanation of the protections already in place or to be added. The following provide an example of concerns noted: ▪ Individual #182 had five injuries related to peer-to-peer aggression. The team merely stated: "The peer-to-peer aggressions are usually retaliation against her. There were some environmental changes in which seating arrangements were changed. Staff continue to follow her BSP to help reduce potential aggression towards others and she does have a tendency to pick on others." This did not show good review of options, such as the need for her to live in a smaller environment or with other individuals, for more training to be done with staff of preventative techniques, review of the adequacy with which the BSP was being implemented, etc. 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 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 supports based on either assessment findings or the need to improve the configuration of services the individual required. To the extent possible, these	Noncompliance

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		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. 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.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. Based on the review of the sample of 10 ISPs, the following highlights some of the findings: ▪ In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation about the individual's appropriateness for a more integrated/less restrictive setting. In addition, at the ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the 10 ISPs reviewed, for none (0%), all of the assessments included the applicable statement/recommendation. 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 habilitation therapy for individuals with ongoing PNM needs). 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, 10 individuals' ISPs (100%) included a clear recommendation from the professionals on the team to the individual and LAR. However, for only three of these individuals (%) was adequate justification provided (i.e., Individual #78, Individual #348, and Individual #88). Many examples of problems have been explained in detail in previous reports, and should be referred to as Facility staff continue to work towards improvements in this area.	Noncompliance

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		○ 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 #64, Individual #300, Individual #296, Individual #78, Individual #348, and Individual #88, whose guardians chose not to pursue transition). Examples of concerns have been included in previous reports, and should be referred to as Facility staff continue to work towards improvements in this area. ▪ In the section below that addresses Section 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 or correct, 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 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	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below.	Noncompliance

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	explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004.2 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 current ISP process, the Facility was using the Preferences and Strengths Inventory. Based on review of the sample of ISPs: ▪ 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. Most often, they were integrated into action steps related to community trips or recreational activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, etc. As just one of many examples: o Individual #300 had a preference for playing Bingo, and an objective was for her to play Bingo in the community. Although only once a year, it showed incorporation of preference to expand community integration, which was good. However, the team missed other opportunities to meaningfully incorporate her preferences. For example, she had a number of barriers identified in relation to work, including refusals to attend or participate in work, but no discussion was documented to show staff considered incorporating preferences to improve her involvement. ▪ None of the individuals' teams (0%) had effectively incorporated their preferences into related action plans, 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	

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		expand individuals' horizons. ▪ None of the individuals' teams (0%) had effectively incorporated their strengths into related action plans. At times, lists of strengths had been expanded beyond activities of daily living or communication to include characteristics/qualities of the individual (e.g., Individual #300, who was described as having a good sense of humor and ability to get along with others, and Individual #521, who was easy to get along with and cooperative). 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, rationales were not 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. 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. For example, the ISP for Individual #300 identified barriers related to a lack of money to implement a skill acquisition program and her refusals to attend work, but did not include plans to address them. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ One of the 10 ISPs (0%) reviewed included specific skill acquisition plans for implementation in the community (i.e., Individual #307). 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 #182, Individual #300, Individual #92, and Individual #88). ▪ Ten of the 10 individuals' ISPs (100%) included at least one measurable objective to enhance individuals' general participation in the community. These	

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		varied in intensity from regular community activities to minimal opportunities. Although ABSSLC had made some progress, the Facility remained out of compliance with this provision. Teams were identifying some preferences and strengths of individuals, and the lists were growing. However, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. Some of the ISPs reviewed had action plans that addressed community skill acquisition 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	Noncompliance

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		developing the Integrated Health Care Plans. However, based on observations while on site, although teams were reviewing draft IHCPs and making changes to them during ISP meetings, they were not discussing measurable goals to determine the effectiveness of the plans. 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 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 #92, "continue her relationship with her counselor," or "continue to attend the Seniors program;" for Individual #296, "Continue Activity Center 6340" or "Skill Acquisition Plan – bathing;" for Individual #88, "encourage [individual] to go for walks," or "continue fostering relationships with family members;" or for Individual #78, "Provide opportunities to increase her drinking of fluids during mealtimes and snack…"). ▪ 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, but in other instances, it was unclear how the goal would be measured, by whom, and/or how often. The following provide just a couple of examples: o For Individual #296, a good individualized and measurable example was: "will be provided supports to assist in seizure activity as evidenced by less than 10 seizures in 12 months, but an example that was not measurable was: "will be provided with supports to prevent skin breakdown as evidenced by no significant skin breakdown within the next year." o For Individual #64, a good example was: "will be provided with supports to control seizure activity AEB [as evidenced by] less than 3 seizures in 12 months…" A poor example was: "will be provided an effective PNMP and nursing protocols that provides [sic] instruction for positioning and nursing methods to decrease risk of choking, aspiration, respiratory compromise, GI [gastrointestinal] problems and bowel management program AEB no choking, aspiration, respiratory issues or incidents in the coming year, absence of significant GI issues such as increase in vomiting, diarrhea and use of suppositories will decrease	

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		over the next year." ▪ Of ongoing concern, the objectives or actions steps for vocational and day program activities were extremely limited, and usually related to attending during certain hours (many of which represented part-time schedules without adequate justification), or "continuing" to work on specific projects or activities. Limited, if any, goals or objectives were targeted towards expanding individuals' day and vocational options or helping them to learn new skills. ▪ 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, and the nursing protocols were generally being used reactively as opposed to proactively. ▪ In most plans, although some limited improvement was seen, 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, 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.	Noncompliance

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		▪ The IHCPs did not consistently include the supports that the team identified in 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 consistently included, such as frequency of psychiatric clinics. ▪ 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..."	Noncompliance

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		However, a frequency was not provided. As a result, it was not clear how the team would know that proactive monitoring was occurring. ▪ In IHCPs, in some 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 sometimes were not provided. ▪ An issue related to the identification of staff responsible noted was the use of generic terms, such as "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 #64, the team included some clear methods (e.g., for constipation, list of daily assessments nursing would do), but then some were vague (e.g., provide opportunities for passive ROM [Range of Motion] to promote bowel motility; or "participate in Senior Citizens Program"); for Individual #300, a number were vague: "will be offered the opportunity to explore new contracts" or "DSP will assist in drinking the recommended fluid intake" or "will assist [individual] with exercise;" and for Individual #307, the team included some that were vague, such as "monitor fluids" or "dental desensitization plans," but some provided more direction, such as educate staff on universal precautions and skin	

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		care]. ▪ 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 not 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. ▪ 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, 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	All plans included some practical and functional interventions. In fact, the vast majority of skill acquisition plans identified functional skills to be taught. Some examples included training on the washing hands, putting on shoes or a belt, making phone calls, activating a switch to turn on a radio, making purchases, etc. Based on this review, teams appeared to be considering a wider variety of skills. However, 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	Noncompliance

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		objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. None of the 10 plans reviewed included a goal related to cooking. None of the plans reviewed included goals related to housekeeping, laundry, 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 #88 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.	
	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	Noncompliance

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		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. 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, aspiration diagnosis, 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 #411, the IHCPs were specifically discussed, but the team did not 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 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	As noted in 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	Noncompliance

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	treatments are coordinated in the ISP.	Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.2 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 6 ISPs reviewed, ISPs were found to have been written in the Flesch-Kincaid Readability Level range of 10.2 to 11.6, with an average score of 11.01… 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 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	Noncompliance

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		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 the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004.2 at III.A addressed ISP monthly reviews. 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. At ABSSLC, Home QIDPs were responsible for the completion of monthly reviews. Since the last review, a group had met with the goal of improving the monthly review process. Based on review of the minutes of these meetings, the group raised a number of important questions and worked to identify practical solutions. A focus was placed on improving the quality of the monthly reviews, and making them efficient to produce and usable to all team members. In the weeks prior to the Monitoring Team's onsite review, a new template was implemented. As the QIDPs generate some new monthly reports, mechanisms should be implemented to provide them with constructive feedback, so the resulting monthlies clearly summarize progress, and identify areas in which teams might need to reconvene to make changes. The Facility submitted just the monthly reviews addressing the ISPs submitted in the sample (i.e., not the monthly reviews for the previous ISP for the individuals in the sample). As a result of these being some of the newest ISPs completed, for a number of individuals, no monthly reviews were submitted, and for others only one or two were submitted. More specifically: ▪ Based on the sample of 10 records, monthly reviews were submitted for four individuals. ▪ Four of four (100%) had timely monthly reviews each the one or two months since their most recent ISP was completed. This included: Individual #64 (one monthly review), Individual #182 (one review), Individual #78 (two reviews), and Individual #88 (one review). ▪ 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 objectives at the end of the ISP document (i.e., not in IHCPs or other plans	Noncompliance

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		referenced in the ISP), and some brief updates on specific topics (e.g., incidents and allegations, updates to the PSI, etc.). No summary was provided with regard to various team members' review of "each program or support included in the ISP." Very brief and not always useful summaries were provided with regard to the action plans that were discussed. ▪ For none of the four individuals, a lack of expected progress was noted requiring action. As a result, the following was not applicable: For ___ of the ___ (___%) did it appear action was taken, and/or that the actions were sufficient to be reasonably expected to remedy the issues. 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. Moreover, examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to medical and nursing care, as well as physical and nutritional management supports. Although some progress had been made in timely monthly reviews, the Facility did not yet have an adequate monthly review process in place. The Facility remained out of compliance with this provision.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial	Previous reports have described training ABSSLC staff underwent with regard to the ISP process. 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 using the now updated 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 was developing a revised competency checklist. This is discussed in further detail below. ▪ ABSSLC was in the process of developing/updating training for the Facilitator	Noncompliance

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	employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	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. The QIDP Educator continued to develop new training materials. For example, in the documentation provided, Facility staff shared revisions to the quizzes used for QIDP training, which touched on a host of important information. 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. Since the last review, Facility staff had done more work to develop a competency checklist for facilitation. As discussed while on site, the items on the list of Facilitation Skills were essential to good facilitation. However, they will need to be defined using measurable indicators to allow objective assessment of various QIDPs' skills. Some work had been done in this regard. For example, "Planning for a team meeting" was a Facilitation Skill listed, and some examples were given, including on the checklist, but also on the second page (e.g., the question: "Assessments and their recommendations completed and pre-populated prior to the team meeting?). For objective measures to exist, criteria would need to be set using these various observable behaviors to determine when a QIDP had showed evidence of "Planning for a team meeting." This process would then need to be repeated for each of the identified Facilitation skills. The Facility is encouraged to work with State Office to develop a list that can be used across all Facilities. In addition, a similar checklist should be developed for the ISP document. ▪ 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. Based on interviews with QIDP Department staff, another Facility had sent a training document related to measurable goals, and the QIDP	

#	Provision	Assessment of Status	Compliance
		Educator was developing training on this topic. Based on review of the material from the other Facility, it presented some good examples of meaningful and measurable (i.e., observable) goals. As discussed with the QIDP Facilitators and other involved staff during the onsite visit, the Facility is strongly encouraged to provide training and mentoring to assist teams in the development of action plans that result in individuals leading full and meaningful lives with opportunities to learn new skills, participate in the community, and build on individuals' strengths and preferences. ▪ This section of the Settlement Agreement also states: "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. 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 as well as the quality of the resulting ISPs, 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.	
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, since November 8, 2013, two individuals had been admitted or readmitted to the Facility. Both individuals' 30-day ISP meetings (100%) had been held within 30 days of their admission. Based on data the Facility provided, 368 ISP meetings were held over the last one-year period between May 15, 2013 and May 14, 2014. No ISP meeting occurred after the 365-day timeline. This resulted in a compliance rate of 100%. The Facility tracked the dates that ISPs were completed and filed. For the last one-year period between May 15, 2013 and May 14, 2014, of the 368 ISP meetings held, 25 ISPs were being finalized and had not yet met the 30-day deadline. Of the remaining 343, 251 plans were filed within 30 days after the ISP meeting. The compliance rate was 73%. As noted in the last report, 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, the Facility had assigned Facilitator QIDPs and Home QIDPs. Beginning in September 2013, the Facilitator QIDPs became responsible for	Noncompliance

#	Provision	Assessment of Status	Compliance
		facilitating the ISP meetings, and finalizing the ISP documents. This appeared to be having a positive impact on the timely completion of the documents. Another positive step the Lead Facilitator QIDP took was to develop a calendar for the three new Facilitator QIDPs to assist them in scheduling so that they could stay ahead of deadlines. 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. Since the last review, an interdisciplinary group had met (e.g., from the QIDP, Behavioral Health Services, Habilitation Therapies, and Active Treatment) to design a training calendar, which seemed to be a reasonable starting point. A system also was needed to document 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 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 #004.2 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ A 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. ▪ At the time of the review, ABSSLC was using a revised version of the Section F: Integrated Protections, Services, Treatments, and Supports audit tool, revised January 2014. 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. ▪ As discussed in relevant sections above, in early September 2013, the QA/QI Council initiated Corrective Action Plans related to the timely completion and filing of ISPs, and the timely submission of assessments. At the 3/10/14 QA/QI Council meeting, it was decided that the CAP on assessment timeliness had achieved its goal and would be closed, but that while progress had been made, the CAP related to timely completion and filing of ISPs would continue. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ Based on discussion with the QIDP Department staff, different audits were completed for the Self-Assessment for Section F and for the internal quality improvement function. It appeared that this was due to the need to complete the indicators that State Office required for Section F for the Self-Assessment, and the Facility's recognition that different indicators would be more helpful. It is not a good use of staff's time to conduct separate audits for these two purposes. The self-assessment function is one that should outlive the Settlement Agreement, and should be functional for the Facility. The Facility should work with State Office to develop an audit process the results of which can be used for both the Self-Assessment and internal quality improvement processes. ▪ For the audit tool, according to the data presented inter-rater reliability had been established for many questions. However, it was unclear whether or not the Facility had established a process to assess inter-rater reliability between the multiple staff responsible for monitoring activities. More specifically,	

#	Provision	Assessment of Status	Compliance
		although inter-rater reliability scores were produced, it was not clear whether inter-rater reliability was being established between all staff responsible, or whoever 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. ▪ 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 Monthly Meeting Notes for Sections F and S, dated 12/17/13, 3/26/14, and 4/30/14, and Corrective Action Plan #16. In the Presentation Book, the Facility also provided copies of QA/QI Data Summaries, and presentations to the QA/QI Council. On a positive note, the QA/QI Data Summaries summarized data from both the QIDP Department and the QA Department. The QA/QI Data Summaries provided data in graph format, and also summarized the data from the audit tools, as well as the inter-rater reliability scores. Although the majority of the summary was a description of the data (i.e., indicators that fell below the "preset" cutoff of 70%), some limited analysis of the data was beginning to be conducted. Much more was needed, particularly to assist in identifying underlying causes for the problematic trends. The recommendation section included some broad recommendations, such as continuing to meet to address inter-rater reliability, and developing corrective action plans to address deficient areas, such as action plans. ▪ The Quarterly Section Reviews provided narrative information that was helpful in identifying accomplishments, challenges, and priority areas for the upcoming quarter. However, except in relation to timeliness of assessments and attendance at ISP meetings, 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 maintained 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 Presentation Book for Section G; o For morning medical meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for following dates: 5/5/14 to 5/9/14; o For hospitalizations in prior six months, copies of follow-up Individual Support Plan Addendum (ISPA) for the following individuals: Individual #138 1/3/14, Individual #281 1/7/14, Individual #162 1/30/14, Individual #452 1/30/14, Individual #468 1/30/14, Individual #394 2/1/14, Individual #86 2/5/14, Individual #385 2/13/14, Individual #145 2/11/4, Individual #409 2/13/14, Individual #434 2/28/14, Individual #145 2/27/14, Individual #452 3/20/14, Individual #2 2/26/14, Individual #285 3/12/14, Individual #540 3/17/14, Individual #359 3/20/14, and Individual #1 3/7/14; 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 (medicine and surgery inclusive of subspecialties (agreeing or reason not agreeing)) and any ISPA related to the consultant report: Individual #332 Neurology 3/10/14, Individual #332 Podiatry 3/18/14, Individual #332 Cardiology 3/6/14, Individual #386 Neurology 10/14/13, Individual # 386 Optometry 11/13/13, Individual #386 Neurology 12/16/13, Individual #386 Neurology 1/14/14, Individual #386 1/20/14, Individual #386 Neurology 1/27/14, Individual #386 Neurology 2/24/14, Individual #386 Urology 3/7/14, Individual #386 Neurology 3/10/14, Individual #386 Ophthalmology 3/19/14, Individual #386 Neurology 3/24/14, Individual #386 Neurology 4/14/14, Individual #386 Ophthalmology 4/16/14, Individual #515 Podiatry 10/15/13, Individual #515 Podiatry 2/18/14, Individual #515 Neurosurgery 2/28/14, Individual #515 Pulmonology 3/28/14, Individual #515 Gastroenterology 4/1/14; Individual #541 Cardiology 10/2/13, Individual #541 Gastroenterology 10/29/13, Individual #541 Cardiology 11/14/13, Individual #541 Podiatry 12/17/13, Individual #541 Urology 1/3/14, Individual #541 Cardiology 2/13/14, Individual #541 Dermatology 2/20/14; Individual # 359 Neurology 10/14/13, Individual #359 Podiatry 10/15/13, Individual #359 Dermatology 10/17/13, Individual #359 Neurology 10/28/13, Individual #359 Dermatology 11/21/13, Individual #359 Neurology 2/10/14, Individual #359 Dermatology 3/20/14, Individual #27 Hematology 10/22/13, Individual #27 Hematology 10/24/13, Individual #27 Hematology 10/30/13, Individual #27 11/19/13, Individual #27 Gastroenterology 12/20/13, Individual #27 Neurology 3/24/14, Individual #304 Neurology 10/14/13, Individual #304 Podiatry 10/15/13, Individual #304 Surgery 1/23/14, Individual #304 Neurology 1/27/14, Individual #304 Hematology 3/4/14, Individual #304 Hematology 4/7/14, Individual #304 Neurology 4/14/14, Individual #304 Gastroenterology 4/16/14, Individual #138 Ophthalmology 10/10/13, Individual #138 PNMT 1/14/14, Individual #138

	Gastroenterology 3/5/14, Individual #138 Podiatry 3/18/14, Individual #138 Gastroenterology 4/8/14, Individual #334 Neurology 10/14/13, Individual #334 Podiatry 1/21/14, Individual #334 Podiatry 2/18/14, and Individual #334 3/18/14. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; and o Elizabeth Greer, RN, Medical Program Compliance Monitor.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility did not use monitoring/auditing tools for Section G.1. The Medical Records Department completed a monthly audit for Section G.2. 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: a review of Primary Care Practitioner and Interdisciplinary Team follow-up to consultant recommendations. o These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. There was no monitoring of the quality content of any IDT response when the IDT was asked to meet concerning a consultation. There was also no information concerning the acceptable time interval between when the team was notified to review the consultant report and the maximum time allotted before providing a response. o The monitoring tools included adequate methodologies, such as record reviews. o The Self-Assessment identified the sample 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 was not adequate to consider them representative samples. The Monitoring Team's findings and the Facility's findings differed, and this might have been due to the small sample size relative to the size of the Facility. o It could not be determined whether the monitoring/audit tools had 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: Medical Records Department staff. 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 at times, but inaccurate at other times. Adequate attendance at morning medical meetings was not calculated based on the appropriate number of required meetings per month for that discipline, but was calculated on the number of meetings for the month. Examples of databases/data sources that were not considered as part of the self-

assessment included monitoring the follow-up of post-hospital ISPAs for quality content and completion within five days of hospital discharge, morning medical meeting tracking of timeliness of closure of open record reviews and other concerns, with a summary of resolved and outstanding/open items at the end of each month.

- The Facility presented some data in a meaningful/useful way, but some concerns were noted. Specifically, the Facility's Self-Assessment:
  - Included self-explanatory tables;
  - Presented findings consistently based on specific, measurable indicators;
  - Did not measure the quality as well as presence of items; and
  - Did not distinguish data collected by the QA Department versus the program/discipline or other departments, such as the QIDP Department.
- The Facility rated itself as being in noncompliance with Section G. This was consistent with the Monitoring Team's findings.
- The Facility 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 need to track response to consultant recommendations.

Summary of Monitor's Assessment: For Section G, the Facility tracked attendance at a number of interdisciplinary meetings. Attendance at the morning medical meeting was tracked, as well as other meetings, such as Infection Control, Restraint Reduction, Medication Variance, and Pharmacy and Therapeutics Committee meetings. However, holding these committee meetings did not result in integrated care, particularly when the percentage of participation and representation of departments was low. The morning medical meeting business was tracked by thorough minutes. However, several areas needed to be tracked to ensure integrated clinical services, such as Individual Support Plan Addendum development. The Facility had not successfully developed post-hospital ISPAs in a timely manner, and with content sufficient to address prevention of recurrence and prevention of repeat hospitalization to the extent possible. Other concerns needing closure were assigned, but not tracked to closure. Primary care providers and interdisciplinary teams' follow-up to consultant recommendations needed tracking.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals	For the time period two weeks prior to the Monitoring Team's visit, the Facility submitted the attendance at the morning medical meetings. This was not confirmed by reviewing attendance rosters separately. The time period was 4/28/14 through 5/9/14. Ten days of morning medical meetings occurred during that two-week time interval.	Noncompliance

Department	# Days Attended	Department	# Days Attended
Nursing Administration	8	Infirmary	10
Hospital liaison	8	Infection Control	2
Habilitation	10	Physical and	10

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<tr><td></td><td>receive the clinical services they need.</td><td>
<table>
<tr><td>Therapies</td><td></td><td>Nutritional Management Team</td><td></td></tr>
<tr><td>QIDP</td><td>6</td><td>Residential</td><td>9</td></tr>
<tr><td>Dietary</td><td>0</td><td>Quality Assurance/Quality Improvement (QA/QI)</td><td>3</td></tr>
<tr><td>Chaplain</td><td>0</td><td>Pharmacy</td><td>10</td></tr>
<tr><td>Psychology</td><td>0</td><td>Psychiatry</td><td>3</td></tr>
<tr><td>Dental</td><td>10</td><td>Medical</td><td>10</td></tr>
<tr><td>Incident Management</td><td>0</td><td>RN Case Manager</td><td>0</td></tr>
<tr><td>Medical Compliance RN</td><td>10</td><td></td><td></td></tr>
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The following information summarizes the contents of the morning medical meeting minutes for the week of 5/5/14 through 5/9/14, the week prior to the Monitoring Team's visit:

The number of meeting minutes totaled five.
Four of five (80%) meetings included a submitted attendance roster.
Five of five (100%) minutes/addenda included discussion of the Campus Coordinator Log.
Five of five (100%) minutes included discussion of the on-call provider report.
Five of five (100%) minutes/addenda included a report by the Hospital Liaison Nurse.
Three of five minutes documented the appointment/assignment of a member of the morning meeting to review the open record for seven or more days prior to the hospitalization/ER visit.
Four assignments were documented for these three meeting minutes.
Five of five (100%) minutes included a discussion concerning Infirmary admissions.
The Infirmary census for the week ranged from six to 10 admissions.
The hospital census was discussed at five of five (100%) meetings.
There were from three to nine hospitalized individuals on each of the days reviewed.
Two of five minutes included discussion of results of an open record review. There were two open record reviews.
From the information submitted to the Monitoring Team, no concern needing closure (other than post-hospital ISPA and open record reviews) was assigned during the five meetings. The Medical Department identified zero concerns that

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#	Provision	Assessment of Status	Compliance
		had been assigned during this time period. ▪ Zero meeting minutes included additional information provided through a Medical Director announcement. ▪ Zero meeting minutes included discussion and resolution of closure items (other than post-hospital ISPA and open record reviews). ▪ Zero chemical restraints were reviewed during the five meetings. ▪ Zero meeting minutes reviewed ISPAs as part of the non-hospital closure process at the medical morning meeting. ▪ One of five meeting minutes reviewed consult reports, as well as whether scheduled consults were not completed. A total of four consults were reported or updates provided as to status of the consultation. ▪ One of five meeting minutes recorded a PNMT report. ▪ Zero of five meeting minutes recorded a Habilitation Therapies report. ▪ Zero of five meeting minutes included information provided by the Dental Department. ▪ Two of five meeting minutes included an update by the Infection Control Nurse. ▪ Zero of five meeting minutes recorded a skin integrity report. ▪ Zero of five meeting minutes recorded a report of any individuals with significant weight gain or loss. ▪ Significant interdisciplinary and critical clinical discussions were recorded in three of five meeting minutes. The Medical Department was asked to provide data for all of the areas listed above. Review of the Medical Department's analysis of the information showed several areas of agreement with the Monitoring Team's analysis of the same minutes. However, there were a number of discrepancies, and these might have been due to interpretation of the minutes and handouts provided. Overall, the meeting minutes clearly reflected the contents and activity of the morning medical meeting. The minutes captured detail in some of the discussions. However, overall, there needed to be a change in format to reduce the time utilized in creating minutes, as well as the length of the documents. The Medical Department is encouraged to explore alternative template options in compiling the contents of the morning medical meeting discussions, assignments, and reports. The attendance at the morning medical meeting was tracked per month. A table labeled "Morning Medical Meeting Attendance Tracking October 2013 – March 2014" provided the monthly attendance rate by discipline. Attendance was mandatory for the Nursing and Medical Departments, and the table indicated 100 percent attendance by these departments in the prior six months. For the other departments, the percentages listed did not take into account the required frequency at these meetings. Determining the number of required meetings per month per department would be required in order to compute the percentage of required meetings attended.	

#	Provision	Assessment of Status	Compliance
		Attendance at other meetings was also tracked for interdisciplinary participation. These included the Restraint Reduction Committee, the Infection Control Committee, the Skin Integrity Committee, the Pharmacy and Therapeutics Committee, the PNMT Committee, the PNMT/Physician Liaison Conference, the Medication Variance Committee, and the Psychiatric Polypharmacy Committee. Attendance was tracked for the Medical Department participation in these committees, except the PNMT committee. The following information was extracted from various graphs provided in the Presentation G Book:	

ABSSLC Committee	Attendance by Medical Staff Representative
Restraint Reduction Committee	0%
Infection Control Committee	50%
Skin Integrity Committee	0%
Pharmacy and Therapeutics Committee	100%
PNMT/Physician Liaison Conference	100%
Medication Variance Committee	25%
Psychiatric Polypharmacy Committee	17%

For these committees to be considered interdisciplinary, and provide evidence of integrated clinical services, representation by the Medical Department will need to increase in five of seven of these committees. When a list of departments attending each of these committees was reviewed, several departments' low level of attendance illustrated concerns related to the use of an integrated clinical approach to providing services.

The Facility submitted ISPAs generated for hospitalizations that occurred during the 30-day time period of 15 through 45 days prior to the Monitoring Team's visit. Documents were submitted for post-hospitalization ISPA/Integrated Health Care Plan (IHCP) involving 18 individuals. These were reviewed to determine the reason for hospitalization, evidence of a record review for events prior to the hospitalization, evidence of identification of new triggers as early signs and symptoms of illness, evidence of recommendations to increase monitoring of specific parameters, and additional steps implemented to reduce the risk of recurrence of illness and hospitalization.

Based on the clinical needs of the individual, not all individuals needed additional action steps/processes as part of the IDT review. However, the IDT did demonstrate one or

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more processes in a number of cases. The findings included the following:

The IDT identified new triggers or early signs/symptoms in zero of 18 individuals.
The IDT identified the need for increased monitoring in one or more aspects of care in three of 18 individuals.
The IDT identified the need for additional testing in two of 18 individuals.
The IDT identified the need for additional consultation in 10 of 18 individuals.
The IDT identified the need for additional treatment in three of 18 individuals.
The IDT identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization in two of 18 individuals.
The IDT identified other specific interventions not further categorized in four of 18 individuals.
Thirteen of 18 were hospitalized for acute respiratory illness.

Ten of these 13 needed further critical discussion of triggers, monitoring needs, additional tests or consultants, etc., to prevent a re-hospitalization than what the IDTs discussed and included in the ISPAs.

Fourteen of 18 ISPAs appeared to miss significant opportunities in discussing additional steps to prevent reoccurrence.
The time from discharge from the hospital to the creation of the initial ISPA was within five days in 11 of 17 (65%) ISPA submitted.

One individual had not been discharged from the hospital at the time of the data submission.

A graph was submitted entitled “Post-hospital Admission ISPA Completion Rate (after emergency transfer) Jan-Mar 2014.” The date of this graph was not indicated. This indicated the following completion per month:
<table>
<tr><th>Month</th><th>% Completion</th><th>Month</th><th>% Completion</th></tr>
<tr><td>January 2014</td><td>78%</td><td>March 2014</td><td>56%</td></tr>
<tr><td>February 2014</td><td>69%</td><td>Average 1st Q</td><td>68%</td></tr>
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The Medical Department was asked to submit documentation of closure to morning medical meetings for the time period 30 to 60 days prior to the Monitoring Team’s visit. The Facility indicated that no tracking system to identify concerns needing closure was utilized at the morning medical meetings.

Attendance at ISP meetings was one measurement of integrated clinical services. Information was forwarded from the QA and QIDP Departments, and was not confirmed by separately submitted evidence. However, the following provides information for
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#	Provision	Assessment of Status	Compliance

several clinical departments (i.e., the number of ISPs per month that were required attendance for each department, followed by attendance rate per required ISPs per month):

Department	February 2014 # ISPs Required to Attend	February 2014 % Required ISPs Attended	March 2014 # ISPs Required to Attend	March 2014 % Required ISPs Attended	April 2014 # ISPs Required to Attend	April 2014 % Required ISPs Attended
Medical	21	52%	19	58%	15	53%
Dental	12	92%	10	90%	11	91%
Pharmacy	0	NA	0	NA	0	NA
Psychiatry	14	100%	10	100%	11	100%
Nursing	30	100%	27	100%	29	100%
OT	15	100%	9	100%	11	100%
PT	17	94%	8	88%	7	57%
Speech	17	88%	12	83%	14	71%
Psychology	19	89%	16	94%	17	94%
Dietary	18	33%	12	92%	17	59%

Separately, a submitted table entitled: "ISP Monthly Attendance by Discipline 10/1/13 - 3/31/14 – all meeting types" listed the attendance numbers and percentages per month and as a total for each department. The following provides this information for the prior six-month period (October 2013 through March 2014):

Department	# Required Meetings	# Meetings Attended	% Required Meetings Attended
Medical	111	63	57%
Dental	68	52	76%
Pharmacy	1	0	0%
Psychiatry	47	42	89%
Nursing (RN CM)	168	166	99%
OT	74	67	91%
PT	80	65	81%
Speech	80	64	80%
Psychology	92	84	91%
Dietary	89	52	58%

Some departments appeared to achieve participation at over 90 percent of required

#	Provision	Assessment of Status	Compliance
		meetings. Other departments needed additional supports and assistance in order to participate in required meetings. The more recent three-month data indicated improvement in attendance by the Dental Department and the Psychiatry Department in achieving 90 percent attendance, but the other departments continued to have a challenge in achieving this level of attendance. The Facility remained in noncompliance with this provision.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Facility submitted consultant reports for two individuals from separate residences on each PCP caseload. Information requested included any Integrated Progress Notes (IPNs) commenting on the consultant reports. Consultations for nine individuals were submitted, with a range of three to 13 consultations per individual. A total of 58 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 58 reviewed, 53 (91%) included the PCP initials, indicating review by the PCP. ▪ Of the 58 reviewed, 53 (91%) 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 ISPAs were requested. When submitted, these were reviewed. o Of the 58 reviewed, 55 would require a comment of agreement or non-agreement with documented rationale. Forty-eight of 55 (87%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of these, 54 of 58 did require PCP IPN entries. Forty-eight of 54 (89%) included PCP IPNs. ▪ Of these, there was evidence that the IDT was asked to meet to develop ISPAs in six of 58. The IDT was informed a meeting was not necessary in 14 of 54. A total of 20 of 58 (34%) PCP IPNs provided guidance as to whether the IDT needed to meet. There was no information for 38 of 58 consultations as to whether the PCP indicated the need or not for IDT review and discussion. • In addition to the six referrals to the IDT for ISPAs, there were an additional three consultations that would have been appropriate for review by the IDT, but were not referred. • Of these six referrals for ISPA development by the IDT in response to a consultant report, two of six (33%)	Noncompliance

#	Provision	Assessment of Status	Compliance
		ISPAs were submitted for review. No evidence was provided to determine whether the IDTs met to develop ISPAs in the other four referrals. The external medical peer review audit process also occurred at the Facility in October 2013 and April 2014. Two indicators in the audit addressed certain aspects of the consultation process. The two indicators reviewed included Indicator #45: "Medical and or surgical consultant recommendations addressed in IPNs," and Indicator #46: "There is a clear explanation in the Integrated Progress Notes as to why the PCP has chosen to not implement the recommendations." Of the 22 records reviewed, there was 100 percent compliance for both indicators at each audit. Separately, a Section V monitoring tool was used for an audit between 2/1/14 and 3/31/14. This audit included indicators added to the Section V monitoring tool in 1/2014. A copy of the audit tool was not submitted, but the six areas reviewed were defined in the review. Ten records (i.e., 2% sample) were randomly selected. The QA Program Compliance Monitor for the Records Department reviewed four of 10 for inter-rater reliability. The six indicators reviewed included: Consult report was reviewed by a provider, IPN completed, IPN documents provider agreement or not, IPN documents reason if there is non-agreement, orders were written as applicable, and there was notation indicating whether or not the provider referred the consultation to the IDT for review. There was 100 percent compliance and 100 percent inter-rater reliability. It was noted that this audit was continuing to take place monthly, with a sample size of five records. Overall, the external audit results were not dissimilar in magnitude to the Monitoring Team's results, but the Monitoring Team's results did not show substantial compliance. The external audit did not review some areas that the Monitoring Team audited. For the Section V tool, there were significant differences in findings with the last clinical indicator (i.e., whether or not the provider referred the consultation to the IDT for review). The reason was not determined, but may have been due to sample size. A two percent sample conducted by the Medical Records Department might not have been sufficient to capture the variation across PCP practice patterns. It was noted that a statewide "Consults Tracking Database" was being adopted into the information technology process at ABSSLC, but had not been accomplished at the time of the Monitoring Team's visit.	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H; o For four individuals from each PCP's caseload, four diagnoses identified from the active problem list of the most recent annual medical assessments, with criteria for justification from the active record, for the following individuals: Individual #49, Individual #458, Individual #538, Individual #95, Individual #361, Individual #212, Individual #353, Individual #432, Individual #4, Individual #304, Individual #262, Individual #25, Individual #242, Individual #535, Individual #63, Individual #240, Individual #415, Individual #493, Individual #443, Individual #515, Individual #411, Individual #269, and Individual #104. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; and o Elizabeth Greer, RN, Medical Program Compliance Monitor.
	Facility Self-Assessment: For Section H, in conducting its self-assessment: ▪ The Facility 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 external and internal medical peer review quality assurance audit, the external and internal medical management audits, Medical Department internal quality assurance audits for GERD, constipation, aspiration pneumonia, etc. o These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews. 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). These sample sizes were adequate to consider them representative samples for the general medical audit, but might have been too small a sample size for the medical management audits. o The following staff/positions were responsible for completing the audit tools: external medical peer and internal medical peer reviewers. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used some other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached, but data also was missing. The quality of the

	data maintained in the databases was noted to be complete and accurate. Examples of databases/data sources that were not considered included tracking tests/evaluations for secondary causes of osteoporosis, tracking evaluations of those with respiratory distress, and tracking of diagnoses to ensure the criteria met national standards. ▪ The Facility, at times, did not present/provide data in a meaningful/useful way. Specifically, the Facility's Self-Assessment narrowly addressed issues by using the medical peer review audits only. Other requested documents indicated the lack of availability of data or lack of understanding of the requests when gathering information. For example, the Pharmacy Department did not provide the number of routine medications prescribed for constipation, but added the pro re nata (as needed) (PRN) medications to this list, and the dental annual assessment log did not include the prior dates of completion for the last quarter of 2013. In addition, the Facility: o Presented findings consistently based on specific, measurable indicators. o Measured some areas with quality indicators, but did not measure the quality as well as presence of items in other instances. ▪ The Facility rated itself as being in substantial compliance with Section H.2. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need to expand the number of audit tools to encompass the breadth of medical services provided.
	Summary of Monitor's Assessment: For Section H, a number of assessments were tracked for timely completion and submission. The completion and timeliness of departmental assessments for ISP development were tracked for all clinical departments. For the Medical Department, the annual medical assessment timely completion rate had improved, but was still not attaining a 90 percent threshold. The quarterly medical reviews also were progressing in timely completion. Dental annual assessments were completed in a timely manner. Numerous audit tools were developed to determine whether or not appropriate evaluations were taking place (e.g., tests ordered at a certain frequency based on a diagnosis). National standards often were used as clinical guidelines to ensure the PCPs were ordering the correct test at the correct time. However, there was less monitoring to determine the outcome of health rather than simply the PCP ordering tests. The Facility should have data that allows assessment of the degree of health by individual and by diagnosis. Additionally, once test results are available or once an exam is completed with abnormal findings, the Facility should use a monitoring tool to determine adequacy and timeliness of the PCP response to the abnormal findings.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Several routine and periodic assessments were reviewed for timeliness in submitted documents for several clinical departments. These included the following: ▪ Two hundred fifty four of 358 (71%) medical annual assessments in the past year were completed in a timely manner. ▪ For 31 of 36 (86%) of the most recent medical annual assessments, completion occurred within 365 days of the prior assessment. ▪ A review of six active records indicated that a medical annual assessment completed in the prior 365 days had been submitted in five of six (83%). ▪ One hundred twenty eight of 134 (96%) annual dental evaluations reviewed were completed in a timely manner. Departments were required to submit completed annual assessments 10 days prior to the ISP meeting date. Information was obtained from the QIDP Department in determining timely submission rates for several clinical departments, and was as follows:	

Department	February 2014 Annuals Submitted Timely	February 2014 % Annuals Completed Timely	March 2014 Annuals Submitted Timely	March 2014 Annuals Completed Timely	April 2014 Annuals Submitted Timely	April 2014 Annuals Completed Timely
#ISPs	32		28		29	
Dental	32	100%	28	100%	29	100%
Medical	28	88%	25	89%	26	90%
Pharmacy	30	97%	28	100%	29	100%
Psychiatry	14	82%	12	92%	13	100%
Nursing	31	97%	28	100%	29	100%
OT/PT	3	50%	4	80%	1	100%
Speech	11	100%	5	100%	8	80%
Psychology	15	85%	19	90%	15	80%
Dietary	30	94%	28	100%	28	100%

Separate data was provided in a document entitled: "Count of Assessments Filed on Time Between 10/1/13 and 3/31/14." The raw numbers of required assessments in the prior six months indicated the level of activity required by each of the departments for preparation of the ISP process. The following lists this information, along with percentage compliance:

Department	# Assessments Filed on Time	# Assessments Required	% Compliance with Timely Completion and Submission

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Dental</td><td>173</td><td>176</td><td>98%</td></tr>
<tr><td>Medical</td><td>153</td><td>177</td><td>86%</td></tr>
<tr><td>Pharmacy</td><td>174</td><td>175</td><td>99%</td></tr>
<tr><td>Psychiatry</td><td>62</td><td>66</td><td>94%</td></tr>
<tr><td>Nursing</td><td>174</td><td>178</td><td>98%</td></tr>
<tr><td>OT/PT</td><td>49</td><td>56</td><td>88%</td></tr>
<tr><td>Speech</td><td>57</td><td>61</td><td>93%</td></tr>
<tr><td>Psychology</td><td>52</td><td>69</td><td>75%</td></tr>
<tr><td>Dietary</td><td>175</td><td>177</td><td>99%</td></tr>
</table>

From this information, most departments achieved compliance of 90 percent or greater. The Medical Department, OT/PT, and Psychology continued to be challenged in reaching this goal.

A separate chart entitled: “Assessment Filing – Number of Times filed later than 10 days for meetings between the dates of 10/1/13 and 3/31/13” provided information, which appeared to disagree with the prior table of information. For instance, it recorded that the Medical Department had 88 assessments filed late and the Nursing Department had 29 assessments filed late. This information needed further interpretation/explanation of findings.
</td><td></td></tr>
<tr><td>H2</td><td>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.</td><td>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. (For one newly hired PCP, the Facility submitted a sample of three active records). The PCPs were asked to provide the criteria or evidence used to determine whether the diagnoses clinically fit the information in the corresponding assessments or evaluations. Evidence was provided through referencing various sources (e.g., consultant reports, test reports, etc.). For 89 of 92 (97%) diagnoses submitted with supportive documentation, the criteria listed were consistent with the diagnosis listed.

Although not a requirement for substantial compliance, the Facility submitted information that there were no in-services provided to the PCPs concerning International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) 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 23 of the 23 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 improvements in its diagnostic practices related to psychiatric disorders.</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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 conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Medical Department utilized several mechanisms in its efforts to ensure timely, quality intervention and treatment, but more work was needed. The morning medical meeting was an inter-disciplinary forum to address change of status in individuals as they occurred. Changes of status requiring hospitalizations, ER visits, or Infirmary admissions were discussed the next business day. Critical clinical discussion among the PCPs provided feedback concerning quality care. An open record review was completed on hospital admissions to review timely treatment, as well as quality of care of the appropriate clinical disciplines. Templates with clinical prompts assisted in the PCP reviewing all relevant aspects of health, which might affect the acute illness. For those individuals hospitalized, a post-hospital ISPA process was required, and the ISPAs were presented at the provider morning meeting. At times, these were delayed beyond five days. More problematic was the quality of the ISPA content, which appeared, at times, to not address steps to prevent a repeat hospitalization. There were other clinical concerns discussed at the morning medical meeting that did not fit in the category of a post-hospital ISPA or an open record review. These were then assigned for review and resolution, and were brought back to the morning medical meeting for closure. Significant consults were reviewed. The participants from the represented departments at the morning medical meeting had made progress in providing quality information and clinical guidance to the open record reviews, ISPA, and discussion of concerns. A remaining challenge for the Medical Department was ensuring all appropriate diagnoses were aggressively evaluated and treated. Another approach to ensuring quality treatment and intervention was the follow-up of results of the external and internal medical management audit. An internal audit was completed every quarter. Action plans were not readily addressed in earlier quarters, but this improved with time. Further information concerning external medical peer review findings is found in relation to Section L.2, and information concerning internal medical peer review findings is found in relation to Section L.3. As discussed with regard to Section I, IHCPs were still not written in a manner that described all of the treatments and interventions that individuals required. Nor did the current IHCPs allow determinations to be made regarding whether or not such treatment and interventions were provided in a timely manner.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Given that Section H addresses all clinical care, other Department's at the Facility will also need to focus their efforts in illustrating compliance with these requirements. The Facility remained out of compliance with this provision.	
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 conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. ABSSLC had two systems in place in which clinical indicators were used to measure quality of care. The internal and external medical management audits focused on six diagnoses, and the results of findings are discussed in relation to Sections L.2 and L.3. In order to ensure the clinical indicators utilized were determined in a clinically justified manner, several in-service trainings occurred, which utilized medical publications as part of the teaching. Examples included articles concerning aspiration pneumonia and sepsis. A template was then created that prompted the PCPs to review all critical aspects of clinical care. Some of these prompts became clinical indicators used in monitoring tools. Some of the SSLC systems monitoring tools were used, with expansion of the number of clinical indicators, such as with Gastroesophageal Reflux Disease (GERD). A number of audits had been implemented, such as diabetes mellitus, aspiration pneumonia, GERD, ER transfers for respiratory distress, and hospitalizations for respiratory distress. Several other audits tools had been developed, but had not been implemented, such as preventive care. The focus for these was the process, which tests were ordered, etc. The clinical indicators chosen did not measure whether there was evidence of clinical improvement for a diagnosis or whether a health care goal had been achieved or maintained. In the future, clinical indicators determining the effectiveness of treatment need to be added to those audits, which are clinically focused rather than documentation focused. As is discussed in further detail with regard to Section I, to assess the efficacy of treatments, individual clinical indicators should be included in individuals' IHCPs and teams should regularly review the data collected to determine whether treatments are effective or need to be reviewed and revised, as appropriate. The Facility remained in noncompliance with this provision.	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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Medical Department tracked the timely completion of quarterly medical reviews, in a	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>effectively monitor the health status of individuals.</td><td>graph entitled: “Quarterly Medical Review: 2014 1st Quarter Facility Completion Rate.”

<table>
<tr><th>Month</th><th>Completion Rate for Quarterly Medical Reviews</th><th>Month</th><th>Completion Rate for Quarterly Medical Reviews</th></tr>
<tr><td>January 2014</td><td>13%</td><td>March 2014</td><td>72%</td></tr>
<tr><td>February 2014</td><td>38%</td><td></td><td></td></tr>
</table>

The Medical Department tracked the completion of medical/open record reviews for hospital admissions, in a graph entitled: “Hospital Admission Medical Chart Review Completion Rate 2014 1st Quarter.” The following summarizes this information:

<table>
<tr><th>Month</th><th>Completion Rate for Medical Record Review</th><th>Month</th><th>Completion Rate for Medical Record Review</th></tr>
<tr><td>January 2014</td><td>80%</td><td>March 2014</td><td>75%</td></tr>
<tr><td>February 2014</td><td>100%</td><td></td><td></td></tr>
</table>

Each business day, the morning medical meeting provided an up-to-date review of all acute health status changes (i.e., Infirmary admissions, hospitalizations, and ER visits) for those individuals on campus as well as those hospitalized. This was done through the on-call PCP report, a review of the 24-hour log, the Infirmary admissions report, and the Hospital Liaison Nurse report. The handouts and minutes provided written documentation of review and discussion of each case. Open record reviews were assigned and reported at the morning medical meeting.

The intention of the internal quality assurance monitoring audit tools, which the Medical Department was currently developing, was ongoing review to determine trends and identify areas needing improvement. With a standardized template and the quality of clinical information required in completion of these templates, the audit tools can reasonably be expected to measure the health of the individuals. These templates included the following: revised annual medical assessment form (with numerous prompts), hospital admission medical record review procedure, quarterly medical review procedure, and the aspiration Infirmary admission assessment procedure. The consistent and complete documentation of this information over time will allow the Facility to track many health diagnoses and indicators.

The Medical Department was able to monitor acute change of health status, but there was less monitoring of health care maintenance. This was an additional component of health status measurement data that Facility staff needed to develop. Examples would include: the</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		percentage of individuals within ideal body weight, as well as those less and those over that range for each quarter, the percentage of individual with osteoporosis for whom the last two Dual-energy x-ray absorptiometry (DEXA) scans indicated improvement, or stabilization of the T score, the number of individuals with a seizure disorder with no seizures in the past quarter, one seizure in the past quarter, etc., the number of individuals with a diagnosis of chronic constipation that required additional intervention beyond routine daily medication (i.e., PRN medications), the number of individuals with a target behavior of Self-Injurious Behavior (SIB) with 10 percent, 25 percent, etc. less SIB events the past quarter compared to the prior quarter, and for those with fall prevention plans, the number of individuals that had no falls, versus falls without injury, versus falls with injury in the past quarter. Tracking the actual health status would allow determination of effectiveness of systems in place (i.e., medical treatment, behavioral plans, dining plans, risk plans (e.g., fall prevention plan). It would allow determination of the health of individuals residing at ABSSLC. In addition, as discussed with regard to Section H.4, it will be important for teams to develop individual clinical indicators and to collect and assess data to identify more subtle changes in health status, and respond appropriately. The Facility remained in noncompliance with this provision.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. For compliance with this subsection, the Medical Department needed to demonstrate creation of audit tools with clinical indicators focusing on the actual clinical values of tests and radiographic reports, etc., to determine whether the current treatment was adequate or needed to be changed (i.e., change dosage, add medication, remove medication, other therapies added, etc.). Although the Facility's current tools were a valuable resource, they did not focus on clinical outcomes for individuals. When change was indicated, the current audits measured whether there was evidence that change occurred through PCP orders, and whether this was done in a timely manner, along with orders for further monitoring to determine improvement or lack of improvement, need for further consultation, or need for further lab testing, scans, etc. Most of the indicators required a PCP order, and therefore, were clinical in nature and focused on completion of a minimum set of monitoring or assessment/evaluation steps nationally recognized as reflecting ongoing quality of care for specific diagnoses such as GERD, aspiration pneumonia, constipation, etc. The challenge will be focusing not on what the PCPs or other clinical departments have ordered or completed, but focusing on the outcome of health of the individual (i.e., measuring the results of treatment and interventions, and the response to this information by the PCPs). The focus of this section is providing a quality improvement process that tracks medical care	Noncompliance

#	Provision	Assessment of Status	Compliance
		response to abnormalities in test results, or clinical findings. As one approach to demonstrating compliance in this area, the Medical Department is encouraged to further review clinical indicators based on lab and radiographic findings, and to provide an audit mechanism to review the appropriateness and timeliness of the PCP response to abnormalities. The data the Facility provided did not specifically address change in treatment (i.e., frequency or type of lab tests, change in medication, change in dosage, additional medication, additional consults, etc.) based on the clinical indicators used. In most instances, the clinical indicators focused on routine treatment expectations, such as frequency of Hemoglobin A1C in diabetes mellitus or whether periodic specialty consultations were obtained. The quality indicators were not sensitive enough to measure responsiveness and timeliness of responsiveness to abnormal lab and test results or other changes in clinical status. The requirements for this subsection focus on preventive care/maintenance care, and do not relate solely to demonstration of responses to individuals' acute care needs. For instance, if a Dilantin level was returned as abnormally high or low, was the PCP response appropriate and timely? If the database indicated five abnormal Dilantin levels across campus in the month, was there a quality improvement process in place to track the PCP response and timeliness to the abnormalities? When data was reviewed related to acute care interventions to abnormal Dilantin levels, was there a trend, and what were the steps taken (i.e., training, etc.) to improve care, followed by further tracking of this information for indications of resolution? Similarly, if a Complete Blood Count (CBC) result indicated abnormally high or low hemoglobin, did the PCP modify the treatment or order additional tests? Were the treatments or tests appropriate (as based on specific standards), and was the response timely? Additionally, the quality improvement process should include indicators accommodating circumstances unique to the individual (e.g., a Dilantin level above the standard reference range is clinically indicated). In other tests, there might be contraindications such as inability to position the individual for a test otherwise indicated (e.g., mammogram), or the guardian might refuse consent for a procedure (e.g., colonoscopy or pap smear). The format of the audit for the test reviewed should take into consideration clinical justification/contraindications, etc., which are then removed from the denominator in calculating compliance. This approach answers a different set of clinical questions than many of the current clinical indicators. Such a system would need to not only incorporate clinical indicators for the Medical Department, but across clinical disciplines.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. The Medical Department submitted the following integrated clinical services written	Noncompliance

#	Provision	Assessment of Status	Compliance
	integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	process/protocols: ▪ Process for Medical Restraint Plans (for Medical and Dental), undated. This appeared to be a draft and had not been finalized or approved and implemented. ▪ DADS Policy: Minimum Common Elements of Care, draft submitted 2/19/14 to replace 9/2013 Policy #5. No further policies were submitted for this section.	

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 ABSSLC's Self-Assessment; o ABSSLC's Section I Presentation Book; o ABSSLC At-Risk Individuals list; o The following documents: IRRFs, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans/IHCPs for the following individuals: Individual #250, Individual #540, and Individual #27 for gastrointestinal issues; Individual #441, Individual #368, and Individual #290 for constipation; Individual #247, Individual #3, and Individual #369 for weight issues; Individual #541, Individual #261, and Individual #463 for urinary tract infections; Individual #70, Individual #296, and Individual #417 for aspiration; Individual #366, Individual #538, and Individual #255 for skin integrity issues; and Individual #241, Individual #191, and Individual #333 for fractures; o For the following individuals' active records, selected documents: most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries past one year, ER report past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, IRRF past one year, and risk action plan past one year for the following individuals: Individual #429, Individual #520, Individual #9, Individual #395, Individual #54, and Individual #385; o Abilene State Supported Living Center At-Risk Individual's Policy and Procedure, dated 2/28/14; o ABSSLC's Observation monitoring tool for ISPs; and o QA/QI Quarterly Section Review of Settlement Agreement Progress Section I: At-Risk Individuals meeting minutes, dated 3/10/14. ▪ **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 #411, on 5/13/14; o ISP meeting for Individual #4, on 5/13/14; and o ISP meeting for Individual #3, on 5/14/14.
	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 had implemented a promising ISP Observation monitoring tool for Section I. Based on a review of the Facility's Self-Assessment: o Only some of the indicators the Facility used for this section were in alignment with the Monitoring Team's indicators. This represented a significant decrease from the previous review. During the previous review, the Facility indicated that since the monitoring tool it was using at that time for Section I was too time-intensive, it was going to be discontinued. Consequently, a number of the indicators that were being monitored at that time were not addressed during the current review. As the Facility continues to review and 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. In addition, clear definition is needed with regard to the criteria auditors should use to rate the various indicators, especially those addressing the quality of the supports provided and the related 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.) need to be provided for the Facility's Self-Assessment data. After clearly identifying the total population (N) used to define the sample selected, (n), an adequate sample size would be needed to consider the data representative of the actual practices being monitored. o As noted in previous reports, in order for the Facility to generate accurate data reflecting the clinical quality of the supports provided and documentation maintained for Section I, 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. As the Facility moves forward in addressing the quality issues, 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. o The Facility needs to be clear regarding what specific criteria were used to determine compliance. The Facility's Self- Assessment included data with regard to Section I.2 that was not related to the requirements of the subsection. In addition, no aggregated data were presented in the Self-Assessment for Section I.3. Although the Self-Assessment indicated the data addressing this area were contained in the Presentation Book for

	Section I, only copies of Integrated Health Care Plans were found. Without aggregated monitoring data, the Monitoring Team was not able to determine the results of the Facility's monitoring activities. The Facility rated itself as being in substantial compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings. However, the Monitoring Team's findings addressed the quality aspect of the supports provided and documentation reviewed. In reviewing the Monitoring Team's report, the Facility should determine how it will assess quality, and also identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data.
	Summary of Monitor's Assessment: Since the last review, the Facility had spent considerable time reviewing and refining the Facility's At-Risk policy and Change of Status process, and had identified a number of areas that were in need of training. At the time of the review, Facility staff indicated that the operationalized At-Risk policy had been completed and the Facility's Policy Committee approved it. In addition, the Facility had reviewed and defined the Change of Status process and integrated this information into the Facility's At-Risk Policy. Also, the Facility had developed a very promising comprehensive ISP Observation monitoring tool that had been implemented at the time of the review. In January 2014, the Facility began observations of the ISP meetings and reviewed the Integrated Risk Rating Forms and Integrated Health Care Plans. In the next six months, the Facility planned to begin to review the data collected and implement follow-up interventions in response to the findings. In addition, a Lead Qualified Intellectual Disability Professional Facilitator was identified to coordinate and facilitate training and mentoring of the QIDP Facilitators. Since the last review, the Facility had invested much effort in reviewing the processes and systems regarding the At-Risk system at ABSSLC. However, there continued to be significant problematic issues regarding the quality of the documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events and health issues. Consequently, at the time of the review, the Facility's efforts had not yet translated into any consistent measurable progress in the documentation reviewed. Regarding the IHCPs, the nursing protocols that were found in the IHCPs were implemented only in the event of an acute issue related to the high/medium health-risk indicator. At this juncture of the compliance review process, it was very troubling that no nursing protocols were included in the IHCPs reviewed that required nursing to conduct regular nursing assessments for high and medium health risks that the individuals were already experiencing, and which warranted the elevated risk ratings from the IDTs. Consequently, the IHCPs reviewed only reflected the long-standing inadequate reactive care systems at ABSSLC. In addition, although nursing interventions are crucial components of the IHCPs, other disciplines involved in the individuals' care also need to include specific interventions addressing the high and medium risk indicators as required by an "integrated" health care plan. 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.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	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 the operationalized At-Risk policy had been completed and the Facility's Policy Committee approved it. ▪ In addition, the Facility had reviewed and defined the Change of Status process and integrated this information into the Facility's At-Risk Policy. ▪ A Lead QIDP Facilitator was identified to coordinate and facilitate training and mentoring of the QIDP Facilitators. ▪ In January 2014, the Facility began observations of the ISPs and reviewed the IRRFs and IHCPs. In the next six months, the Facility planned to begin to review the data collected and implement follow-up interventions in response to these findings. ▪ In addition, the Facility had developed a very promising comprehensive ISP Observation monitoring tool that had been implemented at the time of the review. Although the Facility's Self-Assessment included data generated from this tool, it was based on a sample of one ISP observation conducted in January 2014. This was not a large enough sample (N=34 n=1) to generalize the findings to all ISPs conducted. ▪ Also, an Assessment Workgroup was established to focus on improving the timeliness of the discipline assessments. ▪ A review of the QA/QI Quarterly Section Review of Settlement Agreement Progress for Section I: At-Risk Individuals, dated 3/10/14, indicated that since the last review, the Facility had spent considerable time reviewing and refining the Facility's At-Risk policy and Change of Status process, and had identified a number of areas that were in need of training. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance. The facility is in the process of officially implementing the Operationalized At Risk Policy due to results of self-assessment that demonstrate IDT members lack of [sic] understanding of the procedure of the risk process. Facility processes are constantly changing as results of facility self-assessments provide evidence of lack of progression." Since the last review, the Facility had invested much effort in reviewing the processes and systems regarding the At-Risk system at ABSSLC. However, there continued to be significant problematic issues regarding the quality of the documentation included in the ISPs, IRRFs, IHCPs, and the associated disciplines' assessments regarding what actions were taken in response to pertinent	Noncompliance

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		events and health issues. Consequently, at the time of the review, the Facility's efforts had not yet translated into any consistent measurable progress in the supports provided or related documentation. To assess the Facility's revised risk screening process, members of the Monitoring Team observed three individuals' ISPs meetings (i.e., Individual #411, Individual #4, and Individual #3) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at two (67%) of the observed ISP meetings. The PCP was not present, despite the fact that Individual #411 had declining health, including a number of cardiac issues. Also, the guardian for Individual #411 was not present or on the telephone, and no explanation was provided. ▪ 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 #3 and his staff were present for the ISP via conference call due to his home being on isolation due to a flu outbreak at the time of the review. Individual #411 and Individual #3 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 all (100%) of the ISP meetings. ▪ The IDT consistently used supporting clinical data when determining risks levels for one (33%) of ISPs observed. There was a lack of supporting clinical data presented at the ISP meeting for Individual #3 when comparing the current year to the previous year for issues such as skin integrity. The IRRF indicated that he had been treated several times for sores and lesions, but did not indicate specially how many times and whether this was more or less than the previous year to accurately determine the status of his skin integrity. In addition, although the team for Individual #411 discussed some clinical data, other data was missing. For example, Individual #411 had had meal refusals and the current status was described as "overall decrease in meal refusals," without providing any specific data. Similarly, although a weight range was given, his current weight was not, nor was any indication provided regarding how long he had been within his recommended weight range. ▪ Overall, the risk levels the IDT designated were appropriate for each category for all of the ISPs observed (100%) based on the discussions, information, and data provided by the IDTs. However, the lack of specific comparison data rendered it difficult to consistently assess the accuracy of all the ratings. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in all (100%) of the ISPs meetings observed. ▪ Team disagreements regarding risk levels were noted in two of the ISP meetings (i.e., Individual #411, and Individual #3) and appropriately resolved in both (100%). For example, Individual #411's team discussed a number of risk ratings for which one team member recommended one risk rating, and other team members recommended another,	

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		including, for example, fractures, and osteoporosis. The team's discussion was based on the data, such as data related to fractures and DEXA scan results, and the team referenced the risk guidelines in resolving the differences of opinions. ▪ Based on ISPs observed by the Monitoring Team, the ISP facilitators kept the team focused in all (100%) of the ISPs meetings observed. In addition, other positive observations from the Monitoring Team regarding the ISP meetings included: ▪ The team for Individual #411 reviewed the IHCPs for the high and medium risk ratings. This allowed the team to ensure that the supports discussed were included in the IHCPs. ▪ Individual #411's team celebrated some accomplishments over the last year, including his stopping his use of snuff and improving his diet. ▪ Over the 54 years that Individual #411 lived at ABSSLC, he had developed relationships with the Maintenance Department staff. A member of the Maintenance Department attended his ISP meeting, and clearly had an excellent rapport with Individual #411 and advocated on his behalf. Individual #411 had lunch in the diner each day with Maintenance Department staff, and one of the staff regularly took him to medical appointments and to get haircuts. ▪ The QIDP Facilitator for Individual #4's ISP made several good attempts during the ISP to engage the team in discussions. ▪ Although Individual #3 and his staff attended the meeting via conference call due to the flu outbreak, team members frequently spoke directly to the individual and asked his opinion regarding increasing certain activities that he appeared to like. ▪ The team for Individual #3 discussed the IHCP after each of the health categories on the IRRF was discussed and rated. ▪ Although it appeared that the Nurse Practitioner for Individual #3 was unfamiliar with the Risk Level Guidelines regarding poly-pharmacy, the team members reviewed the Guidelines and appropriately recommended a rating of "high" in alignment with the clinical data. Problematic areas needing focus or improvement included: ▪ For Individual #411, the team did not discuss measurable goals for the IHCP. As a result, it was unclear how the team would know whether or not the supports developed were benefitting the individual. In other words, it was unclear how the team would know whether Individual #411 was doing better or worse, or remaining stable. ▪ The team for Individual #411 did not develop action plans for supports for his low risk areas, despite his having needs for supports. For example, for skin integrity, the team rated him as being at low risk, but the IRRF included skin-related diagnoses and a list of supports (e.g., his skin being assessed daily, and moisturizer being provided). However, the team did not discuss an action plan to ensure these supports were provided. ▪ Individual #411 demonstrated a number of behaviors that either prevented his integration in the community and/or had the potential to make it difficult for him to obtain needed supports and services. For example, he regularly used language and gestures that could be	

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		perceived as inappropriate and/or offensive. He also required assistance of specific staff (i.e., maintenance staff) to complete medical appointments, and would refuse to participate in medical appointments if other staff accompanied him. In addition, in recent years, he had experienced falls and fractures, and was at high risk for osteoporosis, but refused to use a walker. At the ISP meeting, the team, including Behavioral Health Services staff, did not set forth an assertive plan to address these areas of need. As Facility staff pointed out when these issues were discussed after the ISP meeting, as he ages, Individual #411 will likely need to attend more medical appointments, and work needed to be done to attempt to use existing relationships with maintenance staff to widen the scope of staff with whom he is willing to attend medical appointments. Similarly, the knowledge and expertise of Behavioral Health Services staff as well as the lengthy list of preferences should have been used to address his use of inappropriate language that would be unaccepted in community settings, and encourage use of the walker to prevent to the extent possible falls and fractures. Based on discussions with staff after the ISP meeting, the team had evidently met on several occasions to discuss the issue related to his refusal with the walker. However, this had not been shared with the QIDP Facilitator, and was not raised in the discussion at the ISP meeting. Although at the ISP meeting, the team discussed some ideas, no action plans actually were discussed or agreed upon to address these issues. The annual ISP meeting should not be viewed as a separate meeting, but rather as a continuation of other discussions and planning already occurring for the individual throughout the year. In this case, the team should have summarized efforts already tried, discussed any data collected, and revised plans in place or developed new ones. ▪ The team for Individual #4 had very limited discussions regarding her current SAPs and offered few ideas for SAP development. In addition, there were no recommendations for any assessments when determining if a SAP for tooth brushing or use of a water pik was appropriate and functional. ▪ Although Individual #4 had fallen during a seizure and had fractured her nose and damaged some teeth, the team removed her enhanced supervision in the shower for rights restoration noting that: "staff were always with her" during this time. ▪ The PCP for Individual #3 did not participate or contribute to any clinical discussions during the ISP meeting. ▪ The IHCP discussions for Individual #3 did not include the proactive implementation of nursing protocols for his existing health conditions of aspiration, falls, and fractures. In fact, all nursing protocols/assessments were designated to be implemented only after an acute event indicating that Individual #3 would have to become ill before warranting nursing assessments. ▪ The direct support professional for Individual #3 was not included in any of the discussions, even though she was identified as one of his favorite staff members. From the Monitoring Team's observations and record reviews, the Facility continued to make some positive steps forward regarding the structure and format of the at-risk discussions at the ISP	

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		meetings. However, based on review of ISP documents, more efforts are needed to ensure that the risk levels are accurate and are based on complete clinical data that is analyzed from year to year, that the IHCPs reflect the needed clinical intensity in alignment with the appropriate designated risk levels and include nursing assessments in alignment with nursing protocols, that objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the integrated health care plans, and teams clearly document this process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The 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. 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: ▪ Although important, the Facility's Self-Assessment for this sub-section contained data regarding Nursing Protocol Cards, hospitalizations, transfers and discharges, and Infirmary admission paperwork. Thus, it was unclear to the Monitoring Team how these data related to the requirements of the Settlement Agreement for Section I.2. <u>Self-rating</u>: "Based on the findings from this self-assessment, this provision is not in compliance. The Facility recognizes need [sic] to improve activities to utilize to conduct in [sic] 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." Based on a review of records for 21 individuals determined to be at risk (i.e., Individual #250, Individual #540, and Individual #27 for gastrointestinal issues; Individual #441, Individual #368, and Individual #290 for constipation; Individual #247, Individual #3, and Individual #369 for weight issues; Individual #541, Individual #261, and Individual #463 for urinary tract infections; Individual #70, Individual #296, and Individual #417 for aspiration; Individual #366, Individual #538, and Individual #255 for skin integrity issues; and Individual #241, Individual #191, and Individual #333 for fractures), 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 compared to clinical data from the previous year. As a result, it was unclear whether further assessment was needed; and	Noncompliance

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		▪ When recommendations for further assessment were found in the IHCPs, the date of completion was frequently left blank. Thus, it was impossible to determine what precipitated the recommended assessment, and if it was actually timely completed. <u>Nursing Assessments</u> Based on a review of 21 individuals' records for which assessments were to be completed to address the individuals' at-risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. However, from a review of these nursing assessments, it was clear that the Facility was in the process of improving the documentation contained in the Comprehensive and Quarterly Nursing Reviews. Improvement, although not consistently found in many of the assessments the Monitoring Team reviewed, included using some of the past quarterly or annual information and providing an update regarding the current status of the health risk indicators. However, considerable more work was needed regarding the analysis of the information. More specific details are provided with regard to Section M.2. In addition, regarding the Integrated Risk Rating forms, a review of these 21 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. Although the Monitoring Team found that there continued to be 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, and falls, injuries and/or fractures, there was a lack of individual-specific information from the previous year that made it difficult to determine the accuracy of the risk rating that was assigned. <u>Medical Assessments</u> Six records were reviewed to determine adequacy of risk assessment and completeness of risk reduction plans. These included the records for: Individual #429, Individual #520, Individual #9, Individual #395, Individual #54, and Individual #385. The integrated process for addressing individuals' at-risk issues continued to reflect concerns. Based on review records, there appeared to be gaps in assessment, treatment, documentation, and/or follow through to closure. Many of these areas required the cooperation and follow through of the Medical Department as well as other Departments. Two examples are provided in detail: ▪ Since September 2013, Individual #385 was hospitalized twice and required Infirmary admission once. For one admission, a health care acquired pneumonia was diagnosed. The PCP indicated there was no infiltrate on the chest x-ray and the diagnosis was changed to bronchitis with reactive airway disease. Two months later, this individual was placed in the Infirmary for seven days due to reactive airway disease and bronchitis. Two months later, the individual was re-hospitalized again for respiratory distress. Diagnoses of aspiration pneumonia and acute respiratory failure were made, along with sepsis. There was an infiltrate on the chest x-ray in the right upper lobe of the lung. The medical history indicated	

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		a history of reactive airway disease requiring several nebulizer treatments and medication for reactive airway disease along with nasal inhalers and medication for allergies. The individual had a tracheostomy with tracheal diversion in the past with revision due to fistula formation in 2007. More recently, during tracheal care, formula was suctioned from the trachea. An ENT consult was made, and the recommendation was for reflux treatment. A gastrostomy had been placed in the past. Massive reflux had been noted in 1985. In 1994, an upper gastrointestinal series indicated that the individual was unable to empty the stomach unless turned to the right side. Referral to a gastroenterologist was made, and an esophagogastroduodenoscopy (EGD) was done with findings of gastric outlet obstruction requiring balloon dilatation, as well as a hiatal hernia. In February 2014, the individual had a large emesis after transfer in a sling with the head positioned too low. No submitted information indicated how this lack of appropriate positioning was resolved (i.e., further training, review of positioning needs, change in PNMP, etc.) in order to prevent a recurrence. The record appeared to be lacking in steps to be taken to prevent further episodes of reactive airway disease. The individual continued to have reactive airway disease without aggressive assessment. With known marked reflux, there were no further reports or documentation submitted indicating whether a fundoplication had been considered, or whether a jejunostomy was being planned as recommended by the gastroenterologist. The current status of the gastroparesis was not known. There was no gastric emptying study several months after the dilatation to determine the severity of the delay in gastric emptying following the balloon dilatation, and whether the gastric outlet obstruction was recurring or had stabilized. Although the individual had had two surgeries for tracheal diversion in the past, there appeared to be ongoing concerns for recurrent fistula formation, but the documentation of resolution of this concern was not found. Whether other specialty consultations or second opinions occurred to determine risk/benefit for any further evaluation or diagnostic/therapeutic procedure was not submitted. There did not appear to be a plan in place to address this issue. Separately, no quarterly medical review was submitted. The most recent annual medical assessment submitted was from 4/18/13. Routine periodic documentation for this high risk individual appeared to be lacking. An underlying concern was the clinical approach to this and other individuals with acute respiratory distress. If a chest x-ray, at the time of acute respiratory distress, was noted to be clear, the consideration of aspiration pneumonia or aspiration pneumonitis was dismissed as the diagnosis and there was no further evaluation that was triggered. Regardless of the diagnosis made, there needed to be an aggressive approach to resolving and preventing recurrent life threatening illness, but there was no further evaluation despite three more episodes of respiratory illness. ▪ Individual #54 had a prior tracheostomy with tracheal diversion, received nebulizer	

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		treatments, and vacuum tooth brushing. The purpose of vacuum tooth brushing in an individual with tracheal diversion and taking food orally might need further review, based on submitted documentation. This individual had moderate dysphagia, and took nutrition by mouth. This individual required pureed food with applesauce consistency, and liquids thickened to nectar consistency and served ice cold. Reclining at 40 degrees was required for optimal eating. The dining plan was complex and required nine steps. The individual had a number of meal refusals. PNMT was consulted for the aerophagia and bloating. It was not determined whether there was increased meal time monitoring for this individual to ensure all steps of his dining plan were completed correctly, or whether poor positioning, anxiety during eating, etc., contributed to aerophagia. There was a documented history of GERD dating to 2009 from an EGD, which found mild chronic inflammation of the gastro-esophageal junction. More recently, notation was found documenting acid burns at the end of the tracheal tube. There was no information to determine whether a gastric emptying study had been completed. The individual was not prescribed medication for GERD. If there was significant GERD, this might have been a reason for meal refusal. That there had been a prior tracheal diversion indicated the need for additional consultation to determine the current status of that diversion and whether fistula formation had developed, given the acid burns of the tracheal tube. There was no information whether this had been considered or occurred, or further evaluation of the GERD. A repeat EGD would confirm ongoing GERD as well as assess for the presence of Barrett's esophagus. There was no further GERD evaluation to determine the need for a fundoplication or medication treatment. The last modified barium swallow study (MBSS) information submitted appeared to have been 2009. There was significant abdominal bloating and aerophagia, which was referred to the PNMT. The individual was on several medications for constipation. The individual's bowel movements were noted to be soft. Whether there was megacolon or colon dysmotility could not be determined from the record. Given the history of respiratory issues requiring tracheostomy and nebulizer treatments, it was not clear from the record whether the abdominal bloating/distention contributed to the respiratory compromise. Separately, this individual missed a dose of antiepileptic medication during two consecutive days, followed by seizures in 24 hours. There was both a history of sub-therapeutic blood levels of antiepileptic medication as well as toxicity at times. This was complicated by medication refusal. There was no clinical review of this situation to determine if the individual refused medications during times of bloating and discomfort (or the possibility this discomfort was related to GERD). There was no information submitted as to whether a behaviorist had been consulted for the medication refusals. The IRRF considered behavioral health as low risk, but the	

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		data/discussion only included the template prompts and there was no information in this specific section about medication or meal refusals. The individual had osteoporosis, and was prescribed IV bisphosphonates every three months. There was a history of mild primary hypogonadism. No information was submitted indicating any current status/evaluation or referral to endocrinology. There was currently no medical treatment prescribed for the hypogonadism. There was no mention of this diagnosis during discussion of osteoporosis, nor under plans and recommendations of the annual medical assessment. If there were hypogonadism, this would be an added risk factor for osteoporosis. The record did not address this diagnosis and its impact on osteoporosis. There was a considerable delay in completing the hepatitis B vaccine series for this individual. A third injection was due May 2012. This was not ordered until September 2013. Once ordered, there was a several month delay until given in March 2014. Additionally, although there was a need to guide the IDT in determining risk for these high-risk areas, the PCP did not attend the ISP, according to the signed attendance roster. The most recent quarterly medical review submitted was 6/25/13. This record review identified several concerns. The lack of evaluation and treatment of GERD was problematic. Any evaluation of his tracheal diversion to determine functional state/presence of fistula was not submitted and might not have occurred. The reason for meal and medication refusal was not identified. Missed medications were followed by seizures. The degree of hypogonadism and effect on osteoporosis needed further review. Vaccine series were not administered in a timely manner. The PCP did not attend the ISP when there were several high-risk issues needing IDT deliberation. A specific subsection of the IRRF (i.e., behavioral) was left incomplete. This record review indicated significant problems and concerns, which were the responsibility of the Medical, Nursing, Behavioral Health Services, and QIDP Departments. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within	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: ▪ Although the Facility's Self-Assessment indicated that a review was conducted of IHCPs to ensure implementation was within 14 days of the plan's finalization, they included preventive interventions to minimize the condition of risk, they were integrated into the ISPs, and included the clinical indicators to be monitored, no aggregated data were	Noncompliance

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	fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	presented in the Self-Assessment or in the Presentation Book, which was where the Self-Assessment indicated the findings of this review were. 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 21 records for individuals determined to be at risk (i.e., Individual #250, Individual #540, and Individual #27 for gastrointestinal issues; Individual #441, Individual #368, and Individual #290 for constipation; Individual #247, Individual #3, and Individual #369 for weight issues; Individual #541, Individual #261, and Individual #463 for urinary tract infections; Individual #70, Individual #296, and Individual #417 for aspiration; Individual #366, Individual #538, and Individual #255 for skin integrity issues; and Individual #241, Individual #191, and Individual #333 for fractures), 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 21 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator, none sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 21 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some IHCPs addressing, for example, the need to encourage adequate fluids, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the IHCP into the ISPs in 21 of the 21 cases (100%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) consistently included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%).	

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		Although the plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability, or it was not addressed. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this provision. This finding was consistent with the findings of the Monitoring Team. ABSSLC should continue to focus its efforts on developing specific and clinically appropriate IHCPs. Regarding nursing, the nursing protocols that were found in the IHCPs were noted to be implemented only in the event of an acute issue related to the high/medium health risk indicator. At this juncture of the compliance review process, it was very troubling that no nursing protocols were included in the IHCPs reviewed that required nursing to conduct regular nursing assessments for high and medium health risks that the individuals were already experiencing, and which warranted the elevated risk ratings from the IDTs. Consequently, the IHCPs reviewed reflected the long-standing inadequate reactive care systems at ABSSLC. In addition, although nursing interventions are crucial components of the IHCPs, other disciplines involved in the individuals' care also need to include specific interventions addressing the high and medium risk indicators as required by an "integrated" health care plan. 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 Pretreatment 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 five individuals prescribed Reglan: Individual #19, Individual #21, Individual #226, Individual #385, and Individual #267; 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 due to the elevated Reiss Screening Scores; o List of all psychiatrists, including Board status; o The caseload distribution for Staff Psychiatrists; o Curricula Vitae (CV) of all psychiatrists; o Spreadsheet of the status of individuals selected for Desensitization Plans; o Documents related to the Psychiatric Clinics that took place on 5/13/14; 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 May, 2014; o For the past six months, minutes from the committee that addresses polypharmacy; o Chemical Restraint trend analysis; o Documents reviewed in the context of the 5/13/14 Psychotropic Polypharmacy Committee Meeting; o Documentation related to the 5/14/14 Individual Support Plan (ISP) for Individual #462; o Spreadsheet of oral pretreatment 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 Pretreatment Sedation Log for the prior six months; o Medical Pretreatment 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 that the residential RNs received with regard to the administration of the DISCUS; o List of ISP 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 case load distribution, list by Practitioner with residence numbers; 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 (i.e., zero); o List of individuals that have returned from a psychiatric hospital in the last six months (i.e., zero); o The most recent ISP and PTP for the following eight individuals: Individual #544, Individual #447, Individual #59, Individual #517, Individual #533, Individual #105, Individual #348, and Individual #374; 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 pretreatment sedation medication (i.e., Treatment Plan, guardian approval, HRC approval, etc.) for the following individuals: • The Facility selected the records of the following 10 individuals and submitted them as part of the pre-review document request: Individual #320, Individual #461, Individual #518, Individual #462, Individual #478, Individual #278, Individual #168, Individual #46, Individual #460, and Individual #4. • During the onsite review, a member of the Monitoring Team selected the following 13 Individuals: Individual #393, Individual #481, Individual #405, Individual #231, Individual #242, Individual #95, Individual #324, Individual #61, Individual #63, Individual #439; Individual #29, Individual #241, and Individual #424. ▪ **Interviews with**: o Marla Knight, Pharm. D. and Michael Murray, M.D., on 5/13/14, 5/14/14, and 5/15/14; o Michael Murray, M.D., Chief Psychiatrist, on 5/12/14, 5/13/14, and 5/14/14; o Jerry Griffen, D.D.S., Director of Dental Services, and Michael Murray, M.D., on 5/13/14; o Ron Manns, Director of Behavioral Services, and Kathy Theiss, BCBA, Clinical Supervisor, on 5/12/14; o Shae Butts, Human Rights Officer, on 5/13/14; o Sherry Shoopman, Program Compliance Monitor, in conjunction with Michael Murray, M.D. to review Facility Self-Assessment, on 5/15/14; o Stephen Milstead, RN, DM, MHNP, on 5/15/14; and o Lynn Outlaw, APRN, PMHMP, BC, on 5/15/14. ▪ **Observations of**: o Psychiatric Clinic for Residence 5971 Service Avenue, on 5/13/14; o Psychiatric Clinic for Residence 6400 Plum Avenue, on 5/14/14; o The ISP for Individual #462, on 5/14/14; o Brief observation of the Neurology Clinic, on 5/12/14; o Psychiatric Clinic for Residence 6760 Circle Drive, on 5/15/14; o Psychotropic Polypharmacy Committee Meeting, on 5/13/1; and o The following individuals, during the Psychiatric Clinics and visits to the vocational areas and Residences: Individual #488, Individual #218, Individual #284, Individual #88, Individual #464, Individual #177, Individual #180, Individual #523, Individual #301, Individual #256, Individual #537, Individual #120, Individual #369, Individual #51, Individual #424, Individual #478, Individual #510, Individual #463, Individual #278, Individual #525, Individual #83, Individual #170, Individual #390, Individual #303, Individual #469 Individual #168, Individual #239, Individual #187, Individual #263, and Individual #246.
	Facility Self-Assessment: The review of ABSSLC's Self-Assessment was facilitated by an interview with the Program Compliance Monitor (PCM) and the Chief Psychiatrist on 5/15/14. The Psychiatry Department continued with the system changes made in February 2013, in response to

	guidelines from 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. The system developed in response to the new DADS directive initially 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. Through January 2014, this second member could be the Psychiatric Nurse, or one of the two Psychiatric Assistants. At that time, the internal review of the inter-rater reliability data for the prior year was considered to be sufficient to decrease the blind reviews to one per quarter. These three staff members each reviewed one record independently for a total of three per month, one of which was used for the quarterly inter-rater reliability determination, as described above. The one record that was used for the inter-rater reliability assessment each quarter 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 randomly selected three individual records per month from the Psychiatry caseload. The reviews accounted for two percent of the individual records of those receiving psychotropic medication each month, which equated to twenty-four percent of the individuals receiving psychotropic medications on an annual basis. The audit tool encompassed 34 items related to 13 of the 15 provisions 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 by subsection or by item. The inter-rater reliability was reported as a simple percentage of agreement, that 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. The following table summarizes the different methodologies the Psychiatry Department utilized for each of the subsections of Section J. However, only those methods that are in addition to the auditing process are listed:

Subsection	Additional Methods Used to Assess Each Provision
J.1	Review of credentials the Medical Department maintained.
J.2	CPE/PTP Tracking Log the Psychiatry Department maintained (included with evidence for Section J.6.
J.3	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. Documents related to timelines of PBSP and staff training.
J.4	Table generated from data collected from HRC approvals related to Pretreatment Sedation from 9/1/13 to 3/31/14. Quality of the PBSP, as assessed by the Director of Behavioral Health Services.
J.5	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	CPE/PTP Tracking Log the Psychiatry Department maintained.
J.7	1. Reiss Screen Tracking Log the Behavioral Services Department maintained. 2. List of admissions the Admissions Placement Coordinator maintained.
J.8	1. The tracking of psychiatric providers participating in the annual ISP meeting. 2. Review of three finalized ISPs per month, by the Chief of Psychiatry.
J.9	1. The tracking of psychiatric providers participating in the annual ISP meeting. 2. Review of three finalized ISPs per month, by the Chief of Psychiatry.
J.10	1. The tracking of psychiatric providers participating in the annual ISP meeting. 2. Review of three finalized ISPs per month, by the Chief of Psychiatry.
J.11	Monthly tracking data the Psychiatric Polypharmacy Committee generated.
J.12	The internal MOSES/DISCUS Tracking Spreadsheet.
J.13	The CPE/PTP completion spreadsheet, plus an additional three records added to those routinely reviewed.
J.14	No additional information.
J.15	Provision J.15 Tracking Log maintained by the Psychiatry Department.

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 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 the CPEs and the PTP to assess not only for the presence of a psychiatric diagnosis, but also the presence of the symptoms to support that diagnosis. The Psychiatry Department also had developed quality measures specifically for evaluating the CPEs, PTPs, and the information contained in the Integrated

	Risk Rating Form (IRRF), at a frequency of three per month; ▪ The self-assessment process was based on adequate sample sizes, as the goal was to review 24 percent of the records of individuals receiving psychotropic medications every year; ▪ The 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 the CPEs, PTPs, and IRRF. In addition, when scoring the CPE, the internal tool that had been developed assessed not just the presence of a response under each of the subheadings, but also used specific items that should be discussed in that section; ▪ The staff members responsible for completing the audit tools were the following members of the Psychiatry Department: the Chief of Psychiatry, Psychiatric Nurse, 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 met 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 included 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 kept relevant databases, such as the Dental Department's Dental Desensitization Tracking Spreadsheet; and ▪ The Facility presented their data in a useful manner. A detailed description of the number of individual records reviewed, as well as the specific items that were scored, accompanied the Facility assessment for each subsection of Section J. A Results section followed, which described both the positive and negative findings. The final section was the self-rating, which included the Facility's compliance rating, as well as a detailed rationale for that finding. There was agreement between the ratings of the internal review, and the Monitoring Team's review for 11 of the 15 subsections. The four subsections for which the ratings diverged, and the reasons for those differences, were as follows: <u>Section J.4</u>: In making a finding of substantial compliance, the Facility focused on the decrease in the number of administrations of pretreatment sedation, rather than the number of individuals for whom plans to reduce, to the extent possible, the use of pretreatment sedation had been developed. The Facility also did not take into account the absence of plans to reduce the utilization of pretreatment sedation for medical procedures.

	Section J.8: The Facility's finding of substantial compliance did not factor in the deficits in the ISP documentation. Section J.10: In making the finding of substantial compliance, the Psychiatry Department did not take into account the requirement that the Risk-Benefit Analysis must also be discussed during the ISP meeting and in related documentation. Section J.14: The Monitoring Team's review found that in the sample of 15 percent there were signed consents for all individuals prescribed psychotropic medication. The deficits described in the Facility Self-Assessment that resulted in a finding of noncompliance were not found in this review, as discussed in detail in that section of this report. 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: The 15 provisions contained in Section J can be organized according to functional groupings, as discussed below. **Sections J.1 and J.5** relate to the quality and quantity of the psychiatric providers. ABSSLC employed three primary psychiatric providers: the Chief Psychiatrist (who was Board Certified) and two full-time Nurse Practitioners with solid credentials and skill sets. Two Psychiatric Assistants and the Psychiatric Nurse supported the three psychiatric providers. The psychiatric team was found to be sufficient to provide services to the 155 individuals prescribed psychotropic medication. **Section J.3** relates to the inappropriate use of psychiatric medication for punishment or simply to sedate individuals for the convenience of staff. Deficits in the documentation and implementation of chemical restraint caused concerns in the past. During the prior six months, there were no documented episodes of chemical restraint, potentially due to improved psychiatric and behavioral interventions. Historically, the rates of chemical restraint had varied considerably and, thus, random variation might also have played a role in this finding. **Section J.4** relates to the medication for pretreatment sedation. It appeared that the Dental team, working in conjunction with the Psychiatry and Behavioral Health Services Departments made significant progress by developing effective strategies primarily based on common sense and a thorough knowledge of the individual's likes and dislikes. However, there had not been any progress in developing strategies to reduce the need for pretreatment sedation for medical procedures and appointments. **Sections J.2, J.6 to J.9, J.13, and J.15** primarily relate to the provision of direct psychiatric care and the documentation of those services. The evidence for this could be found in the Psychiatric Quarterly Reviews, the Comprehensive Psychiatric Evaluations (CPEs), the Psychiatric Treatment Plans (PTPs), and the ISP

	documentation. The Facility's internal data indicated that, over the past six months, the psychiatric providers had attended 99 percent of the ISPs for the individuals they served, and the length of time they were present at the ISP was in the range of 90 minutes. The current review found that the Quarterly Reviews were being performed as specified, and that the CPEs/PTPs were up-to-date. The most recent ISP documentation also had improved considerably. **Section J.11** relates to polypharmacy. The Polypharmacy Committee appeared to be working well, and the rate of active polypharmacy where the efficacy of each prescribed medication had yet to be proven continued to be in the range of five to six percent. **Section J.12** relates to the MOSES/DISCUS side effect monitoring. The Facility was in substantial compliance with this provision for the Monitoring Team's two previous reviews with solid ratings around 95 percent. Shortly after the Monitoring Team's last review, problems with the implementation of the electronic medical records dropped the completion and timely review rates to the 60 percent range, but Facility staff appeared to have mastered the system, as the completion rates were currently approaching the previously high levels. **Section J.10 and J.14** relate to the Risk-Benefit Analysis and Consent for psychiatric medications. The risk-benefit discussions were both rigorous and comprehensive, and were present in all of the records reviewed. However, the ISP documentation was still deficient for many individuals. Signed consents for psychotropic medication were found in all of the records reviewed. Finally, it is worth noting that the Psychiatry Department's internal QA process appeared to be assisting them in their efforts to continuously improve the quality of their work.

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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
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	At the time of the Monitoring Team's review, the Psychiatrists who diagnosed and treated the individuals residing 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	Substantial Compliance

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	board-eligible psychiatrist.	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. 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; and ▪ Evidence of collaboration between the Psychiatry and Neurology Departments, and the IDT, where this was relevant. The current Quarterly Review documentation also included a section entitled: "Psychiatric Medication 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 Drug Regimen Review (QDRR). The annual PTP contained a comprehensive list of the symptoms related to the individuals' psychiatric diagnosis. The subsequent three 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. There was also an updated, combined case formulation based on the information the IDT discussed in the ISP. The Facility added a section at the end of PTP that specifically addressed recommendations for psychiatric follow-up, including Laboratory Data, in the event that the individual was transitioning to the community. There was also a discussion relative to the feasibility of community transition. The PTP was completed annually in conjunction with the individual's ISP. The CPE also contained a listing of the psychiatric diagnosis for the individual, as well as the Bio-Psycho-Social-Spiritual formulation. The latter section discussed the differential diagnosis and provided detailed information concerning the rationale for the diagnosis of	

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		record, as well as important data detailing the impact of the individual's psychiatric diagnosis on their overt behavior. This was essential for differentiating between those behaviors that were derived from the psychiatric disorder, 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 23 of the 155 (15 percent) 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 present in the records of all of the 23 (100%) individuals contained in the sample. 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 that 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 changed the terminology to "Other Specified" or "Unspecified." The Facility maintained 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 24 individuals for 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 2013, and the most recent occurred in April 2014. The majority of the changes had taken place before the Monitoring Team's previous review, and only eight had taken place during the most recent six-month period. 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 24 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	

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		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 23 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 (for newly admitted individuals) or a PTP had been completed for all of the 23 (100%) 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 23 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 19 percent of the 155 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. An active Positive Behavior Support Plan was included in the records reviewed for 22 of the 23 (96%) individuals contained in this sample who were prescribed psychotropic medication (the narrative related to Section J.8 provides further discussion). The Monitoring Team's initial reviews indicated that the behaviors identified as the "target behaviors" of the psychotropic medication were often 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	Substantial Compliance

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		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. Each of the prior reviews discussed the findings of the most recent five episodes of chemical restraint that occurred during the prior six-month period. The Facility's current data indicated that in the prior six-month period (11/1/13 to 5/13/14), no behavioral episodes required chemical restraint. The review of the Chemical Restraint Trending Data for the past year indicated the frequency of chemical restraint had been trending down over the past year, and the trend line was clearly approaching zero, although there had been significant inter-month variability in frequency. During the interviews with the Chief Psychiatrist and the Director of Behavioral Services, a member of the Monitoring Team explicitly explored the possibility that the absence of chemical restraint might have been related to a change in nomenclature or classification of the STAT use of medications to address episodes of behavioral dyscontrol. These discussions did not reveal any such administrative changes in policy. There also were no transfers/admissions to external psychiatric hospitals during this time period that might have explained this observation. The continued decrease in the use of chemical restraint most likely had been the result of more comprehensive treatment of the underlying psychiatric disorder for those individuals who had periodically required chemical restraint. There might also be an element of random statistical variation, as there had been significant month-to-month variation in the past. In addition, as noted in Section C.6, two episodes of chemical restraint occurred just after the last onsite monitoring review, but before the most recent six-month calendar period. The Facility was found in substantial compliance with this provision of the Settlement Agreement. The prior reviews had indicated that there was no concrete evidence	

#	Provision	Assessment of Status	Compliance
		suggesting that the Facility was using psychotropic medication for punishment or for the convenience of staff. However, deficits in the chemical restraint documentation had made it difficult to rule out the possibility that some of these administrations might have represented an inappropriate use of IM injections of psychotropic medications against an individual's will. Although this was not reviewed this time due to the absence of any chemical restraint episodes, which was very positive, should episodes occur in the next six months, the Monitoring Team will review them. In order to maintain the finding of substantial compliance, the Facility should take steps to ensure that the requirements discussed in previous reports are met in any instance of chemical restraint.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment 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 pretreatment sedation. The pretreatment 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 Services Department had been maintaining data on the frequency with which general anesthesia and pretreatment oral sedation were required to accomplish successful dental appointments. The summary data prepared by the Dental Department for this review indicated that from 10/1/13 through 3/31/14 there had been 1,002 visits to the Dental Clinic, of which 959 (96%) had been accomplished without any oral or general sedation. During this same time period there were eight (0.8%) dental appointments for which the individual received oral pretreatment sedation, and 32 (3%) for whom general anesthesia was utilized. Review of the data related to the specific utilization of pretreatment sedation for dental and medical procedures (from 4/1/13 through 10/18/13) indicated that the orders were primarily for Halcion 0.5 milligrams (mg) or Ativan in a range of one to two milligrams. 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 actually administered the general anesthesia performed the detailed physiological monitoring for the procedure. The monitoring for the physiological effects of the oral pretreatment sedation occurred in three different settings. The medication was administered at the individual's residence approximately one hour before the dental appointment. Thus, the post-administration monitoring was performed at the residence, and then transitioned to the Dental Office at the time of the appointment. After the work in the Dental Office was completed, each individual was transferred to the Infirmary for further monitoring, and was released back to the residence at the discretion of the Infirmary Nursing Staff. Therefore, in order to track the physiological monitoring, it was	Noncompliance

#	Provision	Assessment of Status	Compliance
		necessary to review data from those three different sources: the individual's residence, the Dental Office, and the Infirmary. However, the Dental Department utilized the Restraint Checklist in order to create a complete chronological record, which encompassed data from all three settings. The topic of the physiological monitoring related to the use of pretreatment 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 pretreatment sedation for dental procedures. However, review of the raw data related to the utilization of pretreatment sedation for medical procedures for the prior six months indicated that the majority of pretreatment sedation at ABSSLC was utilized for medical appointments. Obviously, the situations that required pretreatment 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 pretreatment sedation for medical and dental procedures suggested that the issue of pretreatment sedation for medical procedures required more attention. During the Monitoring Team's onsite review, a request was made for a listing of individuals for whom Medical Desensitization Plans had been developed. The Facility's response was that no such plans had been developed. The ABSSLC Desensitization Tracking Worksheet indicated that as of 4/10/14, 81 individuals had been evaluated, and there were 20 "formal written plans," as well as 25 "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. As noted above, 81 individuals had been assessed. The Dental Department estimated that, within the entire Facility population, there were at least an additional 12 individuals who would require assessments, and possibly more. This estimate was based on the presence of poor oral hygiene in 28 additional individuals, 12 were definite candidates, as they had a behavior that could be addressed by desensitization, and interfered with the dental appointment. The Dental Department also had developed a methodology for assessing the results of the desensitization initiation, as indicated below:	

#	Provision	Assessment of Status	Compliance
		% OF INDIVIDUALS AT LEVELS 1-7 *Population: 49 individuals active during 10-1-2013 thru 4-10-2014:* *Level 1 = come into dental office and sit in dental or regular chair* *Level 2 = Level 1, PLUS allow blood pressure/O2* *Level 3 = Level 1-2, PLUS full mouth brushing* *Level 4 = Level 1-3, PLUS using finger to pull lips down and cheeks out* *Level 5 = Level 1-4, PLUS use of mirror to view mouth* *Level 6 = Level 1-5, PLUS scaling with plastic implant scaler, metal scaler, or cavitron* *Level 7 = is able to complete full treatment and scaling at one session per RDH [Registered Dental Hygienist] criteria* *BREAKDOWN:* *Limited/no improvement – 16.00% (still require sedation and/or general anesthesia)* *LEVEL 1 – 4.00%* *LEVEL 2 – 4.00%* *LEVEL 3 – 8.00%* *LEVEL 4 – 2.00%* *LEVEL 5 – 10.00%* *LEVEL 6 – 27.00%* *LEVEL 7 – 29.00%* The initiative to develop Desensitization Plans for medical procedures was less well developed, even though there were many more individuals who required pretreatment sedation for medical procedures. The Facility should expand the assessment of the need for, as well as the development of, Pretreatment Sedation Desensitization Plans for medical procedures in the near future. The development of a database for medical procedures, that is similar to that used to track both the need for and the development of Pretreatment Desensitization Plans for dental procedures, would assist in this process. The finding of noncompliance was carried over from the prior review because of these deficits. However, the significant progress related to the development and implementation of Dental Desensitization Plans was noted.	
J5	Commencing within six months of	Dr. Michael Murray, who was Board Certified in Adult and Adolescent Psychiatry and had	Substantial

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>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 entirely on individuals with ID/DD.

At the time of the prior review, Dr. John Crowley served as a Consulting Psychiatrist for 84 hours per month. On 3/31/14, this consulting contract was terminated.

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 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.

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 May 2014 onsite review, 155 individuals were prescribed psychotropic medication at ABSSLC. Although these were raw numbers that did not take into consideration the census at the Facility, or such factors as the numbers of individuals that had died or transitioned to the community that were prescribed psychotropic medication and so should be viewed cautiously, this number had continued to decline over the past three years, as indicated below:

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

#	Provision	Assessment of Status	Compliance

February 2011	222
August 2011	219
February 2012	199
August 2012	189
May 2013	182
November 2013	168

The Psychiatry Department currently employed one full-time Psychiatrist and two full-time Advanced Nurse Practitioners (APRN) with prescribing privileges.

The psychiatric providers 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 prior reviews, the Facility had performed an analysis of the number of psychiatric practitioners necessary to provide direct clinical care to the individuals that were prescribed psychotropic medication, including fulfilling all of the requirements of the Settlement Agreement. 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 analysis also 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 update 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.

As noted above, the Department had three Full-time Equivalent (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 preparation for the current Monitoring Team's review, the Chief Psychiatrist prepared a chart that listed the caseload distribution, by provider, for each month, from November 2013 to April 2014. This data indicated that the two Nurse Practitioners collectively follow 133 individuals, and the Chief Psychiatrist follows 26. The total number of individuals followed at the time of these calculations was 159, and as noted elsewhere in this report, the total number of individuals prescribed psychotropic medication had declined to 155. The Chief Psychiatrist had developed a table to track this information. The caseload distribution during this time period is reproduced below:

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Provider/Credentials</th><th>November 2013</th><th>January 2014</th><th>April 2014</th></tr>
<tr><td>Contract Psychiatrist</td><td>84 hours
76 Individuals</td><td>48 hours
42 Individuals</td><td>No longer on contract</td></tr>
<tr><td>APRN</td><td>1 FTE
49 Individuals</td><td>1 FTE
62 Individuals</td><td>1 FTE
67 Individuals</td></tr>
<tr><td>Chief Psychiatrist</td><td>1 FTE
96*</td><td>1 FTE
125*</td><td>1 FTE
133* and 27</td></tr>
<tr><td>APRN</td><td>1 FTE
47 Individuals</td><td>1 FTE
63 Individuals</td><td>1 FTE
66 Individuals</td></tr>
<tr><td>Totals</td><td>3.53 FTE
172**</td><td>3.3 FTE
167</td><td>3 FTE
160</td></tr>
</table>
* Via supervision of the caseload(s) of the APRN(s).
**Caseload counts are determined the previous month and vary with time. Also, once individuals in psychiatric services are off all psychiatric medications, they are followed for 60-90 days before being discharged from psychiatric services. Therefore, the total caseload can vary from the total count of individuals on psychiatric medications.

The finding of substantial compliance was carried forward from the Monitoring Team's previous review, as 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.
</td><td></td></tr>
<tr><td>J6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.</td><td>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 individuals' psychiatric status at the annual ISP meeting. It was completed in conjunction with the preparation for the annual ISP, and finalized after the ISP, as it was often changed to reflect the discussion in the ISP meeting.

The review of the medical records of 23 individuals (15% of the 155 individuals prescribed psychotropic medication) indicated that a CPE had been completed within the last two years, and an updated annual PTP had been completed within the past year. These assessments met both the quality and timeliness criteria as set forth in the Settlement Agreement for all of the 23 (100%) individuals in the sample. 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 was four pages in length and was divided into four major sections as follows:

Section I: Annual Psychiatric Update</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Section II: Formulation & Integration
Section III: Psychiatric Medications & Monitoring
Section IV: Benefit vs. Risk of Psychiatric Medications & Placement

Subsequent to the Monitoring Team's prior onsite review, the section related to Discharge Recommendations had been expanded, and the risk-benefit discussion had been changed from the prior format (which was too complicated for teams and guardians to decipher), and was replaced by a summary overview paragraph. This also had been recommended in the Monitoring Team's prior report. 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, from 5/1/13 through 4/30/14, a CPE and/or PTP had been completed within the prior year for 159 (89%) of the individuals prescribed psychotropic medications. The total number differs from the number prescribed psychotropic medications during the onsite review, due to transitions/discharges in early May.

This provision 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 individuals who had been admitted since the Monitoring Team's prior review, and were prescribed psychotropic medication at the time of admission:

<table><tr><th>Individual</th><th>Date of CPE</th></tr><tr><td>Individual #428</td><td>Within 34 days of admission</td></tr><tr><td>Individual #446</td><td>CPE in process</td></tr></table>
The review of the CPE for Individual #428 indicated that it 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.</td><td></td></tr>
<tr><td>J7</td><td>Commencing within six months of</td><td>The spreadsheets produced in conjunction with the Monitoring Team's initial reviews</td><td>Substantial</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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.	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 10/1/13 through 5/15/14. The specific information related to the two individuals, who had been admitted within the timeframe described above, is as follows: <u>Individual #432</u>: Reiss Screen was administered within 21 days of admission. (Total Reiss Score = 0) The Reiss Score was below the clinical cut-off and there was no need for further psychiatric evaluation. <u>Individual #436</u>: Reiss Screen was administered within two days of admission. (Total Reiss Score = 0) The Reiss Score was below the clinical cut-off and there was no reason for subsequent psychiatric evaluation. For individuals that already had a Reiss Screen, the Monitoring Team's initial reviews recommended that the Facility develop a mechanism to record the nature of the change in status that precipitated the decision to pursue a Reiss Screen, as well as any pertinent follow-up if the Reiss Score was above the clinical cut-off score. A Reiss Score above nine should precipitate a CPE that meets the criteria specified in the Settlement Agreement, or there should be a plausible explanation as to why a CPE was not performed for the individual. The Psychiatry Department responded to this recommendation by maintaining a comprehensive spreadsheet to track any change in status or other reasons that would prompt the administration of the Reiss Screen, the date of administration, the action taken as a result of the Reiss score, and/or if it was elevated above the clinical cut-off score. The following individuals were evaluated with a Reiss Screen during this timeframe, due to a change in status, as indicated below:	Compliance

#	Provision	Assessment of Status	Compliance

INDIVIDUALS RECEIVING REISS SCREENING PRN	REASON FOR REISS	DATE OF REISS (SCORE)	DATE SEEN BY PSYCHIATRY	DATE OF CPE
Individual #32	Aggression	10/7/13 (16)	11/6/13	11/6/13
Individual #204	PCP requested depression evaluation	10/24/13 (5)	N/A	N/A
Individual #100	PCP requested due to repetitive arm mannerisms, asking same questions, and history of Obsessive Compulsive Disorder and psychiatric treatment	11/18/13 (4)	N/A	N/A
Individual #383	Recent discharge from psychiatric services but demonstrating "increased challenging behavior"	11/27/13 (14.5)	12/9/13	N/A
Individual #383	Repeat Reiss requested by psychiatry to demonstrate score was now below cut-off	03/10/14 (2)	N/A**	N/A
Individual #434	Psychiatric Consultation	3/18/14 (20.5)	4/16/14	*
Individual #40	No initial Reiss was identified, thus one was done	1/16/14 (0.5)	N/A	N/A
Individual #18	Psychiatric Consultation	2/27/14 (0)	N/A	N/A
Individual	Had not had initial	3/5/14	N/A	N/A

#	Provision	Assessment of Status	Compliance

#521	Reiss screening	(0)		
Individual #42	Psychiatric Consultation	3/5/14 (1)	N/A	N/A
Individual #167	While preparing annual Behavioral Health Assessment for ISP, Psychologist noted no Reiss screening had been done	4/10/14 (2.5)	N/A	N/A

* Guardian/family refused psychiatric services, and the Treatment Team did not feel there were groups to challenge this decision in Court. In addition, Reiss Score may have been affected by nicotine withdrawal.
**Reiss repeated to ensure psychiatric services were not warranted

This data indicated that the Reiss Screen was being utilized when an individual's team developed concerns about a change in an individual's clinical status. However, at the time of the Monitoring Team's prior reviews, there was no formal written policy that would indicate under what specific circumstance an individual should be considered for a Reiss evaluation.

During the current review, this issue was discussed with the Chief Psychiatrist, who indicated that the Facility had developed a procedure that outlined the specific process for 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
  - Reiss Screen (new referrals)
  - Behavioral Data
  - Habilitation Therapy and Health Data
  - Psychosocial Input
  - Family Input

ABSSLC remained in substantial compliance with this provision. There was evidence of

#	Provision	Assessment of Status	Compliance
		ongoing monitoring of the status of 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 three 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 Psychiatric Clinics and the related documents illustrated the active collaboration between the two disciplines. A prior deficit in this collaboration, in terms of case formulation, was the co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional 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 both the Psychiatry and Behavioral Health Services Department sections of 22 of the 23 (96%) individuals' records. The exception to this was the record of Individual #460, for whom the Behavioral Health Services section of the record was missing in the materials the Facility provided. However, the Behavior Treatment Plan was extensively discussed in the documentation contained in the 1/7/14 ISP for this individual. All of the other individual records contained the Behavioral Health Services section, which included the Behavior Support Plan. Section J.8 also contained the terminology "integrate pharmacological treatments with behavioral and other interventions through combined assessments and case formulation." The primary setting during which the active collaboration between the Psychiatry Department and Behavioral Health Services was the most visible occurred within the context of the Psychiatry Clinics. The subject of the collaboration between the Department of Psychiatry and Behavioral Health Services also is discussed with regard to Section J.9.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The primary disciplines that attended the Psychiatry Clinics were Nursing, Psychiatry, Behavioral Health Specialist, Direct Support Professionals, and the Qualified Intellectual Disabilities Professionals. The Psychologist played an active role in this process, and it was clear that the Psychiatrist and the other members of the IDT relied heavily upon the behavioral data and other information the Psychologist provided. Other disciplines, such as primary care providers (PCPs), Occupational Therapy and Physical Therapy were, of course, not able to attend the Psychiatry Clinics, because there were several every week. However, these disciplines often attended the individual ISP meetings. At the time of the Monitoring Team's prior review, the members of the Psychiatry Department had begun attending the ISP meetings to the extent possible. The review of the current sample of 23 individual records found that the primary psychiatric provider had attended the ISP meeting for 20 of the 23 (87%) individuals. The exceptions were the ISPs (and the date of ISPs) for the following individuals: Individual #320 (12/6/13), and Individual #324 (3/11/14). The Attendance Sheet for the 4/22/14 ISP for Individual #393 was blank, so it was not possible to determine if the psychiatric provider had attended. The Psychiatry Department also maintained data to track their participation in the annual ISPs. The summary of this information was as follows: **Psychiatry and the Annual ISP** / **Participation in Relevant ISPs** / **Average Time when Participating in ISP** October 2013 / 100% (15/15) / 63 minutes November 2013 / 100% (6/6) / 110 minutes December 2013 / 90% (9/10) / 86.6 minutes January 2014 / 100% (15/15) / 83 minutes February 2014 / 100% (19/19) / 67.1 minutes March 2014 / 100% (13/13) / 84.2 minutes In May 2013, the Psychiatry Department began to integrate the PTP into the Behavioral Health section of the IRRF. The material in the Behavioral Health Services 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*	

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		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: Hospitalizations for a psychiatric diagnosis within the past 6 months: Review of status and 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] worksheet. 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 worksheet." The current review of 23 individuals' ISPs found a considerable amount of written documentation relevant to the individual's PTP. The extent of this material varied considerably between individual records, which 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. All of the ISPs contained little or no information in the narrative sections of the ISP, as the intent appeared to be to have the entire discussion appear in the IRRF. The rationale for this change was that the IRRF was usually thoroughly reviewed and discussed during the ISP meeting and, thus, placing the material there would ensure the entire Treatment Team reviewed it. The Monitoring Team's current review found that the material in the IRRF, although it followed the prompts DADS Central Office provided, was completed in such a way that it did not provide an adequate amount of information, and did not substantiate that there had been an active discussion of the issues during the ISP meeting. The Psychiatry Department recently had changed this format by adding a lengthy narrative discussion to the IRRF. This section of the combined Psychiatry Department/Behavioral Health Services section of the IRRF was entitled: "Team Deliberations and Final Recommendations/Case Formulation," although the exact	

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		wording varied somewhat between ISPs. This material, which was in the range of two to three pages in length, effectively summarized and brought together the different sections of the IRRF documentation into a cohesive presentation, which included a summary of the relevant deliberations that occurred during the ISP meeting. The ISP documentation that contained this expanded information for the sample of 23 individuals (and date of ISP) were those of the following individuals: Individual #63 (4/10/14); Individual #61 (3/26/14); Individual #242 (4/23/14); Individual #231 (3/18/14); Individual #424 (4/3/14); Individual #405 (3/14/14); Individual #439 (4/23/14); and Individual #518 (6/13/13). The documentation for Individual #518 did not follow this format, but did contain an adequate discussion in both the narrative sections of the ISP and the IRRF. Thus, the ISP documentation was found to be adequate for eight of the 23 individuals. The ISPs for Individual #95 (4/24/14) and Individual #481 (5/8/14) had not yet been finalized and could not be scored. This reduced the total number of ISPs for review to 21, of which eight were found to be adequate (38%). The more recent ISP documentation, which contained a lengthy narrative summary/case formulation, as well as the team deliberations embedded within this summary, indicated that the IDTs had found an effective means of addressing the requirements of this provision. However, this change had occurred so recently that the Facility remained in noncompliance, based on the overall review. However, if these improvements can be sustained in the future, the compliance rates should increase substantially.	
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	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 23 records of individuals receiving psychotropic medication. The Psychiatrist relied upon the data provided by the Behavioral Health Services when making decisions about potential changes in an individual's psychotropic medication. Previously, a significant deficiency in this process, which the Monitoring Team's prior reports identified, 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 PTP and the PBSP 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	Noncompliance

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	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.	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 (PMI) form served as an addendum to the PTP when a new medication was started for an individual already receiving psychiatric services. The identification of the primary symptoms of the individual's psychiatric disorder, which was contained in the PTP, provided a major contribution to the differentiation of learned behaviors from those derived from the individual's psychiatric disorder. A subsequent section 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, and the least restrictive intervention. The review of the 23 records contained in this sample indicated that these areas were completed in all (100%) of the documents reviewed, in a timely 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 all of the 23 (100%) individuals. The interaction of the biological and behavioral-based aspects of the individual's presentation was also discussed in the Bio-Psycho-Social-Spiritual formulation section of 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.	

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		As noted above with regard to Section J.8, a review of the sample of 23 records identified significant differences in the documentation contained in the ISPs. However, the most recent ISP documentation, which contained an expanded narrative case formulation, including the IDT team deliberation during the ISP meeting, had brought the compliance rate to eight of 21 (38%), as two of the 23 ISPs had not yet been finalized. The Psychiatry Department also was tracking these parameters in their own self-assessment process, as noted below: *<u>The results of the self-assessment:</u>* 1. *The active record review for the six month period from 10/01/2013 – 03/31/2014 demonstrated* a. *67% compliance with documentation of a discussion about the least intrusive and most positive interventions to treat the condition,* b. *67% compliance with documentation of a discussion about whether the Individual will be best served through behavioral, pharmacological, or other interventions, &* c. *61% compliance with documentation of non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychiatric medication.* *IRR was 87% for all of the above components monitored to assess Provision J.9 compliance.* 2. *The active record review initiated in March 2014 for those ISPs relevant to psychiatry and occurring in the previous month demonstrated over a 2-month span from 02/01/2014 – 03/31/2014* a. *84% compliance with population of the Behavior Health Prompts in the IRRF by psychology,* b. *84% compliance with discussion of least intrusive and most positive interventions in the IRRF,* c. *100% compliance with discussion as to whether the Individual will be best served through behavioral, pharmacological, or other intervention in combination or alone, and* d. *100% compliance with integration of psychiatry with the PBSP and other supports ad interventions.* Thus, although the Psychiatry Department had made progress in addressing these issues,	

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		ABSSLC remained in noncompliance with this provision. This was due to the deficits in teams' deliberations in ISP meetings and/or the ISP documentation, including specifically the need for teams to deliberate and to document the team's discussion and their conclusions about the specific requirements of Section J.9 of the Settlement Agreement. However, the aforementioned format, found in the more recent ISPs, appeared to effectively address this deficit.	
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. The 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, the prior HRC meetings and discussion with the Human Rights Officer, as well as the interviews with the Chief Psychiatrist during the current review indicated that the process had been fully integrated into the clinical review process and was operating efficiently. The Monitoring Team's current review found that there was an adequate discussion of the risk-versus-benefit analysis in all of the 23 (100%) individual records in the sample. Supporting documentation for these analyses was contained in the Quarterly Psychiatric Review, as well as the PTP. The Quarterly Psychiatry Review form contained specific sections related to: ▪ The evidence that would support the efficacy (benefit) of the current psychotropic medication; ▪ A checklist of commonly experienced side effects, including a space for "other" and a global rating of severity; ▪ The most recent MOSES and DISCUS scores; and ▪ A section to address any questions or comments raised by the last Quarterly	Noncompliance

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		Drug Regimen Review. The Facility had previously documented their risk assessment through a detailed format referred to as the "Risk Analysis of Psychiatric Plan and Other Reasonable Treatments (RAPPORT)." Although this document was no longer used as a reporting method, it was used as a worksheet for the team to compile information needed to complete a thorough risk assessment. The content of this worksheet was as follows: ▪ 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 Medications); ▪ Assessing Potential and Realized Risks (Use Also in Polypharmacy/Side Effects Section of the IRRF); ▪ Validating MOSES by Item Ratings of three or four 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. 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 which many of the IDT members participated. However, the actual results of these deliberations had been simplified into a document in a manner that was more comprehensive to the team and guardians, as per the recommendations in the prior Monitoring Team's review. This summarized information now appeared in the PTP and the IRRF. As noted above, this review found that there was adequate documentation of a risk-versus-benefit analysis in the entire sample of 23 (100%) individual records. The Facility had developed a system that 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	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>provision, which stipulates that “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.”

As indicated in the discussion of Section J.8, the review of the ISP documents, contained in the sample of 23 individuals, found that the documentation for many of the individuals contained only a minimal discussion of the psychiatric aspects of the individuals overall service plans, which included the risk-versus-benefit analysis.

Accordingly, although progress had been made in the preparation 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, Director of Behavioral Services, Clinical Pharm. D., Psychiatric Specialty Nurse, Psychiatric Nurse Practitioners, and Medical Director (occasionally) attended these meetings, which the Pharm.D facilitated. 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 who were in the Stable Polypharmacy group, who were reviewed quarterly, which appeared clinically appropriate.

On 5/13/14, a member of the Monitoring Team observed the May meeting of this Committee. The meeting included a review of the status of each individual whose profile met the criteria for polypharmacy. This discussion focused on the feasibility and current status of the attempts to reduce polypharmacy for each individual.

Documentation from the 5/13/14 meeting provided a summary of the Facility’s progress toward minimizing polypharmacy as of that date. 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><th>5/14</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><td>9</td></tr>
<tr><td>Number of individuals receiving three or more</td><td>108</td><td>46</td><td>46</td><td>43</td></tr>
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</td><td>Substantial Compliance</td></tr>
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medications, regardless of class or indication					
Total number of individuals on polypharmacy	108*	50*	49*	45*	
Total number of individuals receiving psychotropic medication	224	182	168	155	
Percentage of individuals with polypharmacy	48%	27%	29%	29%	

*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 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).

At the conclusion of the 5/13/14 Polypharmacy Committee Meeting, the number of individuals in the AP category was 13, 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 45 (71%) individuals prescribed medication regimens that met the criteria for polypharmacy, which equates to 21 percent of the total number (N=155) of individuals prescribed psychotropic medication.

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 13 individuals they were in the AP category and by definition the medications for these individuals had not yet been justified. However, the latter number also included five individuals who had been admitted to the Facility within the past year. The other three new admissions were placed in the Stable polypharmacy group. The number of medications these five individuals had been prescribed at the time of admission was as follows – along with their current amounts:

- One individual = seven medications – now on three;

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		▪ One individual = six medications – now on five and two being reduced; ▪ Two individuals = five medications – one of these was still on five, the other was on four; and; ▪ One individual = three medications – still on three. The process of sequentially challenging the multiple medications of an individual recently admitted is a difficult process that has to be performed carefully, over several months. When these five individuals were taken into account, the number of individuals in the AP polypharmacy category (as yet unjustified) was reduced from 13 to eight, which equates to five percent of the 155 individuals prescribed polypharmacy with psychotropic medication at the time of the review. ABSSLC clearly had made a great deal of progress in reducing unnecessary polypharmacy. This effort also was reflected in the observations of the Psychiatric Clinics that took place during the 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 SP group, and continued to actively challenge the medications for the individuals in the AP group. The historical data that 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 Polypharmacy Committee Meeting. 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 had placed in the AP grouping had more complex psychiatric presentations and also had historically been prescribed more psychotropic medications. This group also included 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.	

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		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 five 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.	
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 DISCUS and the monitoring of more general systemic side effects related to psychotropic medication with the MOSES, 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 physician. The review of the sample of the records for 23 individuals prescribed psychotropic medication showed that the MOSES evaluation was current (i.e., completed within the last six months) and had been performed at least every six months for the prior year for 21 of the 23 (91%) individuals. The documentation for Individual #278 indicated that the most recent MOSES in the record was dated 9/11/13. The information for Individual #478 indicated a gap of greater than six months between 2/5/13 and 10/8/13. The records of 20 of the 23 (87%) individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner, which had been defined as 14 calendar days. The individuals whose MOSES documentation was not reviewed in a timely manner (i.e., latency between dates) were those of the following individuals: Individual #320 (11/7/13 to 1/21/14), Individual #168 (11/15/13 to 12/3/13), and Individual #518 (11/1/13 to 1/14/14). 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 23 individuals indicated that the Facility carried out quarterly evaluations with the DISCUS, 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. Within this sample of 23 individuals, 10	Substantial Compliance

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		individuals were not prescribed antipsychotic medication. Thus, the parameters related to the administration of the DISCUS were only evaluated for the 13 individuals who were prescribed an antipsychotic agent. The DISCUS had been performed quarterly for seven of the 13 (54%) individuals who were prescribed antipsychotic medication in this sample. The exceptions were Individual #46 (for whom there was a gap between 8/30/13 and 12/20/13), Individual #4 (only one DISCUS in the record, dated 7/7/13), Individual #481 (7/11/13 to 1/10/14), Individual #324 (10/9/13 to 2/12/14), Individual #242 (10/25/13 to 3/5/14), and Individual #61 (10/10/13 to 2/20/14). 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. This review found that for these 13 individuals, the DISCUS had been reviewed in a timely manner for 10 of the 13 (77%) individuals. Those for whom there was a delay were: Individual #518 (11/1/13 to 1/14/14), Individual #320 (11/7/13 to 1/24/14), and Individual #421 (1/10/14 to 2/10/14). 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 five 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 and eight at the time of the November 2013 review. The following sample included all five (100%) individuals who fit the above criteria, including: Individual #19, Individual #21, Individual #226, Individual #385, and Individual #261. Review of the records of these five individuals related to the MOSES indicated that the examination had been performed at least every six months for all (100%) of the individuals. The evaluations also were reviewed with regard to the elapsed time between when the nurse completed the evaluation and the PCP reviewed. This analysis indicated the review by the prescriber had been completed in a timely manner for none (0%) of the five individuals. The individuals for whom there was a delay of greater than 14 calendar days between the completion of the evaluation and the review by the Provider were as follows (interval between exam and review): Individual #19 (3/6/14 to 4/1/14, and 12/16/13 to 1/7/14), Individual #21 (11/12/13 to 1/7/14), Individual	

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		#385 (11/6/13 to 1/10/14), Individual #26 (12/2/13 to 1/3/14), and Individual #226 (4/3/14 to 4/24/14). With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for three of the five (60%) individuals. The two individuals for whom there were deficits were: Individual #261 (there was only one evaluation in the record, dated 12/2/13), and Individual #226 (there was a gap greater than three months between the 10/30/13 and 4/3/14 exams). Once completed, the prescribing physician had reviewed the DISCUS evaluations in a timely manner for none of the five (0%) individuals in the sample. The individuals for whom there was a gap of greater than 14 days between the evaluation and the review by the prescriber were (interval between exam and review): Individual #19 (3/6/14 to 4/1/14, and 12/16/13 to 1/7/14), Individual #21 (11/12/13 to 1/22/14), Individual #385 (2/10/14 to 3/27/14), Individual #261 (12/2/13 to 1/21/14), and Individual #226 (4/3/14 to 4/24/14). During the Monitoring Team's current onsite review, a request was made for the documentation related to the training provided to the nurses regarding the administration of the DISCUS. 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 12/13/13 and 12/20/13, for the PCPs on 12/20/13, and for the Psychiatric Providers on 12/18/13. The Monitoring Team's prior review found that 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, and ABSSLC was found to be in substantial compliance with this provision at the time of the prior two reviews. However, following the Monitoring Team's 11/13 review, the Facility transitioned to electronic medical records for the MOSES and DISCUS. Difficulties in the implementation of this system in the electronic filing of both the MOSES and DISCUS evaluations contributed to the significant deficits in the completion of these evaluations, as well as the timely review by the prescriber. The data that illustrates the impact of this change to electronic records was reviewed in the self-assessment prepared by the Clinical Pharm.D. for Section N.5 and is reproduced below: 1. *For the 6 month [sic] time period: 100% of MOSES assessments were timely, 61% of DISCUS assessments were timely, and 72% of MOSES and DISCUS assessments were reviewed in a timely manner by the Prescriber. The most current data (January 2014 through March 2014) is reflective of notable improvement after implementing a new process which required campus-wide*	

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		training: *October 2013: MOSES 100% DISCUS 67% Timely review 100%* *November 2013: MOSES 100% DISCUS 67% Timely review 67%* *December 2013: MOSES 100% DISCUS 38% Timely review 67%* *January 2014: MOSES 100% DISCUS 67% Timely review 33%* *February 2014: MOSES 100% DISCUS 67% Timely review 67%* *March 2014: MOSES 100% DISCUS 67% Timely review 72%* During the onsite review, the Clinical Pharm.D. presented data derived from her recent Quarterly Drug Reviews, for 4/1/14 to 5/14/14. A total of 86 individuals (of the 204 reviews) required MOSES evaluations every six months, DISCUS evaluations every three months, and timely review by the Prescriber within 14 days of completion of the evaluations. The results indicated that 70 individuals (81%) were in compliance for one or more parameters. This data substantiates both the deficits that followed the transition to electronic medical records and the subsequent adaptation to the new system. However, as with the current review, the deficits were primarily related to the completion and review of the DISCUS evaluations as well as the timely review of the MOSES evaluations. The review of the 23 records contained in the current sample described above, indicated that the MOSES was competed as scheduled for 21 of the 23 individuals (91%); the corresponding rate for timely review by the prescriber was 20 of 23 individuals (87%). Only 13 of the individuals in the sample were receiving an antipsychotic agent, and seven of these 13 individuals (54%) had been evaluated with the DISCUS every three months. The corresponding analysis regarding the timely review by the prescriber indicated that for 10 of the 13 individuals (77%), the review by the prescriber had occurred within the allotted time. For those five individuals who were prescribed Reglan and were not also receiving a psychotropic medication, the MOSES had been completed as scheduled for all five (100%), but the timely review by the prescriber was deficient for all of them. The corresponding completion rate for the DISCUS was three of the five (60%), but all of these had deficits regarding the timely review.	

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		The visual inspection of raw data indicated that many of the deficiencies occurred during the time period that corresponded to the aforementioned problematic implementation of the electronic medical record system. The corresponding data collected by the Pharm.D. also documented a decline in completion rates following the implementation of the new system, followed by a return to the historically high rates of completion. The Settlement Agreement recognizes that compliance can be continued for provisions that have been in compliance for repeated reviews, and then develop deficiencies related to a one-time event. Both the historical and current data indicate that the Facility had developed successful strategies for ensuring that these evaluations were completed and reviewed in a timely manner. This system was adversely impacted by the problematic implementation of the electronic medical record for the MOSES and DISCUS, but the Facility had now adapted to that system and appeared to be returning to their historic high levels of compliance. Accordingly, the finding of substantial compliance was carried forward for this review. In order to maintain substantial compliance for the next review, the Facility will need to demonstrate that the problems are fully resolved.	
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	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 23 (15%) of the 155 individuals prescribed psychotropic medication identified adequate documentation to support the psychiatric diagnosis of record 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, and summarized in those individuals' ISPs. This subject is also discussed in more detail with regard to Sections J.2 and J.6. The criteria for this section also address the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were referred to in ABSSLC documentation as the "target behaviors" of the psychotropic medication. As noted above, with regard to Sections J.8 and J.9 of the Settlement Agreement, a persistent problem with the documentation in ABSSLC records had been the dual identification of a specific behavior as being both a "target behavior" of the prescribed psychotropic medication, and also as being present on a learned or behavioral basis. There had been significant improvement in this area, which is discussed in detail with regard to Sections J.8 and J.9. The objective symptoms of the psychiatric disorder and the related behavioral	Substantial Compliance

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	quarterly.	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 format of the meetings was not strictly formalized, but generally followed the outline of the 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. 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 (BMI); type of diet; allergies to medications; the results of the most recent MOSES and DISCUS evaluations; the results/comments of the last quarterly review by the Pharm.D., including the response to those comments; a description of any	

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		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 23 (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 in relation to Section J.6. This section of the Settlement Agreement also addresses the question of ABSSLC's capacity to monitor the efficacy of the prescribed psychotropic medication. As indicated in the discussion of 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 23 (100%) individuals. 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 23 (100%) individuals. The review of the active records for 23 of the 155 individuals (15%) prescribed psychotropic medication indicated that the information that relates to the criteria specified in this provision was uniformly present in all of the records, as detailed above. The observations of the Psychiatric Clinics also confirmed that the discussions in those meetings corresponded to the format of the records. Accordingly, the Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	
J14	Commencing within six months of the Effective Date hereof and with	The review of the Rights/Consents sections of the records for the sample of 23 individuals indicated that 19 individuals had a Guardian of the Person. Those individuals	Substantial Compliance

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	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.	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, where 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 in the individual's residence. Another member of the treatment team 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. This was a member of the team that 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. Observations of the HRC Committee meetings during the Monitoring Team's prior review indicated that discussions 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. Psychiatric providers now attended primarily at the request of the HRC Officer, when it was felt that their direct input would be beneficial to the Committee. The interview with the HRC Officer and the review of the meeting minutes indicated that the HRC was now proficient in understanding the risk-versus-benefit process. It was noted that the manner in which the risk-versus-benefit information was formatted was particularly helpful. The side effects documented in the Quarterly Psychiatric Review were identified as being particularly helpful to the	

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		Committee as well. The HRC review of the 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 all 23 (100%) records of individuals receiving psychotropic medication. The information packets assembled for the 5/13/14 review of the psychotropic medication prescribed for Individual #446, Individual #273, Individual #241, and Individual #29 were also reviewed and found to contain sufficient information. The direct observations of the Human Rights Committee review of the use of psychotropic medications during the Monitoring Team's prior reviews, as well as the documentation from the more recent 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 process to document the Psychiatric Department's risk-versus-benefit assessment, which was being systematically implemented (albeit, not necessarily discussed and deliberated by the entire IDT). The Monitoring Team's earlier 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. It is noted that the Psychiatry Department's own self-assessment had identified a few instances in which the signed consent had not been filed in the individual's record, and for this reason they had listed themselves in noncompliance with this provision. It is conceivable that the 100 percent compliance found in the current review was simply due to the composition of the sample. However, it is also possible that this finding was a result of the Psychiatry Department's efforts to rectify this matter as part of their internal quality improvement process. Accordingly, based on the Monitoring Team's findings, ABSSLC was found to be in substantial compliance with this provision of the Settlement Agreement.	

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J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	ABSSLC had previously 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. Given the number of individuals who were followed in the Neurology Clinic, and the relative percentage of those who met the criteria described in this provision, it appeared nearly impossible for the Psychiatrists to physically attend these Clinics, which could last in excess of three hours. 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. These problems appeared primarily logistical in nature, because the existing Neurology Clinic was organized to bring all individuals from a specific residence, that were due to see the Neurologist, in at the same time. This enabled the direct support professionals and the nurse to provide information to the Neurologist. The individuals who were also followed by the Psychiatry Department were interspersed throughout these large groups, making it impossible to develop a separate Neurology-Psychiatry Clinic within the current system. The period of observation of the Neurology Clinic on 5/12/14 confirmed that it would be extremely difficult to arrange the schedule so that the individuals with psychiatric disorders were reviewed at a specific time. During the Monitoring Team's initial reviews, the Facility had indicated that if, in the future, more Neurology consultation time was required the contract could be expanded. During the past year, an additional Neurologist had been hired to augment the primary Neurologist. This had made it possible to provide one extra Neurology Clinic per month, for several months. However, once the Neurology Clinic appointments were current, there no longer appeared to be a need for this extra resource, and the Facility relied on the primary Neurologist at the time of this review. The methodology used to assess the degree to which there was coordination between the Psychiatry and Neurology Departments involved locating a recent (i.e., 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 to the individual's psychotropic medication, as well as other aspects of the individuals' psychiatric status. The existence of a corresponding reference to the Neurology Consultation in the Psychiatry section of the record also was assessed. Documentation that the individual had been seen in a Neurology Clinic during the past year was present in 10 of the 23 individuals. Documentation that the Neurology Clinic	Substantial Compliance

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		had occurred appeared in the Psychiatric Quarterly Review Notes for all of the 10 (100%) individuals in this subsample. Thus, the Psychiatry Department was tracking the occurrence of and results from a Neurology Consultation for all of the individuals in the sample that they followed. The Neurology Notes also referenced the psychotropic medications for all 10 (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 medications prescribed by the Neurologist. The language of this provision of the Settlement Agreement is specific in stating that the Psychiatrist and the Neurologist coordinate the use of medications "when they are prescribed to treat both seizures and a mental health disorder." At the time of the onsite review, the list of individuals prescribed anticonvulsant medication for psychiatric purposes identified 45 individuals. However, many of these individuals did not have a comorbid seizure disorder, as anticonvulsants were primarily used by 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. The Psychiatry Department prepared a detailed spreadsheet for the 36 individuals prescribed anticonvulsants for a psychiatric indication and who did not have a seizure disorder. The review of this document indicated that it contained both the specific medication, as well as the specific psychiatric diagnosis. In May 2013, the Psychiatry Department developed the "Provision J.15 Tracking Log" to monitor the status of the nine individuals for whom anticonvulsant medications were used for both psychiatric and neurological purposes, as described in this provision. The current summary of this initiative appeared in the Facility Self-Assessment related to Section J. *<u>The results of the self-assessment:</u>* 1. *The Provision J.15 Tracking Log currently tracks 9 Individuals with shared indications between Neurology and Psychiatry for seizure medications. For the 6-month span of 10/01/2013 – 03/31/2014, 8 of the 9 Individuals with shared indications between Neurology and Psychiatry for seizure disorder medications were seen in the Neurology Clinic. Of the 8, two did not have shared indications at the time of the Neurology Clinic. Coordination was achieved for these Individuals, one by phone via the PCP during the clinic & one via a Psychiatric Consultation from the PCP. Six of the 8 Individuals (75%) seen by the Neurology in the 6-month span assessed have clear documentation of the active participation by the Psychiatric Provider with the Neurologist directly or via the PCP.*	

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		2. The active record review for the six month period from October 2013 to March 2014 demonstrated *a. 100% compliance with documentation of medications prescribed to treat both seizures and a mental health disorder, and* *b. 100% compliance with documentation of the discussion of the results of the Neurology Consult with the IDT when active participation in the Neurology Consultation process was not documented.* The following table provided more specific information regarding the current process as it related to these nine individuals: *Provision J.15* *NEUROLOGY LIST (last amended 05/12/2014)* *Indiv. # / Neurology Clinic Date / Provider(s) present in Neurology Clinic / Subsequent Quarterly Documents Shared Indications – IDT discussion* *Indiv. #481 / 10/28/2013 / Not documented / Yes / Yes* *Indiv. #323 / 10/28/2013 / Not documented / Yes / Yes* *Indiv. #137 / 11/04/2013 / Yes / Yes / Yes* *Indiv. #526 / 11/04/2013 / Yes / Yes / No* *Indiv. #393 / 12/16//2013 / Yes / Yes / Yes* *Indiv. #180 / 03/24/2014 / Yes / No Quarterlies since Neuro visit* *Indiv. #215+ / 01/20/2014 / Yes / Yes* *Indiv. #76*+ / 03/10/2014 / PCP requested Psych Consult after Neuro visit / No Quarterlies since Psych Consult* *Indiv. #525 / 04/14/2014 / Yes / Subsequent Quarterly Review has not yet occurred* **This individual had Zyprexa discontinued during a medical hospitalization, and VPA was begun as it was felt this would treat both the psychiatric and seizure disorders. A Psychiatric Consultation was performed on 3/12/14, and has not yet been seen for*	

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		Quarterly Review. *+New* ABSSLC was found to be in substantial compliance with this provision, because they had developed and implemented a systematic process to coordinate the treatment of 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 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 at the entrance meeting, 5/12/14; o Section K Presentation Book; o Section K Self-Assessment, updated 5/3/14; o Table outlining staff progress on obtaining certification from the Behavior Analysis Certification Board; o Psychology Procedure: Behavior Services Peer Review, revised 5/3/14; o Minutes from meetings of the Behavior Support Committee (BSC), from 10/2/13 to 3/26/14; o Minutes from meetings of the Internal Peer Review Committee (IPRC); o Minutes from meeting of the External Peer Review Committee, on 10/4/13, 11/13/13, 1/17/14, and 2/14/14; o Psychology Monthly Progress Note (12/13 to 2/14): Individual #276, Individual #545, Individual #525, and Individual #447; o Psychology Monthly Progress Note (1/14 to 3/14): Individual #517, Individual #196, Individual #430, and Individual #59; o Psychology Monthly Progress Note (2/14 to 4/14): Individual #280, Individual #334, Individual #505, Individual #24, Individual #256, Individual #397, Individual #327, and Individual #182; o Targeted Problem Behavior Data Sheets: Individual #280 (1/27/14 to 5/18/14), Individual #517 (12/30/13 to 3/30/14), Individual #334 (12/30/13 to 4/6/14), Individual #196 (1/6/14 to 3/31/14), Individual #276 (12/30/13 to 4/6/14), Individual #505 (1/27/14 to 5/18/14), Individual #545 (11/25/13 to 4/6/14), Individual #24 (2/1/14 to 4/30/14), Individual #256 (1/27/14 to 5/4/14), Individual #430 (12/30/13 to 3/30/14), Individual #397 (2/3/14 to 5/4/14), Individual #525 (12/2/13 to 3/31/14), Individual #447 (1/1/14 to 3/31/14), Individual #59 (12/30/13 to 4/6/14), Individual #327 (2/1/14 to 4/30/14), and Individual #182 (1/27/14 to 5/4/14); o Replacement Behavior Data Sheets: Individual #280 (1/27/14 to 5/18/14), Individual #517 (12/30/13 to 3/30/14), Individual #334 (12/30/13 to 4/6/14), Individual #276 (12/30/13 to 4/6/14), Individual #505 (1/27/14 to 5/18/14), Individual #545 (11/25/13 to 4/6/14), Individual #24 (2/1/14 to 4/30/14), Individual #256 (1/27/14 to 5/4/14), Individual #430 (12/30/13 to 3/30/14), Individual #397 (2/3/14 to 5/4/14), Individual #525 (12/2/13 to 3/31/14), Individual #59 (12/30/13 to 4/6/14), Individual #327 (2/1/14 to 4/30/14), and Individual #182 (1/27/14 to 5/4/14); o Functional Assessment: Individual #280, Individual #517, Individual #334, Individual #196, Individual #276, Individual #505, Individual #545, Individual #256, Individual #430, Individual #397, Individual #525, Individual #447, Individual #59, Individual #327, and Individual #182;

	○ Abbreviated Functional Assessment: Individual #24; ○ Behavior Health Assessment: Individual #280, Individual #517, Individual #334, Individual #196, Individual #276, Individual #505, Individual #545, Individual #24, Individual #256, Individual #430, Individual #397, Individual #525, Individual #447, Individual #59, and Individual #182; ○ Behavioral Health Evaluation/Update: Individual #432; ○ Behavior Protocol, Behavioral Health Assessment, Functional Assessment, Behavior Support Plan: Individual #428; ○ Master list of individuals receiving counseling from Behavioral Health Services Licensed Professional Counselor (LPC); ○ Treatment Plan and Psychotherapy Progress Notes (12/13 to 2/14): Individual #298, Individual #301, Individual #354, Individual #447, and Individual #324; ○ Minutes from Behavior Support Committee reflecting review of Treatment Plan: Individual #298 and Individual #354; ○ Positive Behavior Support Plan: Individual #280, Individual #517, Individual #334, Individual #196, Individual #276, Individual #505, Individual #545, Individual #24, Individual #256, Individual #430, Individual #397, Individual #525, Individual #447, Individual #59, Individual #327, and Individual #182; ○ ABSSLC Behavioral Health Service Department policy, undated; ○ Psychology Procedure: Training Staff on Behavior Support Plans, revised 3/1/14; ○ BSP Competency Checklist Observation completed by K. Theiss: Individual #440, Individual #478, Individual #2, Individual #140, Individual #3, and Individual #379; and ○ BSP Competency Checklist Observation completed by M. Lozano: Individual #518, Individual #220, and Individual #182. ▪ **Interviews with**: ○ Direct Support Professionals, on 5/12/14; and ○ Ron Manns, BCBA, Director of Behavioral Services, and Kathy Theiss, BCBA, Clinical Director, on 5/15/14. ▪ **Observations of**: ○ Center Incident Management Review Team, on 5/12/14; ○ Behavior Support Committee, on 5/14/14; ○ Restraint Reduction Committee, on 5/15/14; and ○ Internal Peer Review Committee, on 5/15/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, updated 5/3/14. 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 K, in conducting its self-assessment: • The Facility used monitoring/auditing tools. ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: a rubric used to review the components and quality of Functional Behavior Assessments,

	and a rubric used to review the components and quality of Positive Behavior Support Plans. o The Self-Assessment identified the sample(s) sizes. o The following staff/positions were responsible for completing the audit tools: the Director of Behavioral Services. o Inter-rater reliability was assessed on the sample of Functional Assessments and Positive Behavior Support Plans. The BCBA staff member who reviewed these documents completed this. ▪ The Facility reviewed other relevant data and documentation. This included: a review of the department staff and their progress in obtaining certification as Board Certified Behavior Analysts; a review of minutes of the Behavior Support Committee, Internal Peer Review Committee, and External Peer Review Committee; a review of a sample of monthly progress notes; a review of the Facility database of Integrity and Reliability Monitoring of PBSP implementation; and a review of the in-service database. ▪ The Facility's licensed counselor completed a monthly analysis of counseling services. ▪ The Facility consistently presented data in a meaningful/useful way. ▪ The Facility rated itself as being in compliance with three subsections of Section K, including K.1, K.2, and K.3. Of these, the Monitoring Team found the Facility to be in substantial compliance with Section K.2 and K.11. The Facility identified clinical oversight by BCBA staff as meeting the requirements of Section K.1. While it had developed some very good peer review processes, there had been a recent change in the function of the External Peer Review Committee. Until the benefit of this change can be assessed, the Monitoring Team rated the Facility as being out of compliance with Section K.3. ▪ The Facility's data identified areas of in need of improvement. Corrective Action Plans had been developed to address identified need areas related to Sections K.4, K.5, K.11, and K.12.
	Summary of Monitor's Assessment: The Facility had completed a great amount of work towards meeting the requirements outlined in Section K of the Settlement Agreement. Staff in the Behavioral Health Services Department had continued to work on obtaining certification. Supervision by Board Certified Behavior Analysts (BCBA) had increased. Peer review had been extended to include weekly meetings of the Internal Peer Review Committee. This allowed for a review of particularly difficult cases and provided a mechanism for reviewing progress on new positive behavior support plans (PBSPs) following initial implementation. Hopefully, this review process will allow for timely identification of difficulties and needed program revision. Observation of meetings of the Behavior Support Committee and the Internal Peer Review Committee revealed good participation and robust discussion. The format used when developing Positive Behavior Support Plans continued to evolve. With all new plans noting whether the individual had a Crisis Intervention Plan (CIP), staff were alerted to review another document as needed. Staff training also was addressed in this new format. A three-tiered staff training program involved competency assessed through verbal report, role-play, and on-the-job performance. Behavior Health Specialists, Behavior Health Assistants, and Behavior Coaches provided training. It was

	particularly positive to observe the flexibility in scheduling of behavior coaches to ensure training across all shifts. Weekly meetings with direct support professionals in all of the homes had also been initiated. Behavioral Health Services staff also had begun conducting regular assessment of data accuracy, data integrity, and treatment integrity. The frequency of these measures was determined at peer review meetings and was specified in the PBSP. To move towards substantial compliance, the focus should be on the following areas: continued emphasis on ongoing review of challenging cases with assessment of the benefits of the revised process for external peer review; continued work on data collection systems to ensure that reported measures of behavioral events are accurate and reliable; completion of assessments that provide information on current structural and functional variables that contribute to problem behavior; development of PBSPs that emphasize training on functionally equivalent replacement behavior, comprehensive preventative strategies, and adequate schedules of reinforcement that utilize individually identified preferences; and continued emphasis on staff training on PBSP implementation, particularly as evidenced while working directly with the individual.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., review of staff roster only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. At the time of the Monitoring Team's visit, the Department of Behavioral Health Services was staffed with a BCBA Director, an additional BCBA (identified by the Director as the department's Clinical Supervisor), and 16 Behavioral Health Specialists, eight of whom had obtained board certification as behavior analysts. Of the remaining eight Behavioral Health Specialists, four had completed all coursework and supervision requirements and four had completed at least some of the required courses. The Clinical Supervisor provided onsite bi-weekly supervision, required for certification. The Director of Behavioral Health Services had organized the department to ensure that BCBA staff were paired with those staff who had not yet achieved certification. The BCBA staff provided oversight and ongoing review of all assessments and support plans developed by non-certified staff. This was a commendable practice. Although significant progress had been made, the Facility remained out of compliance with this provision because a number of the professionals in the Behavioral Services Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, and continuing concerns with the quality of behavioral programming. Issues related to the quality of behavioral	Noncompliance

#	Provision	Assessment of Status	Compliance
		programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	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.	The Facility provided the Monitoring Team with a copy of its revised Psychology Procedure regarding Behavior Services Peer Review. Per this policy, the Facility maintained a three-tiered peer review process. ▪ The Behavior Support Committee continued to meet weekly to provide annual review of assessments and treatment plans including the individual's Positive Behavior Support Plan, and where applicable, the Crisis Intervention Plan and Counseling Treatment Plan. The Director of Behavioral Services chaired this committee, with BCBA staff participating on a rotating basis. A promising practice was regular attendance by the Behavior Coach Team Leader. o Documentation provided by the Facility for a six-month period of time reflected regular meetings of the Behavior Support Committee between 10/2/13 and 3/26/14. o Observation of the Behavior Support Committee during the week of the onsite review reflected thoughtful and active participation by the staff in attendance. It was also evident that careful consideration was given to the proposed schedule regarding plan monitoring. For example, when the author of the plan for Individual #241 suggested that staff should demonstrate competency through role-play, the Director of Behavioral Services indicated that observed competency should be the standard at least for the first few months of plan implementation. It was also promising that staff were asked to present information on plan implementation and efficacy at a meeting of the Internal Peer Review Committee approximately two months after the plan was first introduced. This timely follow-up is most commendable. ▪ The Department also had established an Internal Peer Review Committee that began meeting weekly as of October 2013. This committee reviewed difficult cases that the Director of Behavioral Services identified. BCBA staff participated on a rotating basis, with staff from other disciplines invited as appropriate. o Minutes from these meetings were reviewed. While feedback was evident, it was difficult to identify the date of the review as the minutes	Noncompliance

#	Provision	Assessment of Status	Compliance
		noted the date the plan was presented to the BSC, but not the date it was presented to IPRC. Staff should change the format of the meeting minutes, so that it is clear who was in attendance at the review and the date of the review. o Observation of the Internal Peer Review Committee held during the week of the onsite review again reflected active participation and thoughtful discussion by those present. Staff identified numerous variables that could have affected one gentleman's behavior after he and his peer moved to a new home. Additionally, the Behavior Coach Team Leader displayed a real willingness to adjust his schedule and others to ensure that staff training needs could be met. ▪ The External Peer Review Committee had been revised at its scheduled meeting in March 2014. Staff from the Abilene State Supported Living Center were now paired with staff from the Corpus Christi State Supported Living Center. External peer review was no longer conducted by a committee of qualified professionals, rather it was conducted by a single reviewer who was a BCBA level facility director. This absence of a committee will likely reduce the robustness of the review. Further, plans were no longer chosen because they were particularly challenging, instead the Quality Assurance Department identified them from the plans scheduled for annual review. o The minutes from four meetings of the External Peer Review Committee held between 10/4/13 and 2/14/14 were reviewed. The meeting held in October noted those in attendance, reflected fairly detailed feedback, and identified follow-up activities. As this process was changed in March, it will be necessary to interview staff and review upcoming meeting minutes to determine whether or not the new format results in sufficient external review. o Given that external peer review had not occurred in March and there was no evidence of an April meeting, monthly external peer review had not occurred. The Facility had developed some very appropriate and comprehensive peer review strategies, particularly within the department. The regular meetings of the Internal Peer Review Committee ensured that particularly challenging cases could be reviewed and timely assessment of plan efficacy could occur. However, external peer review had not occurred monthly and until the change in the External Peer Review process can be evaluated, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K4	Commencing within six months of the Effective Date hereof and with	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

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	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.	noncompliance finding from the last review stands. A request was made for three consecutive months of psychology progress notes for the 16 individuals in the sample. This resulted in a review of 48 monthly progress notes. A summary of findings is provided below: ▪ Behaviors targeted for reduction were identified and graphed in all of the progress reports (100%). Operational definitions of the targeted problem behaviors were provided in 11 of the 48 reports (23%). This information was provided consistently in the reports for Individual #334, Individual #447, and Individual #327. Definitions were provided in the most recent report for Individual #280 and Individual #505. ▪ In 45 of 48 reports (94%), the replacement behavior(s) was identified and graphed. No graphic display of replacement behavior was included in the reports for Individual #397. Operational definitions of replacement behavior(s) were provided in six of 48 reports (13%). This was consistently included in the reports for Individual #334, and in the most recent reports for Individual #280, Individual #505, and Individual #327. ▪ Behavioral criteria were provided for all identified targeted problem behaviors in 42 of 48 reports (88%). The exceptions were the reports for Individual #24 and Individual #430. The three consecutive monthly progress reports for Individual #24 noted that criteria for disruptive behavior would be established after 30 days of data collection. However, frequency data was included back to 4/13. The three consecutive monthly reports for Individual #430 included behavioral criteria for only two of the four targeted problem behaviors. ▪ Behavioral criteria for identified replacement behavior(s) were provided in nine of the 48 reports (19%). This was found consistently in the reports for Individual #280 and Individual #334, and in the most recent report for Individual #196, Individual #505, and Individual #327. ▪ In all of the progress reports (100%), targeted problem behavior was graphically displayed as frequency per month. Five reports included additional information on the weekly frequency of the targeted problem behavior, and two reports included daily frequency of the targeted problem behavior. While it was promising that the department had initiated daily or weekly examination of behavioral change, this was not consistently evident in all progress notes. As has been noted in the past, monthly graphing of data can mask important changes in rates of behaviors that might be due to changes in programming, changes in medication, changes in habilitation programs, or other important variables. ▪ In 36 of the 45 reports (80%) where replacement behavior was displayed graphically, data was presented as frequency per month. The exceptions were the reports for Individual #334 and Individual #24 for whom percentage of opportunities and percent correct were displayed, and Individual #327 for	

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		whom the graph was labeled opportunities. As noted above, monthly graphing of data can mask important changes in rates of behaviors that might be due to changes in programming, changes in medication, changes in habilitation programs, or other important variables. ▪ Thirty-eight of the 48 reports (79%) included information regarding current monitoring of PBSP implementation. This was reported in the text, in a graphic display, or both. Monitoring included the following measures: staff knowledge of the PBSP determined through interview, treatment integrity determined via review of video recording, inter-observer agreement, and group engagement determined through a Planned Activity Check. Reports provided information on some or all of these measures. Reported data is summarized below. o Interview scores were reported in 36 of the 38 reports (95%). Scores ranged from 50% to 100% with an average of 86.4%. o Treatment integrity scores were reported in 34 of 38 reports (89%). Scores ranged from 0% to 100% with a mean of 78%. o Inter-observer agreement scores were reported in 35 of 38 reports (92%). Scores ranged from 0% to 100% with an average of 83.3%. o Planned Activity Checks (PLACHECKS) were reported in 25 of 38 reports (66%). Scores ranged from 0% to 100% with a mean of 45.4%. As has been noted in the past, little information regarding an individual's level of engagement is gained by reporting group PLACHECK scores. ▪ Reports for five individuals, noted progress or the lack thereof in their counseling programs. It was concerning that the 2/14 report for Individual #256 noted that she was refusing to attend counseling. This was to be addressed at the next interdisciplinary team meeting. By 4/14, there was still no information about counseling. ▪ The reports for Individual #505 included updates on his progress with his dental desensitization program. ▪ Each progress note (100%) ended with a section regarding recommendations. Data sheets for targeted problem behaviors identified in the PBSP for 16 individuals were reviewed. For 14 of these individuals, data on replacement behavior was also reviewed. A summary of the findings is presented below: ▪ For 11 individuals in the sample, the most recent data sheets reflected frequency measures recorded within half hour intervals. The remaining five individuals in the sample had data recorded using an ABC (antecedent-behavior-consequence) measurement system. ▪ For the 11 individuals for whom frequency measures were collected, there were blocks of time when no data were recorded. However, a review of graphs in the monthly progress notes did not reveal any indication that data were missing,	

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		and, therefore, rates of targeted problem behavior might have been underreported. ▪ For seven of the 11 individuals for whom frequency measures were collected, there were data sheets in which lines had been drawn through an eight-hour block of time. This suggested that staff recorded data at the end of their shift rather than within the designated half hour intervals of time. ▪ A review of replacement behavior data sheets for 14 individuals revealed the following; o Over the period of time during which data was provided, nine of the 14 individuals were learning/practicing one replacement behavior, four individuals were learning/practicing two replacement behaviors, and one individual was learning/practicing three replacement behaviors. o Data reflected at least daily use of the replacement behavior for only five individuals in the sample (36%). o Daily rates of replacement behavior ranged between .08 times per day to 4.25 times per day. o Individual #327 utilized her replacement behavior 4.25 times per day, while Individual #397 utilized his two replacement behaviors .08 and .10 times daily. As noted in Section K.9 of this report, it is important that sufficient opportunities be provided for the individual to learn to use appropriate means of obtaining the same outcome that results from his/her problem behavior. Further, it is suggested that if a person is not utilizing his/her replacement behavior, staff should make revisions to the plan, be it in the teaching methodology or identified functionally equivalent alternative behavior. Due to an outbreak of flu on campus during the week of the onsite review, observation of individuals in their homes and day programs did not occur. Therefore, there is no report on the recording of data when problem behavior was observed. The Facility had undertaken steps to ensure that data was accurate and reliable. As the current monitoring plan focused on a review of documented behavioral incidents, it is likely that some occurrences of problem behavior were not documented. This issue has been consistently observed and reported by the Monitoring Team during onsite reviews of the Facility. With continued evidence of missing data, the accuracy of the measures used to inform clinical decisions is questionable. Data sheets reflected limited training on replacement behavior, an essential component of behavior change. As noted above, the Facility remained out of compliance with this subsection of the Settlement Agreement.	
K5	Commencing within six months of	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a	Noncompliance

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	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.	smaller sample) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. As observed during the Monitoring Team's previous reviews, screening for psychopathology, emotional, and behavioral issues was completed either through the psychiatric clinic's completion of a psychiatric assessment or the completion of the Reiss Screen for Maladaptive Behavior to screen for the need for a psychiatric assessment. The Reiss screenings were used to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss Screening process is discussed above with regard to Section J.7 of the Settlement Agreement. The Monitoring Team requested and obtained the most recent functional behavior assessment for the 16 individuals in the sample. A summary of findings is provided below. ▪ Fifteen of the 16 reports were labeled Functional Assessment. Completion dates were between 10/24/13 and 2/13/14. The report for Individual #256 was not dated, but it was signed on 3/21/14. The report for Individual #24, dated 1/3/13, was labeled an Abbreviated Functional Assessment. ▪ For seven of the 16 individuals in the sample (44%), the report was completed one to several weeks prior to the ISP. The assessment for Individual #397 was completed on the same day as his ISP. The timing of the functional assessment in relation to the annual ISP meeting could not be determined for Individual #59, as her ISP document was not dated. Six assessments (38%) were completed one to several weeks after the individual's ISP. The final assessment for Individual #24 had been completed over one year before her ISP. Staff should complete or update the functional assessment shortly prior to the annual ISP meeting. ▪ All of the 16 assessments (100%) identified indirect descriptive methods of determining behavioral function. Descriptive assessment was identified in 15 of 16 reports (94%). The exception was the report for Individual #196. The Director of Behavioral Services is commended for his emphasis on direct observation in developing a hypothesis regarding behavioral function. ▪ Specific instruments used for indirect assessment were the Questions About Behavioral Functioning (QABF), the Functional Analysis Screening Tool (FAST), and/or the Functional Assessment Interview Form (FAIF). In nine of the 16 reports (56%), information from older rating scales or interviews were reviewed or updated with current staff. As rating scales, in particular, can be administered fairly quickly, staff should have current staff complete them. ▪ In nine of the 15 reports in which direct observation was completed to determine behavioral function, problem behavior was not observed. For three of these individuals, behavioral services staff then reviewed videotaped episodes of problem behavior (Individual #280 and Individual #505) or reviewed ABC	

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		(antecedent/behavior/consequence) data sheets (Individual #334) to assess the chain of events. No further assessment was completed for the remaining six individuals (Individual #256, Individual #430, Individual #397, Individual #59, Individual #327, and Individual #182). Staff should review video recordings when in vivo observations do not include problem behavior. ▪ 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, medical and/or psychiatric variables were identified. o Several reports noted that escape from demands was the likely function of the identified problem behavior(s). However, it was suggested that this escape did not require the assistance of another person (i.e., it was not socially mediated). However, it could be argued that, in fact, it was socially mediated, as removal of demands is indicative of staff behavior. This was evident in the Functional Assessments completed for Individual #280, Individual #505, and Individual #59. ▪ All of the assessments (100%) included the identification of replacement behavior. Thirteen of these (81%) reflected replacement behaviors that were equivalent to at least one of the hypothesized behavioral functions. ▪ Graphs depicting the frequency of targeted problem behaviors were included in all of the reports (100%). It should be noted that although the graph was labeled frequency, the report for Individual #447 suggested that a partial interval recording was utilized to measure her aggressive behavior. This discrepancy in measurement systems should be resolved. ▪ Individual preferences were reported in each of the reports (100%). The method used to determine an individual's preferences included the following: in five cases, the individual was interviewed; in four cases, staff were interviewed; and in seven cases, a formal assessment was completed alone or in conjunction with individual or staff interview. The information found in the report for Individual #196 was obtained through staff interview almost two years earlier and should have been updated. ▪ Fifteen of the sixteen reports (94%) were signed. ▪ Some individual-specific concerns were raised when reviewing the functional assessments. These are described below. o When describing Individual #545, it was noted that he often crawled about his living environment and would sometimes pull peers to the floor "…in what appeared to be a playful manner." It is suggested that neither of these behaviors are appropriate, particularly for a 43 year-old man. o It was noted that Individual #256 was on a special diet because of her intolerance of and increased sensitivity to gluten. It was suggested that	

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<tr><td></td><td></td><td>her autism diagnosis was responsible for the latter. Gluten sensitivity is not part of an autism diagnosis and should not be assumed to be the result of this syndrome.
o When describing the communication skills displayed by Individual #525, it was noted that he would answer affirmatively if staff asked him if he was an alien. It is suggested that this type of questioning was disrespectful to the individual.

Although the Facility had made progress in ensuring standard presentation of annual Behavioral Health Assessments, 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 assessments should be completed for each individual by his/her ISP meeting. As noted above, a limited review was conducted and the Facility remained out of compliance with this provision of the Settlement Agreement.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>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 request was made for the most recent Behavioral Health Assessment (BHA) for the 16 individuals in the sample. The Facility provided assessments for 15 of the 16 individuals. A note was provided indicating that Individual #327 did not have a BHA. No explanation was provided. It should be noted that while each assessment identified the most recent full psychological evaluation, in which functioning levels were identified for both intellectual skills and adaptive behavior, the instrument(s) used was not identified in 14 of the 15 reports. The exception was the report for Individual #276. It should also be noted that a different name was used in this section of the report for Individual #334. There was no information provided regarding assessment of adaptive behavior using the Vineland Scale of Independent Behavior - Revised, the Adaptive Behavior Scale, or some other standardized tool. The table below lists the date of the assessment, the most recent full psychological evaluation, and the most recent Inventory for Client and Agency Planning (ICAP).

<table>
<tr><th>Individual</th><th>Date of BHA</th><th>Psychological</th><th>ICAP</th></tr>
<tr><td>Individual #280</td><td>10/22/13</td><td>11/5/04</td><td>8/3/11</td></tr>
<tr><td>Individual #517</td><td>1/27/14</td><td>7/21/98</td><td>4/12/12</td></tr>
<tr><td>Individual #334</td><td>10/23/13</td><td>6/__/11</td><td>3/31/12</td></tr>
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</td><td>Noncompliance</td></tr>
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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Individual #196</td><td>11/20/13</td><td>4/4/89</td><td>2/7/13</td></tr>
<tr><td>Individual #276</td><td>1/6/14</td><td>7/7/05</td><td>3/16/11</td></tr>
<tr><td>Individual #505</td><td>10/1/13</td><td>10/1/91</td><td>8/3/11</td></tr>
<tr><td>Individual #545</td><td>12/15/13</td><td>4/23/93</td><td>6/20/12</td></tr>
<tr><td>Individual #24</td><td>1/30/14</td><td>3/14/90</td><td>2/1/12</td></tr>
<tr><td>Individual #256</td><td>2/24/14</td><td>3/__/11</td><td>5/__/13</td></tr>
<tr><td>Individual #430</td><td>1/14/14</td><td>3/26/96</td><td>1/15/13</td></tr>
<tr><td>Individual #397</td><td>10/22/13</td><td>6/25/95</td><td>10/6/10</td></tr>
<tr><td>Individual #525</td><td>1/29/14</td><td>3/1/10</td><td>9/5/11</td></tr>
<tr><td>Individual #447</td><td>1/16/14</td><td>10/1/85</td><td>7/24/13</td></tr>
<tr><td>Individual #59</td><td>12/12/13</td><td>9/28/89</td><td>1/23/12</td></tr>
<tr><td>Individual #182</td><td>12/9/13</td><td>3/31/96</td><td>2/7/13</td></tr>
</table>

Based upon the information provided, assessments for only three of 15 individuals (20%) referenced an assessment of cognitive ability within the last five years. The individuals were Individual #334, Individual #256, and Individual #525. The I-CAP was current within three years at the time of the BHA for 14 of the 15 individuals (93%). The ICAP for Individual #397 was overdue by the standards established by the State and the Facility.

Assessments were not yet current and based on complete and accurate clinical and behavioral data. As noted above, the Facility remained out of compliance with this provision of the Settlement Agreement.</td><td></td></tr>
<tr><td>K7</td><td>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.</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.

Since the Monitoring Team's last visit, four individuals had been admitted to the Facility. As two of these admissions occurred in late April, behavioral health assessments were not due at the time of this visit (i.e., one month from admission). Documents were requested for the two individuals admitted earlier in the six-month time frame. A review of these documents is provided below.
▪ The Behavioral Health Assessment had been completed for one individual (50%) within the identified period of time. Regrettably, it was unclear whether the report provided to the Monitoring Team for Individual #432 was complete, as there was no signature page. The Behavioral Health Assessment for Individual #428 was completed 39 days after his admission.
▪ Although not related to compliance with this subsection, of note, a Behavior Protocol had been developed for Individual #428 the same day as his admission</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		to the Facility. This provided staff with information on his reported problem behaviors, guidelines for responding to his problem behaviors, and instructions for documenting occurrences. ▪ A Functional Assessment also had been completed for Individual #428 just over one month after his admission. It would be advisable to update this once the individual has had sufficient time to adjust to his new environment and once staff have become more familiar with the individual. ▪ Although not related to compliance with this subsection, of note, a Behavior Support Plan was developed for Individual #428 one day after the Functional Assessment was completed. Again, it would be advisable to review this plan regularly to ensure that it best meets the needs of the individual as he adjusts to his new environment. The Facility did not meet the required one-month timeline for completion of the psychological assessment for one of two newly admitted individuals. Further, as evidenced with regard to Section K.6, standard psychological assessment procedures were not regularly conducted. As noted above, the Facility remained out of compliance with this subsection of the Settlement Agreement.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	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. The Facility provided a master list of individuals involved in counseling services with the Department of Behavioral Health Services licensed professional counselor. A total of 20 individuals were identified for participation in individual and/or group counseling. Treatment Plans and Psychotherapy Progress Notes were reviewed for a sample of five individuals. A summary of findings is provided below. ▪ The Treatment Plans included the following: a brief history of the individual and the reason for referral; diagnosis; goals and objectives; intervention; goal and objective progression; integration and generalization; and treatment plan reviews and updates. ▪ All of the goals and objectives (100%) were written in observable and measurable terms. Conditions under which the behavior was to occur were identified in every case (100%). ▪ References were identified in the intervention section in every plan (100%). ▪ Generalization plans were described in four of the five plans (80%). The exception was Individual #354 for whom generalization would be addressed once he had completed specified steps in his counseling plan. This was an appropriate plan of action. ▪ All of the Treatment Plans (100%) were signed.	Noncompliance

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		▪ The Psychotherapy Progress Notes included data on the current step in the treatment plan. This was evident for all five individuals in the sample (100%). One data point was collected per session, reflecting a correct or incorrect demonstration of the targeted skill. It is suggested that multiple data points might be appropriate when the individual is learning a chain of responses or when the objective notes that the behavior will be exhibited multiple times per session. ▪ For two individuals, there was evidence that the Behavior Support Committee had reviewed their Treatment Plans. This level of peer review was commendable. The Facility had clearly made progress in designing counseling plans that could be objectively measured to determine efficacy. As noted in the Self-Assessment however, community-based therapists with whom the Facility contracted were not being held to the same standard. The plan was for the staff in the department to work with these providers to resolve this matter. Based on this limited review, the Facility remained out of compliance with this subsection of the Settlement Agreement.	
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.	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. The Positive Behavior Support Plan was provided for all 16 individuals in the sample. These were reviewed to determine whether essential elements were included in each plan. A summary of this review is provided below. ▪ Ten of the 16 plans (63%) identified the implementation date. One was implemented less than one month after the individual's ISP, three were implemented over one month after the ISP, five were implemented over two months after the ISP, and one had been implemented nearly 10 months before the current ISP. It is suggested that the PBSP for Individual #24 should have been updated/revised to correspond to her current ISP year. Staff should ensure that all plans have the implementation date noted. ▪ A rationale for the PBSP was provided in all of the reports (100%). Fourteen of the 16 plans (88%) referenced the most recently completed Functional Assessment. (The exceptions were the plans for Individual #545 and Individual #447.) This was helpful in understanding the prevention strategies, the identified replacement behavior, and the consequences applied when the targeted problem behavior occurred. ▪ Operational definitions of targeted problem behaviors were included in all of the PBSPs (100%). A concern was identified in one of the plans. The PBSP for Individual #276 noted that he might display behavior that is not self-injurious.	Noncompliance

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		As this was described as slapping his face/head to display excitement, there are two concerns. First, this behavior is potentially harmful. Second, this requires staff to interpret his "excitement." ▪ All of the PBSPs (100%) identified the potential function of the targeted problem behaviors. ▪ Operational definitions of replacement behaviors were included in 14 of 16 PBSPs (88%). The plan for Individual #545 noted that he would wait for staff attention, but this did not describe his observable behavior. The plan for Individual #256 noted that she would gain attention appropriately, but again this did not describe her observable behavior. The PBSP for Individual #24 noted that she was to use the sign for later to request a delay in completing a task. However, in the teaching section, it was noted that she could verbalize this request. It would be helpful if staff understood the specific response to be taught. ▪ Twelve of the 16 PBSPs (75%) identified functionally equivalent replacement behaviors. Comments specific to individual plans are provided below. o The PBSP for Individual #280 indicated that he was to learn to respond when asked if he needed assistance with a task. While this provided him a means of escaping staff contact, it did not offer him a means to escape tasks. o Individual #196 was to learn to engage with staff. However, escape was also identified as a possible function of her behavior. This was not addressed. o It was hypothesized that Individual #545 displayed his problem behavior when he had nothing to do or was not receiving attention. His replacement behavior was to learn to wait. This did not provide him with a functionally equivalent means of obtaining attention. o It was hypothesized that Individual #397 displayed his problem behaviors when not engaged in meaningful activities or when he wanted to escape a request. His identified replacement behavior was to talk about things other than cigarettes. This did not address either of the suggested functions. ▪ Descriptions for teaching replacement behaviors were included in all 16 PBSPs (100%). Some plans provided very clear guidelines for staff to follow, while others were brief or problematic. Individual examples are provided below. o When training Individual #276 to ask for a delay, staff were advised to repeat the request sooner (i.e., every two minutes) if he did not demonstrate the replacement behavior. However, in the prevention section of his plan, it was noted that he should be asked to do something one time as he did not like repeated requests. Staff were advised to wait five to 10 minutes before repeating a request. It is suggested that more	

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		rapid presentation of repeated requests during replacement behavior training might create an aversive situation that could result in aggressive or self-injurious behavior. o Teaching guidelines for Individual #505 suggested that staff were to prompt him to revise his communication if he gave the "wrong" card. It was unclear how staff would be able to determine that the card he gave did not represent what he wanted. Further, staff were to ensure that he did not display precursors to challenging behavior prior to trips. Two identified precursors were combativeness and hostility. It is suggested that these terms should be replaced with descriptions of observable behavior. o Individual #24 was learning to request a delay when asked to complete a task. Steps were outlined for staff to teach this behavior. If she did not respond during the first training trial, staff were to repeat the steps twice more. If she still did not respond, staff were advised to leave her alone. This will effectively result in her escaping the demand. o Individual #256 was to earn a check mark whenever she engaged in an activity. The plan then indicated that when she had accumulated "so many checks" she could choose an item from the reinforcer box. This should be clarified for staff. o Although there were guidelines for teaching Individual #430 to follow a schedule, there were no guidelines for teaching him to request a break. As escape was hypothesized to be the function of his problem behaviors, it would appear that this was the more important replacement behavior to teach. o Appropriately, Individual #525 was to learn to ask for the nurse when staff observed behavior that suggested he might be in pain. However, he was to be taken to the nurse whether or not he verbalized. It is unclear how this will result in his learning the identified replacement behavior. As language is difficult to prompt, it might be more appropriate to teach him a gesture to indicate that he wants to see the nurse. ▪ Specific schedules for teaching the identified replacement behavior were identified in 11 of the 16 plans (69%). ▪ Preventative strategies were included in each of the 16 PBSPs (100%). The breath and quality of these strategies varied across plans. Individual-specific comments are provided below. o Prevention guidelines for Individual #334 were clearly and thoroughly described. These included guidelines for the provision of choices, engagement, termination of preferred activities, and escape from loud and crowded environments. o To support the dignity of the individual, staff should identify materials	

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		that are age appropriate. For example, Individual #545 was to be offered preferred objects, such as a rattle, to hold. It is suggested that an alternative, but age-appropriate object could be identified for this 43 year-old man. o The prevention section of the plan for Individual #397 had several problems. First, staff were directed not to bribe the individual in an attempt to stop his problem behaviors. As bribe means to entice someone to do something illegal, this term should not be used in a behavior support plan. Second, it was noted that the individual would occasionally make reasonable offers in an attempt to "bargain" for things he wants. However, staff should not give in to these requests. Further, the described escalation chain began with an appropriate request, which could end in self-injury, aggression, and/or property destruction. It is suggested that the ability to negotiate reasonably is a positive behavior that should be reinforced. o In the plan for Individual #525 it was noted that he might experience pain when he is placed in a lift for check and change. Alleviation of this pain was not addressed in the prevention section. o Individual #327 was to receive verbal and physical praise whenever she complied with requests or exhibited appropriate behavior. Staff should explain what is meant by physical praise. ▪ Strategies for applying reinforcement on a regular schedule were identified in ten of the 16 PBSPs (63%). The following are examples of such regular reinforcement strategies: o Individual #334, Individual #256, Individual #447, and Individual #59 were to earn tokens throughout the day for specified appropriate behaviors. o Individual #196, Individual #545, Individual #327, and Individual #182 were to receive individualized attention on a regular schedule throughout the day. o Individual #505 was to earn a preferred drink for going to work and a diner coupon for completing a work objective. ▪ Consequences for targeted problem behaviors were identified in all of the PBSPs (100%). Twelve of the 16 PBSPs (75%) included instructions to staff to tell the person to stop displaying the behavior. Staff should ensure that consequences are clearly specified and do not inadvertently reinforce the behavior targeted for reduction. Individual-specific examples are provided below. o The PBSP for Individual #196 indicated that she was to clean up any mess that she had made when she displayed disruptive behavior. She was to be praised for complying with this requirement. There was no indication what staff were to do if she refused to clean up.	

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		○ Included in the consequence section of the PBSP for Individual #256 were guidelines for responding to her "autistic features and bizarre behaviors." Bizarre behavior was defined and clearly did not relate to an autism diagnosis. Therefore, it was misleading to pair autism with this identified behavior. ○ The plan for Individual #430 noted that after he was told to stop engaging in self-injurious behavior, he should be offered a break or a transition to his room. As escape was the hypothesized function of self-injury, this consequence might very likely reinforce the behavior. ○ In the plan for Individual #397, it was noted that aggression or self-injury were likely to occur following agitation. Agitation was not operationally defined in the plan. ▪ Potential reinforcers were listed in 14 of the 16 PBSPs (88%). ▪ Baseline or comparison data were provided in all of the 16 PBSPs (100%). ▪ Behavioral objectives were included in all of the plans (100%). Staff should carefully proof these statements. One goal for Individual #505 was for him to exhibit self-injurious behavior zero times or less for six consecutive months. ▪ Instructions for data collection were included in all of the plans (100%). ▪ Eight of the 16 PBSPs (50%) were written utilizing an updated and improved format. The following additional information was included: ○ An indication of whether the person had a Crisis Intervention Plan. This was useful information, as it would guide the staff member to also review this document. ○ An identification of training needs – a level of staff competency based on the perceived difficulty of the plan and a schedule of plan monitoring were specified. ○ A grid for staff training was included in the staff instructions section of the plan. ▪ Fifteen of the 16 PBSPs were signed (94%). As reported by the Director of Behavioral Services, the Facility had not yet developed an accurate method for tracking consents. This had been addressed in a Corrective Action Plan. Although the Facility continued to make progress in this area, problems remained with regard to tracking and obtaining timely consent and program implementation, and the quality of the plans particularly in the areas of teaching replacement behavior, comprehensive prevention strategies, and adequate schedules of reinforcement. For these reasons, the Facility remained out of compliance with this subsection of the Settlement Agreement.	

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K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The 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. As noted in the undated ABSSLC Behavioral Health Services Department policy, the author of the PBSP would determine the schedule for monitoring plan implementation by. Scheduling of measures of treatment integrity, data integrity, and inter-observer agreement would be determined by the complexity of the plan, the intensity and frequency of the targeted problem behavior(s), and the phase of the plan. The Behavior Support Committee, the Internal Peer Review Committee, and/or the External Peer Review Committee might provide consultation regarding the monitoring schedule. As noted in the Detailed Instructions for PBS Integrity and Reliability (I/R) Monitoring, staff were to review video recordings to of episodes of targeted problem behavior. The directions related to the Antecedent-Behavior-Consequence Form clearly guided staff to review footage 15 minutes before the event occurred. This same advice should be applied when reviewing incidents recorded using scatterplot data sheets to ensure that staff observe what was occurring in the environment before the behavior was exhibited. In March 2014, staff began reviewing data sheets to assess integrity. The expectation was that scatterplot data would be recorded up to the previous hour interval, while ABC data would be recorded within the shift. Given that the system used to determine the data accuracy was driven by documented occurrences of problem behavior, no opportunity was built in for staff to review times when problem behavior might have occurred, but were not documented. As noted in Section K.4 of this report, the Monitoring Team has consistently observed a lack of documentation when problem behaviors were observed while visiting the Facility. For this reason, it might be possible that the frequency of problem behavior is underreported and data accuracy might be lower than reported. Checks on actual recording of data throughout the day had just begun in March. Until the Facility can ensure that data is accurately and reliably recorded, it remains out of compliance with this provision of the Settlement Agreement.	Noncompliance
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.	Although the Facility did not use a readability scale to assess whether PBSPs were written so that staff implementing the plans could understand them, the Monitoring Team found the plans to be clearly written with specific instructions for staff to follow. Department staff were conducting periodic checks to assess staff knowledge of plans. A series of 10 questions were posed to identified staff. If the staff member did not answer a minimum of nine of 10 questions correctly (90%), he/she undergoes immediate re-training. As reported in the Facility's Self-Assessment, 1181 interviews were conducted between 10/1/13 and 3/31/14. Average scores to five of the 10 questions met the	Substantial Compliance

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		criteria of 90% or better. The overall average was 86%, with a range of 62.10% to 97.44% on each of the 10 questions. The Facility is commended for the system it had in place to assess staff knowledge and understanding of PBSPs. The Facility is also commended for developing plans that were written clearly. The Facility was found to be in substantial compliance with this provision of the Settlement Agreement.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	The Facility had developed a three-tiered plan for training staff on PBSPs. This consisted of the following: ▪ All staff were trained on the plan with their understanding assessed through verbal report. ▪ Identified staff were then required to demonstrate competency through role-play. ▪ Lastly, follow up training was provided in vivo through observation of those staff as they worked with the individual. As outlined in the Psychology Procedure/Training Staff on Behavior Support Plans, the author of the plan would train the Behavior Coach to implement the components of the plan. The Behavior Coach would then provide training to direct support professionals following the described training format. Additionally, the Behavioral Health Specialist (BHS) assigned to the home would meet weekly with direct support professionals to review plan implementation and identified problems. The Facility provided copies of nine completed BSP Competency Checklist Observation Forms. The department's Clinical Supervisor had completed six forms and the Lead Behavior Coach had completed three forms. These forms were used to provide feedback to the Behavior Coach as he/she provided training on the PBSP to a direct support professional. In general, these completed forms reflected positive feedback and thoughtful constructive criticism to those coaches conducting training. Trainers were often complimented on their interaction style, their direct response to staff questions, and their effective training on key elements of the PBSP. If the behavior coach suggested even a slight variation to what was written in the PBSP, the observer was quick to point out that there should be a strict adherence to the plan. Ideas for modifications or adjustment to the plans might be very appropriate, but they should first be reviewed with the BHS. Similarly, the Behavior Coach was advised to review all questions and concerns with the BHS. Overall, the feedback reflected appropriate support and guidance to the Behavior Coaches. It might be interesting to solicit feedback from the coaches regarding this process. The revised format for PBSPs included a grid to guide competency-based training on plan implementation. Staff were assessed on their ability to recall and/or implement	Noncompliance

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		preventative strategies, teach replacement behavior, apply consequences when problem behavior occurred, and record data. Performance was assessed through verbal report, role-play, or observation. The new PBSP had been introduced for plans developed in 2014. With limited data regarding the efficacy of this revision as it related to staff training, the benefits could not be fully determined. However, evidence presented in Section K.11 of the Self-Assessment suggested that this was a promising practice. In order for the Facility to achieve substantial compliance, staff training on PBSPs would need to occur for a significant number of individuals. At the time of the Monitoring Team's review, the Facility remained 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.	At the time of the visit, 361 individuals were in residence at the Facility. Employed within the Behavioral Health Services department were a Director, a Clinical Supervisor, and 16 Behavioral Health Specialists. Eight of the Behavioral Health Specialists had obtained board certification as behavior analysts. One of these Behavioral Health Specialists was dedicated to providing counseling services to identified individuals at the Facility. Additionally, seven Behavioral Health Assistants were employed, with two vacant positions at the time of the visit. This calculated to an average of one Behavioral Health Specialist to every 24 individuals in residence. The ratio of one assistant to every professional staff member was not met at the time of the visit. Although the Department employed a sufficient number of professionals to maintain an average ratio of one for every 30 individuals, the Facility remained out of compliance with this provision as a sufficient number of Behavioral Health Specialists had demonstrated competency in Applied Behavior Analysis as evidenced by certification. Further, the required ratio of one assistant to every two professionals was not met at the time of the visit.	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, titles and degrees; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all PCPs new to the Facility since Monitoring Team's last 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, and list per PCP of total CME credits during this time period; o Copy of any clinical guidelines developed and implemented since Monitoring Team's last visit; o Minutes of Infection Control Committee meetings during the prior six months; o Minutes of Skin Integrity Committee meetings during the prior six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken, including date of audit from which information retrieved; o For each PCP, two most recently completed quarterly medical reviews from each assigned residence: Individual #298, Individual #502, Individual #530, Individual #332, Individual #393, Individual #301, Individual #325, Individual #250, Individual #234, Individual #467, Individual #347, Individual #406, Individual #214, Individual #343, Individual #65, Individual #51, Individual #248, Individual #178, Individual #321, Individual #279, Individual #126, Individual #299, Individual #334, Individual #424, Individual #478, Individual #16, Individual #150, Individual #417, Individual #392, Individual #485, Individual #8, Individual #55, Individual #520, Individual #497, Individual #270, Individual #264, Individual #182, Individual #430, Individual #527, Individual #547, Individual #269, and Individual #437; 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 (i.e., both general medical and medical management audits), including information concerning number of corrective action plans, and QA Department follow-up of these corrective action plans; o List of individuals who died since the Monitoring Team's last visit or had

	clinical/administrative death reviews 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 (DNR), 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. Information was submitted for the following: Individual #129, Individual #529, Individual #524, Individual #408, Individual #15, Individual #216, Individual #353, Individual #394, and Individual #156; 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 Monitoring Team's last 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 (i.e., clinical, administrative, etc.) that remain incomplete or outstanding. o Thirty-six most recent annual medical assessments and physical examinations and prior annual assessment and examination for the following individuals: Individual #141, Individual #64, Individual #324, Individual #348, Individual #521, Individual #256, Individual #489, Individual #92, Individual #366, Individual #485, Individual #88, Individual #500, Individual #105, Individual #546, Individual #405, Individual #291, Individual #230, Individual #172, Individual #38, Individual #451, Individual #36, Individual #443, Individual #278, Individual #533, Individual #187, Individual #469, Individual #307, Individual #144, Individual #63, Individual #240, Individual #231, Individual #383, Individual #424, Individual #23, Individual #25, and Individual #242 ; 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 individuals: a) with tracheostomies, b) with fractures, date of fracture, type of fracture (i.e., compound, simple, stress, etc.), bone fractured (i.e., location), c) with injuries requiring visit to ER or hospitalization since the last Monitoring Team onsite review, and d) with pica or ingesting inedible object, date of ingestion, object/liquid ingested, whether

	taken to ER or hospitalized, since the last onsite review; o Policies or procedures for medical screening and routine evaluations; o For those women over 40, date of last mammogram and reason listed if not up-to-date (i.e., guardian refusal, etc.); 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 (i.e., 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 (i.e., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake and Vitamin D intake (i.e., based on diet, average percentage of meal ingestion, feeding formula, etc.); 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, for10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations): Individual #7 1/26/14, Individual #2, Individual #533, Individual #7 2/3/14, Individual #432, Individual #374, Individual #15, Individual #31, Individual #386, and Individual #468 ; o Length of stay for Infirmary admissions for past six months, if applicable; o Infectious disease data per quarter by category of infection last two quarters; o Summary report or trend analysis of infectious disease/communicable disease last two quarters; o Avatar pneumonia tracking forms/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, 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 Infection (UTI), 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;

	○ All policies and procedures related to seizure management; ○ A list of individuals being treated for seizure disorders, including name of individual, residence/home, diagnosis (i.e., type of seizure), and medication regimen; ○ List of those with status epilepticus since the Monitoring Team's last visit; ○ List of seizure medications, per individual, for diagnosis of seizure disorder; ○ List of those going to ER for uncontrolled/prolonged/new onset seizure since Monitoring Team's last visit; ○ List of individuals with refractory seizure disorder; ○ List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; ○ Numbers and percentage of individuals with diagnosis of seizure disorder on zero, one, two, three, four, and five antiepileptic drugs (AEDs); ○ Numbers and percentages of persons on older AEDs (i.e., Phenobarbital, Dilantin, Mysoline, and Felbamate); ○ Dates of last two completed annual medical assessments and annual physical examinations for all individuals; ○ Dates of last two completed quarterly medical reviews/IPNs completed for all individuals; ○ Number of individuals with VNS in place, date of placement, and date of replacement, if applicable; ○ 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.); ○ For the last five individuals to whom pretreatment sedation was administered for a medical procedure, all information related to medical pretreatment sedation used, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and IPN entries. Information submitted for following individuals: Individual #304, Individual #36, Individual #518, Individual #97, and Individual #510; ○ Ten most recent PNMT recommendations for which physician orders were written based on those recommendations; ○ List of missed medical appointments with reasons past six months; ○ Presentation Book for Section L; ○ DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; ○ 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 include the reason/indication. For those with a history of hysterectomy, list of the reasons for the hysterectomy; ○ 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-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. 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 IPNs, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent ISP and subsequent addendums, most recent BSP, and past three medical quarterly reviews: Individual #429, Individual #520, Individual #9, Individual #395, Individual #54, and Individual #385; o Minutes of the medical morning meeting with handouts during the Monitoring Team's visit for 5/14/14 and 5/15/14. ▪ **Interviews with**: o Richard Chengson, MD, Medical Director; o Edward Craig, MD, Settlement Agreement Compliance Physician; o Eric Williams, DO, Staff Physician; o Dolores Erfe, MD, Staff Physician; o Mary Pat Artch, RN, NP-C, Staff Nurse Practitioner; o Sonia Shoup, APRN, ANP-C, Staff Nurse Practitioner; and o Elizabeth Greer, RN, Medical Program Compliance Monitor. ▪ **Observations of** o Morning medical meetings, on 5/14/14 and 5/15/14.
	Facility Self-Assessment: For Section L, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Quality of Medical Care audits (internal to the Medical Department). o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement for some areas of clinical care, but needed to expand the auditing tools to other areas of clinical care. 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. o The Self-Assessment identified the sample 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). These sample sizes were adequate to consider them representative samples.

	○ The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tools: Medical Department staff. ○ 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 for some databases but incomplete in others (for example, tracking closure concerns). Databases were accurate. Examples of databases/data sources that were not considered include content of the post-hospital ISPA, response of PCPs to abnormal test results, and determining health status of individuals for various diagnoses through specific indicators to determine outcome of care on the individuals. ▪ The Facility presented some data in a meaningful/useful way, but some problems were noted. Specifically, the Facility's Self-Assessment: ○ Provided charts and graphs with clear explanations, or listed findings. ○ Presented findings consistently based on specific, measurable indicators. ○ At times, did not measure the quality as well as presence of items. ▪ The Facility rated itself as being in noncompliance with the all subsections of Section L. The Monitoring Team was in agreement with the Facility self-assessment concerning compliance for Section L. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying for example the need to ensure sustainability of the QA process, and the need to create a comprehensive Medical Department policy manual.
	Summary of Monitor's Assessment: The Medical Department had made significant gains towards achieving compliance. Based on the findings from the Facility's quality assurance processes, a number of templates were created to assist the PCPs in identifying all contributing factors toward the development of acute respiratory distress. In many instances, this resulted in a more aggressive and complete work-up of respiratory distress. Critical decision-making for respiratory distress and other acute care issues was evident at the morning medical meeting, although not consistent across all discussions. A new template for the quarterly medical reviews had made this document more practical and valuable to the practitioner. Completion rates were tracked and had shown significant improvement over the past four months. A number of monitoring tools had been created to meet the health care needs of the individual. These were separate from the external and internal medical peer review audits, which continued to occur. The timeliness of closure to action plans from the peer review audits had initially been problematic, but more recent corrective actions had been completed in a more timely manner.

	Open record reviews were done routinely for those recently hospitalized. Although more work was needed, the Medical Department had clearly taken a number of steps towards to development of a robust medical quality assurance system. The morning medical meeting continued to struggle with efficiency in getting all significant clinical areas reviewed and addressed. The minutes, although thorough, needed to be abbreviated yet retain the important clinical points that had been documented. Improved tracking for several areas was needed. For example, timeliness of post-hospital ISPAs, content of post-hospital ISPAs, and closure of other concerns needing additional information at the morning medical meeting required improvement and tracking. A remaining challenge for the Medical Department was ensuring all appropriate diagnoses were aggressively evaluated and treated. As illustrated in the Monitoring Team's review of a sample of at-risk individuals, at times, medical assessments and follow-through to ensure needed treatment was provided was lacking. Another significant concern was the use of Do Not Resuscitate (DNR) Orders at the Facility. At the time of the review, 28 individuals had DNR Orders in place. Sixteen listed no medical justification. For other individuals, the clinical justifications required State Office's review or a second opinion to ensure the State Office guidelines were followed in determining a terminal condition. At times, Ethics Committee reviews of these DNRs showed approval even without the necessary terminal diagnosis. Of further concern, in 2014 the Facility and/or State Office policy reduced the choice(s) offered to guardians/families concerning treatment options. Previously, an individual was ordered to be full code but without chest compressions due to severe osteoporosis that would result in flail chest, or due to abnormal anatomic location of the heart in which chest compression would not be effective. However, intravenous (IV) medication, intubation, bagging, and oxygen were permitted. The Facility policy no longer allowed for such options. The rationale for the new policy was not provided. However, families made the decision to institute the DNRs for 13 of the 28 individuals based on the change in policy.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall	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 363 as of 4/1/14, there were five PCPs responsible for this population. The Medical Director had a caseload of 21. Other PCPs had caseloads ranging from 61 to 74. There was one vacancy in	Noncompliance

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	ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	the department. An additional 74 individuals were assigned to a locum tenens physician. During the Monitoring Team's visit, a new locum tenens physician was working with the Medical Department, but had specific assigned duties that did not include care of an assigned caseload. The individuals on this caseload were assigned to other PCPs on a temporary basis. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was "updated" 9/23/13, but more recent information indicated this date was no longer accurate. Not all current PCPs were listed. One PCP had left, but was still listed. Another PCP had been at ABSSLC during the Monitoring Team's prior visit, but was not listed. Four of five PCPs were current in CPR. Additionally, the Settlement Agreement Compliance Physician was current in CPR. Of the five staff PCPs in the Medical Department, a list of CME credits was submitted for five of five PCPs. CMEs for locum tenens were not submitted. For the five staff PCPs, CME credit completion over the prior six months ranged from one to 37.5 hours. The topics that were covered included: multidisciplinary osteoporosis management, management of venous thromboembolism, oral pharmacologic agents for type II diabetes mellitus, sepsis in the emergency department, acute rhinosinusitis, controlled substance prescribing in the geriatric population, colorectal screening, constipation diagnosis and treatment, male hypogonadism and osteoporosis, hypertension, arthritis pain, attention deficit disorder, Alzheimer's care, therapeutic options for advanced congestive heart failure, and sacral neuromodulation as a surgical option for bladder and bowel control. The majority of the topics that were covered included areas of importance to primary care and the individuals residing at ABSSLC. Topics were not specific to developmental disabilities. In order to ensure all medical staff were knowledgeable concerning the various aspects of medical services at ABSSLC, a number of training sessions were completed. For new hires and locum tenens, several documentation templates were reviewed. The actual templates reviewed from in-service to in-service were not identical lists, but included one or more of the following: ▪ Quarterly Medical Review Template; ▪ Annual Medical Assessment and Plan Template; ▪ State Office Medical Care Policy 009.2 subsection E "PCP Orders;" ▪ Client Report Template; ▪ Consultation Report Template; ▪ Aspiration Infirmary Admission Assessment Template; ▪ Orders for Diagnosis of Aspiration; ▪ Cervical Cancer Risk Estimate Form; ▪ Preventive Care Flow Sheet Template; and ▪ Hospital Admission Medical Chart Review. Dates of in-service were 11/19/13, 1/13/14, 1/14/14, 2/2/14, and 3/21/14.	

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		Additional in-services were completed on specific topics: ▪ Reclast, on 3/4/14; ▪ MOSES and DISCUS prescriber review of completed assessments, on 1/28/14; ▪ Writing orders for immunizations which require a series of injections, on 1/9/14; ▪ Annual EKGs for Atypical Antipsychotics, on 1/9/14; ▪ Abilene 7th Round Exit Transcript Review, on 11/12/13; ▪ Atypical Antipsychotics and Metabolic Side Effects, on 11/7/13; ▪ Case Study, on 11/7/13; ▪ Rationale for Eliminating Bedrails when possible, on 11/26/13; ▪ Revised "Annual Physician Orders" form, on 2/13/14; ▪ Monitoring protocol for Seroquel, on 3/4/14; and ▪ Narcan and Flumazenil on 3/4/14. <u>Physician and Other Departmental Participation in Team Process</u> ▪ For the two morning medical meetings observed, there was a signed attendance roster for two of two meetings. ▪ For the two morning medical meetings observed, there were seven hospitalizations (i.e., Individual #19, Individual #52, Individual #436, Individual #91, Individual #325, Individual #349, and Individual #468), and 12 admissions to the Infirmary (i.e., Individual #392, Individual #76, Individual #515, Individual #337, Individual #172, Individual #126, Individual #344, Individual #91, Individual # 52, Individual #145, Individual #546, and Individual #325). Based on the Monitoring Team's observations and review of documentation: ▪ **On-call PCP participation:** For the two morning medical meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in two of two meetings. ▪ **Attending PCP participation:** The attending PCP for the individual (when not the on-call PCP) participated in the discussions concerning health status changes/on-call concerns in two of two meetings. ▪ **Campus 24-hour medical log report**: The Campus 24-hour medical log report was reviewed at two of two morning medical meetings. ▪ **Hospital Liaison Nurse updates:** The Hospital Nurse Liaison reported an update for hospitalizations during the two of two observed meetings. ▪ **Assignment of follow-up to meeting participant:** There were seven critical clinical questions raised/identified needing closure that were followed by assignment of the concern for further review by one or more morning medical meeting attendees concerning steps to be taken to close the concern. ▪ **Assignment of open book/record review:** There was one assignment for one hospitalization/ER visit/Infirmary admission requesting an open record review for the seven to 14 days prior to the illness to review monitoring of care, positioning documentation, feeding concerns, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the PNMT, listing preventive areas to be considered based on the diagnosis causing the acute illness,	

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		adequacy of medical evaluation, need for consultation, review of medication and medication side effects, etc. ▪ For **previously assigned open book/record reviews**, one was presented during the two morning meetings. ▪ **Closure discussions**: There were four prior concerns with assignments for follow-up, which were presented at the medical morning meetings. ▪ **Follow-up requested ISPA reviewed:** There was one brief summary of an ISPA that had been assigned to an IDT in responding to concerns referred by the medical morning meeting. ▪ **Infection control updates:** During the two medical morning meetings, there were no infection control updates presented. ▪ **Summaries of completed consultations:** During the two medical morning meetings, there were two summaries presented of completed consultations. ▪ **Dental Department updates**: The Dental Department provided brief updates/information during zero of two medical morning meetings. ▪ **PT/OT/Speech Therapy and PNMT updates:** The PT, OT, Speech Therapy, and PNMT presented updates during one of two medical morning meetings. ▪ **Skin integrity updates:** Skin integrity reports/updates were provided at one of two medical morning meetings. ▪ **Discussion of significant weight change:** There was a discussion of individuals with significant weight loss or gain at zero of two medical morning meetings. Additionally, other business was conducted during the morning medical meetings observed, including the Dietary Department presented a report at one of two medical morning meetings. The strengths noted at the medical morning meeting included the following: there appeared to be routine attendance by many clinical departments. Various reports were well prepared and presented. There was interdisciplinary critical clinical discussion for at least six individuals with significant health challenges. The PCPs had prepared reviews of the significant cases to be discussed. Weakness and concerns included the following: not all discussions of critical clinical areas included an aggressive approach, although this had much improved. A uniform aggressive approach to evaluation and treatment remained a challenge. Although several PCPs demonstrated an aggressive approach appropriate to the needs of the individual, one or more PCPs did not always pursue additional tests/evaluations needed as evidence to rule in or out contributing comorbid conditions of significance to optimize treatment, especially when the current treatment failed to prevent a repeat hospitalization. Concerns needing closure were not routinely tracked. The routine review of the number of outstanding post-hospital ISPAs, open record reviews, and concerns needing closure needed to be created as part of a tracking log. Quality of the ISPAs was not tracked, and the morning meeting did not determine whether the ISPAs addressed the concerns or needed to be returned to the IDT for further review. The activity of the morning meeting needed to be summarized monthly for concerns/ISPA/open record reviews closed and those carried to the following month. This would allow a determination of the number of requests closed in a timely manner, as	

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		well as record the level of activity of the morning meeting. Templates had been created to assist in a uniform reporting approach at the morning medical meeting. The following template/form prompted the PCPs to research relevant areas of concern with appropriate detail to be of value to the discussions at the morning medical meeting: ▪ "Hospital Admission Medical Chart Review" – This template included the following information to be completed: Transfer order date, PCP signing order, transfer diagnosis, hospital diagnosis, PCP completing record review, date of record review, period of time reviewed, hospitalizations in prior six months along with discharge diagnosis, and summary of events leading to the transfer along with recommendations to prevent a recurrence of ER/hospital transfer. It was also noted that several of the departmental updates were formal reports that were then included as part of the minutes of the morning medical meeting. Examples included QIDP report on ISPAs, infection control updates, Dental Department updates, Habilitation Therapies Updates, Nutrition Services updates, Pharmacy Department updates, Nursing Department updates, Psychiatry updates, Skin Integrity Updates, and PNMT updates. This allowed for increased accuracy of completing the meeting minutes and reduced time in completing the minutes. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted for 363 individuals. Five entries had the same current and prior annual medical assessment, indicating either a new admission in the prior year or a database entry error. These were removed, leaving 358 individuals. Of these, 254 of 358 (71%) of the annual medical assessments were completed within 365 days of the prior assessment. Although a copy of the 20 most recent annual medical assessments and physical examination evaluations were requested, the Facility provided 36 for review. The prior annual assessment was also submitted in each case. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For the 36 individuals, compliance was 31 of 36 (86%). ▪ For the 36 most recent annual medical assessments, there was an interval history included as part of the document in 36 of 36 (100%) reviews. ▪ For the 36 most recent annual medical assessments, the major active problems listed had plans of care addressing each of the significant current diagnoses in 36 of 36 (100%) assessments. ▪ For the 36 most recent annual medical assessments, 36 (100%) addressed smoking history. ▪ Family history was not available for one individual that had been an orphan. An adequate/helpful family history was recorded in 25. Compliance was 25 of 35 (71%) applicable charts. ▪ A discussion of readiness/requirements for transition to the community was included in 36 of 36 (100%). On 10/10/13, a new "Annual Medical Assessment and Plan Form" was in-serviced. This template had many	

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		prompts to ensure completeness of the document. Under the section of "Assessment," there were several diagnoses listed common to the ID/DD population. A new addition to this list was "history of aspiration pneumonia." It included several prompts for specific information to ensure the PCP provided all essential clinical history on at least 10 areas including: last aspiration pneumonia date, most recent chest x-ray date and findings, last modified barium swallow date and findings, last PNMT report date and recommendations completed, last gastroenterology and/or pulmonary consult, last dental evaluation, whether suction tooth-brushing occurred, history of GERD and treatment, degree of risk for aspiration and preventive steps, and review of medication to determine any indicated changes to reduce risk of aspiration pneumonia. On 1/9/14, a revised "Annual Medical Assessment Plan" Form was in-serviced. The change included the diagnosis of GERD being added to the Assessment section of the form. The GERD section had several prompts, including: a head of bed elevation order present, an anti-reflux diet whether the individual ingested nutrition by mouth, appropriate diet if BMI greater than 25, whether an EGD, pH probe, Upper Gastrointestinal (UGI), or fundoplication had occurred in the past, with dates and findings, annual assessment of signs and symptoms of GERD for drug re-evaluation, evaluation of alarm symptoms for GERD, need for Gastrointestinal (GI) referral, etc. On 2/11/14, a further revised "Annual Medical Assessment and Plan" form was in-serviced. In which the section for "history of aspiration pneumonia" was further expanded to include "reactive airway disease/wheezing/COPD/asthma: comment whether dx of GERD might be contributing to above respiratory concerns," and under the GERD section, an additional prompt for whether "the dx of GERD is contributing to any of the following respiratory concerns: aspiration, reactive airway disease/ wheezing/ COPD/asthma." It was noted that the PCPs all used the same template. The format used was easy-to-read, and the additions should be helpful. As discussed in further detail below, assessments in these areas often still were not adequate, but these prompts should be helpful in improving practice. As part of the monitoring review process, the Monitoring Team selected the medical records of six individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on identifying individuals with various diagnoses/health care issues, and selecting a sample of individuals from each high-risk category (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This sample was done to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included preventive care flow sheet, physician orders for the prior one year, IPN for the prior one year, the most recent three 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 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	

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reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed.

From six medical records reviewed:

- Five of six (83%) submitted annual medical assessments had been completed in the prior 365 days.
- Active problem lists appeared to be thorough in five of six (83%).
- Six annual medical assessments were reviewed for a smoking history and/or substance abuse history. Six of six (100%) had information about smoking history.
- A family history was documented (or attempts at obtaining this information) in six of six (100%) charts.
- Six of six (100%) had information discussing requirements for transition.

These six medical records also were reviewed to determine whether the physician IPN note used the SOAP format for acute illness documentation. For each record, three acute illness PCP IPNs were identified.

- In six of six charts (100%), the SOAP format was used.
- Six of six (100%) of SOAP IPNs included the date.
- Six of six (100%) of SOAP IPNs included the time.
- Six of six (100%) of SOAP IPNs recorded vital signs or referenced vital signs available elsewhere in the active record or an adjacent IPN.

Quarterly Medical Reviews

The Medical Department provided a list of the two most recent quarterly medical reviews that were completed on all individuals. Information for 363 individuals was provided. The following provides the number of individuals per quarter that had a completed quarterly medical review. Although many dates were listed, the review indicated most of the quarterly medical reviews were outdated. Many had the last quarterly medical review completed in 2012. Only the time period from October 2013 to April 2014 was counted for compliance percentages. This was broken down into two complete quarters (October - December 2013 and January – March 2014), and a partial quarter for April 2014. The date of the document was 4/8/14.

Quarter	# Individuals for which Quarterly Medical Reviews Were Due	# Quarterly Medical Reviews Completed on Time	% Quarterly Medical Reviews Completed on Time
October to December 2013	363	3	0.8%
January to March 2014	363	109	30%
April 2014	Not available	8	

As an added step in improving compliance with timely completion of quarterly medical reviews, the Medical

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		Program Compliance Nurse began to distribute monthly lists of quarterly medical reviews on each PCP's caseload. This additional step was associated with an increased completion compliance rate since January 2014. Quarterly medical reviews of six medical records were reviewed for completeness. Using a cut-off date of 3/31/14, for the most recent quarterly medical review submitted, two of six (33%) had a quarterly medical review for the first quarter of 2014. Zero of six (0%) had a quarterly review for the last quarter of 2013. The two most recently completed quarterly medical reviews were submitted for each individual from each residence. Forty-two quarterly medical reviews were assessed for timeliness and content with the following results: ▪ A template format was used/completed in 42 of 42 quarterly medical reviews. ▪ Forty-two of 42 (100%) included the date of the quarterly review completion. ▪ Thirty-six of 42 (86%) were current from the first quarter 2014. ▪ Changes in diagnoses and/or new diagnoses were listed in 27 medical quarterly reviews. ▪ Changes in weight over the quarter were recorded in 42. ▪ There were brief comments/entries listing numbers of seizures per quarter (if applicable) in 25 of 26 applicable medical quarterly reviews. ▪ There was documentation of changes in medication in 19 of 42 medical quarterly reviews. ▪ Important/abnormal labs and drug levels/radiographic test results were documented in 31 of 42 medical quarterly reviews. ▪ Zero individuals had documentation of an ER visit. ▪ Zero individuals had documentation of hospitalization. ▪ Seven individuals had documentation of Infirmary admission. Seven of seven included the reason for the Infirmary admission. ▪ Twenty-nine individuals had documentation of consultations completed, listing the specialty. On 1/21/14, a revised "Quarterly Medical Review Template" was in-serviced. This template provided the essentials in documenting changes in the prior 90 days, and included such areas as vital signs, diagnoses with change, medication changes, important diagnostic tests (date and brief results), important/abnormal labs and drug levels (date and results), important consults (date and results), hospitalization date and reason, ER transfer date and reasons, Infirmary admissions date and reason, quarterly change in weight, current weight with recommended weight range, and specific prompts for neurology, gastroenterology, respiratory, genitourinary, and endocrine concerns. On 1/8/14, an in-service was provided for "Purpose and completion of Quarterly Medical Review Form." The impact of this template, and the in-service training provided, was noted, as the quality of the quarterly medical reviews was much improved and consistent across PCPs. *Access to Specialists* Off-site specialist appointments were not reviewed during this Monitoring Team visit as evidence during the	

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Monitoring Team's prior visit indicated substantial compliance with this aspect of medical services.

Onsite, specialty clinics were held to meet the needs of the individuals from October 2014 through March 2014. The following chart provides details of these specialty clinics:

Specialty	Date of Clinic	Appointment Scheduled	Appointment Completed	Initial Completion Rate	Follow-up to Prior Appointment Scheduled Or Other Documentation	Follow-up Completion Rate
Dermatology	10/17/13	9	8		1	
	12/19/13	8	7		1	
	1/16/14	4	4		0	
	2/20/14	3	2		1	
	3/20/14	4	4		0	
	Total	**28**	**25**	**89%**	**3**	**100%**
Gynecology	10/30/13	3	2		1	
	3/5/14	2	2		0	
	Total	**5**	**4**	**80%**	**1**	**100%**
Neurology	10/14/13	9	0		9	
	10/28/13	34	29		5	
	11/4/13	36	29		6	
	12/16/13	27	21		6	
	1/13/14	30	21		8	
	1/20/14	30	18		12	
	1/27/14	5	0		4	
	2/10/14	30	24		6	
	2/24/14	40	33		7	
	3/10/14	40	30		10	
	3/24/14	31	19		10	
	3/25/13	3	2		0	
	Total	**315**	**226**	**72%**	**83**	**98%**
Pap & Pelvic	10/25/13	10	5		5	
	12/20/13	7	1		6	
	2/27/14	10	4		5	
	3/26/14	8	3		0	
	Total	**35**	**13**	**37%**	**16**	**83%**
Podiatry	10/15/13	43	33		10	

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			11/19/13	40	30		10	
			12/17/13	39	32		7	
			1/21/14	34	21		11	
			2/18/14	40	20		10	
			3/18/14	34	28		1	
			Total	**230**	**164**	**71%**	**49**	**93%**
		Urology	10/4/13	6	5		1	
			11/1/13	5	5		0	
			1/3/14	8	7		1	
			2/7/14	8	7		1	
			3/7/14	2	2		0	
			Total	**29**	**26**	**90%**	**3**	**100%**
		VNS clinic	10/14/13	8	8		0	
			10/28/13	7	5		2	
			11/4/13	7	7		0	
			11/25/13	3	0		3	
			12/16/13	5	5		0	
			1/13/14	8	3		5	
			1/20/14	6	5		1	
			1/27/14	10	8		2	
			2/10/14	6	5		1	
			2/24/14	6	5		1	
			3/10/14	5	3		2	
			3/24/14	5	4		0	
			Total	**76**	**58**	**76%**	**17**	**99%**
		Total		**718**	**516**	**72%**	**172**	**96%**

Missed Appointments
The Medical Department submitted a list of all medical appointments made on campus and off-site, as well as a list of all missed appointments, with reasons. The following provides the number of missed appointments for all causes by month:

Month	# Missed Appointments	Month	# Missed Appointments
October 2013	29	January 2014	41
November 2013	16	February 2014	37
December 2013	19	March 2014	33
Total	175		

This number was less than the onsite specialty appointments total listed above. There appeared to be need

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		for further review of the data. The following lists the number of missed appointments due to the most common reasons. Not all reasons are listed: **Reason for Missed Appointment** / **# Missed Appointments** Specialist office canceled: 10 Illness of individual: 18 Refused: 12 Would not wait: 3 Individual on quarantine: 27 Inclement weather: 12 No dictation: 8 No show with no other reason documented: 35 Community placement/activity related to community placement: 11 Some reasons provided were beyond the control of the Medical Department (i.e., specialist office canceled, illness of individual, individual on quarantine, etc.). Other reasons indicated need for improved communication with the specialists (i.e., no dictation) or with other Facility departments (i.e., no show with no reason, community placement activity), and other reasons indicated need for referral for a potential behavior plan if there were repeated refusals. The quality of the consultation referrals is reviewed as part of the peer review process. This is discussed in further detail in relation to Section L.2 and L.3. In addition, the Monitoring Team's findings with regard to the follow–up on consultations are discussed in relation to Section G.2. On 10/29/13, an in-service was provided concerning "discussion of initial consultation referrals." An in-service, dated 11/20/13, was provided to the PCPs for completion of the revised "Consultation Report" form to include additional information available to the consultant at the time of the visit. This expanded the template of information required to include pertinent labs and pertinent diagnostic reports. <u>Preventive Care</u> ▪ Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in six of six (100%) records reviewed. ▪ Preventive care flow sheets were updated to 2013 in five of six records reviewed. One was updated to 2014. All (100%) had been updated. ▪ Current vision screening was documented within the prior 12 months in two of six (33%) records, and in five of six (83%) records in the prior 24 months. ▪ Audiological screening occurred in six of six in the past three years.	

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		▪ From submitted documents, the influenza vaccination had been given to four of six (67%) individuals during 2013. ▪ Whether the individual needed to receive varicella vaccine (i.e., depending on birth date and immunity status), and whether it was given if indicated, was recorded in four of the six (67%) active records reviewed. During review of the records, it was noted that all six were considered immune, but this was not clearly indicated in the documents reviewed. Four were born prior to 1980, and two had positive antibody test results recorded. ▪ Whether the individual needed to receive a hepatitis B vaccine (i.e., depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or being tracked for completion), was recorded in six of six (100%) active records reviewed. There was delay in administration of the third dose in one individual (due 5/2012, ordered 9/2013, and administered 3/2014). ▪ A Tdap had been given to four of six (67%) individuals, although it is recommended that this be verified to ensure a Tdap had been administered rather than a Td or TT. For one individual the nursing assessment indicated a Td had been given and not Tdap. For one individual, there was no evidence a Tdap had been administered, ▪ A pneumococcal vaccination had been given to six of six (100%) individuals. ▪ For individuals age 60 or over, a zoster vaccine had been given to two of two (100%) individuals. It was noted that one or more annual medical assessments did not provide the needed detail for immunization status, but simply stated: "all immunizations are current." The annual medical assessment should be a stand-alone document and include a list of immunizations and dates administered. 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. The DADS SSLCs policy "Preventive Health Care Guidelines," dated 8/30/11, was to be followed. A total of 149 women were identified as being over the age of 40. Of these, there were 14 women aged 70 or greater. These were not further included in the compliance analysis. Of the 135 women between the ages of 40 and 70, 16 had reasons not to have a mammogram (i.e., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 119 women, 93 had mammograms within the prior year. If following the above "Preventive Health Care Guideline," this was a compliance rate of 78 percent. However, it appeared that some PCPs were following the U.S. Preventive Services Task Force Recommendations (USPSTF). The denominator would have changed by removing 29 women under the age of 50, and removing 11 aged 75 or greater (three were between the ages of 70 and 74 and were not removed). Of these 109 women, 10 had reasons not to have a mammogram. Of the remaining 99 women, 90 had mammograms within the prior two years. If following the USPSTF recommendations, this was a compliance rate of 90 of 99 (91%). It is recommended that the Medical Department members agree on one standard to follow, as it appeared the PCPs adhered to various standards. A review of submitted "policies or procedures for medical screening	

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		and routine evaluations" did not include any updates from the "Preventive Health Care Guidelines," dated 8/30/11. From the sample of six medical records reviewed, there were three 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). One was completed in 2012, and one was ordered in 2013, but no results were available. Compliance was one of two (50%). A list of 143 women between the ages of 21 and 65 were submitted, along with date of last pap smear, and any other information concerning a gynecological preventive exam. Of these, 17 had a history of hysterectomy. Seventeen were for benign or unknown reasons. These 17 were removed from the list of 143. Reasons were provided for those not completing a pap smear and pelvic exam. Physical challenges were listed for 32 individuals. Lack of family consent occurred for eight. These were removed from the list. The remaining 86 would be eligible for pap smears. Thirty-seven completed the pap smear procedure. However, seven of these were more than three years ago, and there was no information to determine whether HPV screening had been included, which might allow for a five-year interval. Five had behaviors, 10 refused, and for six, no information was provided regarding when the attempt was documented or whether the procedure could not be completed. There was no information to determine whether a behavioral support plan had been created to assist in increasing cooperation. For 28 individuals, no information was available for not completing a pap and pelvic exam. Compliance was 30 of 86 (35%). From the sample of six active records reviewed, there were two females between the ages of 21 and 65. Two of two (100%) females had documentation of reasons for not completing cervical cancer screening within the prior three or five years. The Facility was found to be compliant with screening colonoscopy completion during the Monitoring Team's prior visit and campus-wide data was not further reviewed during this visit. Review of screening colonoscopy did occur for the six active records reviewed. There were three individuals from the age of 50 to 75. One of three (33%) had a colonoscopy completed in the past 10 years. It was noted that for one individual with a history of colonoscopy dated 1997, a high sensitivity fecal hemoccult was ordered, but the lab results indicated a fecal occult blood test result, not specifically indicating the high sensitivity fecal hemoccult. A second individual had no history of colonoscopy, and had fecal occult blood testing, but no reference to high sensitivity fecal hemoccult testing. Documentation needed clarification as to which test was completed in both cases. A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T score usually would be an important aspect of the work-up provided through a DEXA scan.	

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		Additionally, based on the T score, treatment would be ordered to optimally treat the individual. Follow-up DEXAs to determine T scores are indicated at intervals (i.e., every two to three years) to determine effectiveness of treatment. A total of 223 individuals with a diagnosis of osteopenia or osteoporosis were reviewed. The list included one duplicate name, and additional information was submitted for three individuals that were not listed. For 12 individuals on the list, no information was submitted. Of the 223, 211 had a DEXA scan submitted. Of the 211 individuals reviewed, the T score was interpreted as normal for one individual. The remaining 210 had either osteoporosis or osteopenia. One hundred sixty nine were diagnosed with osteoporosis and 41 were diagnosed with osteopenia. Twenty-five of the 210 had T scores or histories indicating the need for further review to determine accuracy of the diagnosis (i.e., a T score indicated osteoporosis but the diagnosis provided was osteopenia, for example). ▪ Two hundred ten of the 211 DEXA scans were considered current (completed within the prior three years). ▪ One hundred eighteen of 210 with osteoporosis or osteopenia were treated with a bisphosphonate or alternative medication to treat or prevent osteoporosis. ▪ Fifty of 210 with osteoporosis or osteopenia were treated with Prolia. ▪ Thirteen of 210 with osteoporosis or osteopenia were treated with other therapeutic options. ▪ Submitted documentation indicated 34 of 210 with osteoporosis or osteopenia were not treated with an additional medication to treat osteoporosis or osteopenia. Sixteen of these 169 (9%) with osteoporosis did not receive additional medication. ▪ One hundred of 211 (47%) were treated with calcium supplementation. ▪ Eighty-three of 211 (39%) were treated with Vitamin D supplementation. It appeared that the submitted information was incomplete and/or the diagnoses of osteoporosis and osteopenia were undertreated. It is recommended the Medical Department create a database for this information, and complete record reviews to determine adequacy of treatment for osteoporosis and osteopenia to ensure quality of care. For men with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Eighty-six men were determined to have osteoporosis or osteopenia. The following lists the status with several recommended tests, based on submitted information: ▪ Zero of 86 had a testosterone level recorded. ▪ Zero of 86 had renal function recorded. ▪ Zero of 86 had liver function recorded. ▪ Eighty-three of 86 had thyroid function recorded. ▪ Zero of 86 had a CBC recorded. ▪ Zero of 86 had a calcium level recorded. ▪ Eighty-four of 86 had a Vitamin D level recorded. ▪ For 64 of 86, a listing of prescribed medications, which might contribute to	

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		osteoporosis/osteopenia was submitted. The submitted information appeared incomplete. It was likely that many of these tests were run routinely or at specific intervals, but ordered for other reasons than as a screen for potential secondary causes of osteoporosis/osteopenia. To ensure that evaluation of secondary causes of osteoporosis/osteopenia are complete, it is recommended that the Medical Department develop a database tracking the results of these various tests. The submitted lab information appeared to lack a key for interpretation of the headings, and the results for each individual did not line up with the initial headings, adding potential error to data analysis. For women with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Twenty women were listed with one or more recommended tests. Based on submitted information: ▪ Zero of 20 had renal function recorded. ▪ Zero of 20 had liver function recorded. ▪ Nineteen of 20 had thyroid function recorded. ▪ Zero of 20 had a CBC recorded. ▪ Zero of 20 had a calcium level recorded. ▪ Eighteen of 20 had a Vitamin D level recorded. ▪ For 17 of 20, a listing of prescribed medications, which might contribute to osteoporosis/osteopenia was submitted. For both men and women, only 106 names were submitted for evaluation of secondary causes of osteoporosis/osteopenia. A separately submitted file indicated 222 individuals at ABSSLC had osteoporosis or osteopenia. Based on submitted information, 106 individuals had partial and inadequate evaluations for secondary causes of osteoporosis/osteopenia. One hundred sixteen individuals had no evaluation. The Monitoring Team requested active record documentation of the amount of daily calcium and vitamin intake based on the diet, feeding formula, average percentage of meal taken or formula ingested, or any other information that would be helpful to the PCPs in determining the amount of these nutrients in the food, and the appropriate amount of supplement which needed to be prescribed to ensure both adequate intake and avoid excessive amounts of these nutrients that could lead to adverse outcomes. In response, the Facility indicated that the annual nutritional assessment calculated the daily calcium offered in the diet. No examples of current annual nutritional assessments were submitted that demonstrated estimated daily calcium in the offered diet From the sample of six medical records reviewed, six individuals had a diagnosis of osteopenia or osteoporosis. Six individuals had completed a DEXA scan. Six of these DEXA scans were completed in the prior three years. ▪ Of these, six (100%) had a DEXA scan/T score recorded. ▪ Of these, six (100%) had a T score consistent with the diagnosis of osteoporosis or osteopenia.	

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- Of these, six (100%) had been prescribed supplemental calcium and vitamin D.
- Of these, two of six had a bisphosphonate ordered.
- Of these, zero of six had Miacalcin prescribed.
- Of these, four of six had other alternative medications prescribed for treatment of osteoporosis or osteopenia.
- One of six had an additional diagnosis of mild primary hypogonadism, but an evaluation of current status of the condition was not submitted. This had additional potential impact on treating osteoporosis.

Acute and Emergency Care

Documentation was provided for ER visits from November 1, 2013 through April 30, 2014. The Medical Department submitted the following table that listed raw data by month, including the number of ER visits for the month and the most frequent/common categories of diagnosis for the visits:

Month	# ER Visits	Trauma	GI	Respiratory	Neurology	Infection	Cardiology	Bleeding	Other
November 2013	6	3	0	1	0	0	0	0	2
December 2013	11	0	0	3	2	2	0	0	4
January 2014	17	1	0	10	4	2	0	0	0
February 2014	14	0	0	8	5	0	0	0	1
March 2014	12	1	0	3	2	1	2	0	3
April 2014	19	0	5	5	3	1	2	0	3
Total	79	5	5	30	16	6	4	0	13

The active record was reviewed for 10 individuals who had most recently gone to the ER and returned. These individuals are listed in the documents reviewed section. The following summarizes the results of this review, based on the submitted documentation. It was noted that for two individuals, the submitted documentation appeared to be incomplete, as no information was submitted until arrival at the ER for these two individuals. Whether a pre-ER visit IPN occurred could not be determined.

- Information was submitted indicating that the ER was provided appropriate medical background information prior to the arrival of the individual for five of 10 (50%) records.
- Prior to the transfer to the ER, a PCP was onsite for eight of these transfers. In seven of eight (88%) records, the PCP had written an IPN that included the date and time.
- For seven of seven (100%) PCP transfer IPNs, vital signs were recorded or referenced from another

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IPN.

- For seven of seven (100%) PCP transfer IPNs, the reason for the transfer was documented.
- In seven of seven (100%) PCP transfer IPNs, the SOAP format was utilized.
- A copy of the ER report was available in 10 of 10 (100%).
- Of the 10 ER visits, diagnostic categories included: respiratory distress (two), trauma (two), cardiac diagnosis (one), genitourinary (GU) diagnosis (two), and viral syndrome (three).
- When the individual returned to the Facility after evaluation at the ER, eight of the 10 active records had a PCP IPN. One returned to the ER and was hospitalized after a short interval and would not have had a PCP IPN note. Eight of nine (89%) applicable records had a PCP IPN.
- Eight of eight (100%) post-ER visit PCP IPNs included date and time.
- Six of eight (75%) post-ER visit PCP IPNs included recording of vital signs.
- Eight of eight (100%) post-ER visit PCP IPNs utilized a SOAP format.
- A summary of ER information and findings was included in eight of eight (100%) PCP IPNs.
- When returning to the Facility, one returned to the individual's residence, and nine individuals returned to the Infirmary.
- For eight of 10 (80%), treatment was considered timely. Based on the information submitted, here were no perceived delays in care in transferring the individuals to the ER. For two records, there was no information submitted prior to the ER visit.

Documentation was provided for hospital admissions from November 1, 2013 through April 30, 2014. The following table lists this raw data by month, including the number of hospitalizations for the month and the most frequent/common categories of diagnosis for the admissions. The Medical Department provided this information:

Month	# Admissions	Respiratory	Neurology	GU	GI	Bleeding	Infection	Other
November 2013	10	5	1	0	1	0	1	2
December 2013	9	8	0	0	0	0	0	1
January 2014	17	10	0	0	3	0	1	3
February 2014	11	4	1	0	0	0	1	5
March 2014	7	2	0	0	1	0	0	4
April 2014	8	3	0	0	2	0	0	3
Total	62	32	2	0	7	0	3	18

ABSSLC had an Infirmary. Documentation was provided for Infirmary admissions from November 1, 2013

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through April 20, 2014. The following lists the month, the number of Infirmary admissions for the month, and the most frequent/common category of diagnosis for the admissions. The Medical Department provided this information:

Month	# Admissions	Trauma	GI	Respiratory	Infection	Fever	Neurology	Dental/ Post Op	Other
November 2013	48	4	2	6	6	0	0	0	30
December 2013	39	0	0	4	6	0	2	0	27
January 2014	42	0	1	7	1	4	0	0	29
February 2014	42	0	2	10	7	2	0	0	21
March 2014	49	2	1	4	9	3	0	0	30
April 2014	37	0	1	3	7	0	0	0	26
Total	257	6	7	34	36	9	2	0	163

- The number staying one day or less was 101.
- The number staying two days was 25.
- The number staying three days was 13.
- The number staying four days was six.
- The number staying five days was nine.
- The number staying six days was nine.
- The number staying seven to 10 days was 19.
- The number staying 11 to 20 days was 15.
- The number staying 21 to 30 days was five.
- The number staying 31 to 60 days was six. Of note, the Monitoring Team noted six individuals, while the Medical Department submitted a document indicating five individuals stayed 31 to 60 days.
- The number staying 61 or more days was three. Of note, the Monitoring Team noted three individuals, while the Medical Department submitted a document indicating two individuals stayed over 60 days.

Pneumonia

The Facility submitted data that had been entered into the Avatar database. Information concerning pneumonias was submitted for the time period from October 2013 through March 2014.

- According to this database, there were 25 pneumonias during this time period. As discussed in

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further detail below, other information reviewed called this number into question, and raised the possibility that there were additional pneumonias not included in the Avatar database.

- Of these, 17 were categorized as aspiration pneumonia.
- Off-site physicians diagnosed 18 of 25 pneumonias.
- As part of confirmation of the diagnosis of pneumonia, the following information was provided in the data submitted:
  - Twenty-five of 25 had a chest x-ray completed. For 23 of these 25, the chest x-ray confirmed findings compatible with a pneumonia.
  - For nine of the 25, data indicated blood cultures were obtained. Blood cultures were positive in three of 25.

In summary, supportive evidence was found for the diagnosis of pneumonia for 25 of 25.

- According to the data, seven individuals were taking by mouth (PO) nutrition at the time of the pneumonia. For seven of seven, there was documentation of a therapeutic diet with varying textures and fluid thickenings. For one of the 25, the Avatar data did not include this information.
- Seventeen of 25 individuals had a feeding tube prior to the onset of the pneumonia. Fifteen of 17 were gastrostomy tubes, zero was gastro-jejunostomy tube, and two were jejunostomy tubes. The formula flow rate for those with jejunostomy tubes was continuous in zero of two. For those with gastrostomy tubes, nine utilized an intermittent flow rate, three utilized continuous feeding, and three utilized bolus feedings.
- For those diagnosed with aspiration pneumonia, there were five recorded as taking food and fluid by mouth. Two of the five individuals admitted for aspiration pneumonia had a modified barium swallow study. One subsequently had a feeding tube placed.

On 3/6/14, the PCPs were provided in-service training on DADS "Enteral Feeding Clinical Guidelines for the PCP."

The incidence of types of pneumonia per month from the Avatar database was as follows:

Month	# Pneumonia Cases	# Aspiration Pneumonias	# Bacterial Pneumonias	# Viral Pneumonias
October 2013	3	1	1	1
November 2013	4	4	0	0
December 2013	3	1	2	0
January 2014	8	5	3	0
February 2014	5	4	1	0

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March 2014	2	2	0	0
Total	25	17	7	1

Separately, in graph form, the number of pneumonias per quarter was provided in a document entitled: "ABSSLC Infection Tracking." For the quarter of October through December 2013, the number of pneumonia cases listed was 10, which agreed with the Avatar data. For the quarter January through March 2014, there was a discrepancy. The Avatar data indicated 15 pneumonias during that quarter, but the "ABSSLC Infection Tracking" listed 19. It is recommended that the Facility review the entry of data for quality and completeness to ensure different data sets agree with this basic information.

Additionally, from a document providing information for those with a diagnosis of pneumonia in the prior six months that take food by mouth, there was an individual listed with aspiration pneumonia in October 2013, and another individual with aspiration pneumonia in November 2013, which were not listed in the Avatar database.

From submitted information for a document request for absolute numbers of pneumonia cases per month, the data agreed with the Avatar data for two of the six months (December 2013 and February 2014). For the other months from October 2013 through March 2014, there was lack of agreement in numbers of new cases of pneumonia per month. In comparing the various databases for pneumonia, there were 11 individuals were listed in one or more pneumonia databases, but not all.

To improve PCP clinical practice and adherence to the Facility guidelines and clinical expectations for evaluations, several in-service trainings occurred on aspiration pneumonia, along with development and training of new or revised templates used in completing evaluations and reviews of cases of aspiration pneumonia.

- On 11/19/13, PCPs were provided in-service training on DADS "Reducing the Risk for aspiration pneumonia for the PCP."
- On 12/12/13, the PCPs were provided in-service training on "discuss aspiration pneumonia."
- On 1/9/14, the PCPs were provided in-service training on a new "Aspiration Infirmary Admission Assessment" form. This form provided extensive probes for the PCPs as they completed a review of the clinical course and findings for the Infirmary admission. The template had numerous prompts for topic headings of events leading to aspiration if identified, risk factors for aspiration, medications, current diet, review of systems, physical exam, abnormal findings, past diagnostic tests, initial assessment and plan, list of potential referrals, and other potential orders.
- On 1/9/14, the PCPs also were provided in-service training on a revised "Orders for Diagnosis of Aspiration" form, which included eight potential orders for various consultants and positioning orders.

Sepsis

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Twenty-one individuals were diagnosed with sepsis in the time period from October 2013 through March 2014. The following table provides the breakdown per month:

Month	# Sepsis Cases	Month	# Sepsis Cases
October 2013	4	January 2014	6
November 2013	2	February 2014	5
December 2013	4	March 2014	0
Total	21		

The PCPs received in-service training concerning urosepsis on 11/20/13, and concerning sepsis on 12/12/13.

Trauma
During the time period from October 2013 through March 2014, 14 individuals went to the ER or were hospitalized for injuries.

Month	# Injuries Requiring ER Visit or Hospitalization	Month	# Injuries Requiring ER Visit or Hospitalization
October 2013	2	January 2014	4
November 2013	4	February 2014	2
December 2013	0	March 2014	2

Month	Head injuries	Laceration	Fracture	Other – Not Further Categorized
October 2013	0	0	1	1
November 2013	2	0	0	2
December 2013	0	0	0	0
January 2014	0	0	2	2
February 2014	1	1	0	0
March 2014	2	0	0	0

During the time period from October 2013 through March 2014, there were nine fractures. There were no events in which more than one fracture occurred. The fracture site included the following: face (one), upper extremity (one), and lower extremity (seven).

The PCPs were provided an in-service on "How to Complete an Injury Report (PCP responsibilities)," dated 3/4/14.

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		Chronic Conditions and Specific Diagnostic Categories *At Risk Individuals* The integrated process for addressing individuals' at-risk issues continued to reflect concerns. Based on review records, there appeared to be gaps in assessment, treatment, documentation, and/or follow through to closure. Many of these areas required the cooperation and follow through of the Medical Department as well as other Departments. Two examples are provided in detail: ▪ Since September 2013, Individual #385 was hospitalized twice and required Infirmary admission once. For one admission, a health care acquired pneumonia was diagnosed. The PCP indicated there was no infiltrate on the chest x-ray and the diagnosis was changed to bronchitis with reactive airway disease. Two months later, this individual was placed in the Infirmary for seven days due to reactive airway disease and bronchitis. Two months later, the individual was re-hospitalized again for respiratory distress. Diagnoses of aspiration pneumonia and acute respiratory failure were made, along with sepsis. There was an infiltrate on the chest x-ray in the right upper lobe of the lung. The medical history indicated a history of reactive airway disease requiring several nebulizer treatments and medication for reactive airway disease along with nasal inhalers and medication for allergies. The individual had a tracheostomy with tracheal diversion in the past with revision due to fistula formation in 2007. More recently, during tracheal care, formula was suctioned from the trachea. An ENT consult was made, and the recommendation was for reflux treatment. A gastrostomy had been placed in the past. Massive reflux had been noted in 1985. In 1994, an upper gastrointestinal series indicated that the individual was unable to empty the stomach unless turned to the right side. Referral to a gastroenterologist was made, and an esophagogastroduodenoscopy (EGD) was done with findings of gastric outlet obstruction requiring balloon dilatation, as well as a hiatal hernia. In February 2014, the individual had a large emesis after transfer in a sling with the head positioned too low. No submitted information indicated how this lack of appropriate positioning was resolved (i.e., further training, review of positioning needs, change in PNMP, etc.) in order to prevent a recurrence. The record appeared to be lacking in steps to be taken to prevent further episodes of reactive airway disease. The individual continued to have reactive airway disease without aggressive assessment. With known marked reflux, there were no further reports or documentation submitted indicating whether a fundoplication had been considered, or whether a jejunostomy was being planned as recommended by the gastroenterologist. The current status of the gastroparesis was not known. There was no gastric emptying study several months after the dilatation to determine the severity of the delay in gastric emptying following the balloon dilatation, and whether the gastric outlet obstruction was recurring or had stabilized. Although the individual had had two surgeries for tracheal diversion in the past, there appeared to be ongoing concerns for recurrent fistula formation, but the documentation of resolution of this concern was not found. Whether other specialty consultations or second opinions occurred to determine risk/benefit for any further evaluation or diagnostic/therapeutic procedure was not submitted. There did not appear to be a plan in place to address this issue.	

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		Separately, no quarterly medical review was submitted. The most recent annual medical assessment submitted was from 4/18/13. Routine periodic documentation for this high risk individual appeared to be lacking. An underlying concern was the clinical approach to this and other individuals with acute respiratory distress. If a chest x-ray, at the time of acute respiratory distress, was noted to be clear, the consideration of aspiration pneumonia or aspiration pneumonitis was dismissed as the diagnosis and there was no further evaluation that was triggered. Regardless of the diagnosis made, there needed to be an aggressive approach to resolving and preventing recurrent life threatening illness, but there was no further evaluation despite three more episodes of respiratory illness. ▪ Individual #54 had a prior tracheostomy with tracheal diversion, received nebulizer treatments, and vacuum tooth brushing. The purpose of vacuum tooth brushing in an individual with tracheal diversion and taking food orally might need further review, based on submitted documentation. This individual had moderate dysphagia, and took nutrition by mouth. This individual required pureed food with applesauce consistency, and liquids thickened to nectar consistency and served ice cold. Reclining at 40 degrees was required for optimal eating. The dining plan was complex and required nine steps. The individual had a number of meal refusals. PNMT was consulted for the aerophagia and bloating. It was not determined whether there was increased meal time monitoring for this individual to ensure all steps of his dining plan were completed correctly, or whether poor positioning, anxiety during eating, etc., contributed to aerophagia. There was a documented history of GERD dating to 2009 from an EGD, which found mild chronic inflammation of the gastro-esophageal junction. More recently, notation was found documenting acid burns at the end of the tracheal tube. There was no information to determine whether a gastric emptying study had been completed. The individual was not prescribed medication for GERD. If there was significant GERD, this might have been a reason for meal refusal. That there had been a prior tracheal diversion indicated the need for additional consultation to determine the current status of that diversion and whether fistula formation had developed, given the acid burns of the tracheal tube. There was no information whether this had been considered or occurred, or further evaluation of the GERD. A repeat EGD would confirm ongoing GERD as well as assess for the presence of Barrett's esophagus. There was no further GERD evaluation to determine the need for a fundoplication or medication treatment. The last modified barium swallow study (MBSS) information submitted appeared to have been 2009. There was significant abdominal bloating and aerophagia, which was referred to the PNMT. The individual was on several medications for constipation. The individual's bowel movements were noted to be soft. Whether there was megacolon or colon dysmotility could not be determined from the record. Given the history of respiratory issues requiring tracheostomy and nebulizer treatments, it was not clear from the record whether the abdominal bloating/distention contributed to the respiratory compromise.	

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		Separately, this individual missed a dose of antiepileptic medication during two consecutive days, followed by seizures in 24 hours. There was both a history of sub-therapeutic blood levels of antiepileptic medication as well as toxicity at times. This was complicated by medication refusal. There was no clinical review of this situation to determine if the individual refused medications during times of bloating and discomfort (or the possibility this discomfort was related to GERD). There was no information submitted as to whether a behaviorist had been consulted for the medication refusals. The IRRF considered behavioral health as low risk, but the data/discussion only included the template prompts and there was no information in this specific section about medication or meal refusals. The individual had osteoporosis, and was prescribed IV bisphosphonates every three months. There was a history of mild primary hypogonadism. No information was submitted indicating any current status/evaluation or referral to endocrinology. There was currently no medical treatment prescribed for the hypogonadism. There was no mention of this diagnosis during discussion of osteoporosis, nor under plans and recommendations of the annual medical assessment. If there were hypogonadism, this would be an added risk factor for osteoporosis. The record did not address this diagnosis and its impact on osteoporosis. There was a considerable delay in completing the hepatitis B vaccine series for this individual. A third injection was due May 2012. This was not ordered until September 2013. Once ordered, there was a several month delay until given in March 2014. Additionally, although there was a need to guide the IDT in determining risk for these high-risk areas, the PCP did not attend the ISP, according to the signed attendance roster. The most recent quarterly medical review submitted was 6/25/13. This record review identified several concerns. The lack of evaluation and treatment of GERD was problematic. Any evaluation of his tracheal diversion to determine functional state/presence of fistula was not submitted and might not have occurred. The reason for meal and medication refusal was not identified. Missed medications were followed by seizures. The degree of hypogonadism and effect on osteoporosis needed further review. Vaccine series were not administered in a timely manner. The PCP did not attend the ISP when there were several high-risk issues needing IDT deliberation. A specific subsection of the IRRF (i.e., behavioral) was left incomplete. This record review indicated significant problems and concerns, which were the responsibility of the Medical, Nursing, Behavioral Health Services, and QIDP Departments. *GERD* ▪ As part of the review of six records, GERD was reviewed. ▪ Of the six, four were diagnosed with GERD. Not each individual would have had the listed test or	

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procedure, but the following provides evidence of the spectrum of treatment at the Facility.

- Of these four, results of an EGD or UGI report were available or discussed in the IPN/ISP in four of four cases. For one individual, the last EGD recorded was 2009, and the individual was noted to have acid burns at the end of the tracheal tube despite a history of tracheal diversion.
- Of these six, two had a fundoplication.
- Of these six, five had a feeding tube.
- Of these six, three had appropriate medication prescribed.
- Of these six, three had a tracheostomy. Additionally, one had a tracheostomy in the past but not currently.

- Care was considered to follow clinical guidelines/national standards for evaluation and treatment of GERD in four of six (67%) reviews. Further information is provided above with regard to "At-Risk Individuals."

The PCPs were provided in-service training on the topic of "Chronic Conditions and specific diagnostic categories at-risk individuals," dated 1/16/14.

Tracheostomies
Twelve individuals currently had tracheostomies.

Newly Diagnosed Chronic Conditions
Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. One individual was newly diagnosed with diabetes mellitus type II in the past six months. One individual was newly diagnosed with cardiovascular disease in the past year, but there were no new cardiovascular disease diagnoses in the most recent six months. One case of a newly diagnosed cancer was reported in the past six months.

Pica

Month	# Individuals	# Pica Events	ER Visit	Hospitalization	Procedure/Surgery
October 2013	5	10	0	0	0
November 20	4 (7)	11 (19)	0	0	0
December 2013	5 (8)	10 (16)	0	0	0
January 2014	2 (3)	3 (7)	0	0	0
February 2014	7 (6)	7 (6)	0	0	0

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March 2014	4 (5)	7 (9)	0	0	0
Total	12	48	0	0	0

The Medical Department submitted two sets of data (one in parentheses, the other without parentheses). It was noted that the two sets of data were not in agreement.

Chronic Constipation
Three hundred forty three of 363 individuals had a diagnosis of constipation, or received treatment for constipation at least weekly or as needed. The document request was for those receiving treatment on a routine basis at least weekly and not on an as needed basis only. From this list, 40 individuals were identified that received medication on an as needed basis only and these were removed. Those on routine medications for constipation totaled 303 of 363 (83%).

An untitled document listed the number of bowel obstructions or bowel perforations per month. This included the diagnosis of ileus:

Month	# Bowel Obstructions	Month	# Bowel Obstructions
October 2013	2	February 2014	0
November 2013	2	March 2014	1
December 2013	1	April 2014	1
January 2014	0	Total October to April	7

Skin Integrity
A Skin Integrity Committee met on 1/30/14, 2/27/14, and 3/27/14. Minutes were submitted for these three meetings. In these meeting minutes, the focus was on developing and implementing preventive and treatment strategies. The 1/30/14 minutes included data, but the 2/27/14 and 3/27/14 minutes did not include data to determine trends. However, there was documentation of inter-disciplinary involvement/cooperation in developing systems to meet the skin integrity needs of the individuals.

Data concerning prevalence of decubiti was provided periodically at the morning medical meeting and the Nursing Operations Officer provided updated information at this meeting the week of the Monitoring Team's visit. The following information was derived from this report:

- There were 11 active pressure ulcers documented for April 2014. There were two Stage 1 ulcers, six Stage 2 ulcers, one Stage 3 ulcer, one Stage 4 ulcer, and one unstageable ulcer. Six resolved during the month of April. Five of these 11 were new pressure ulcers. Five of the 11 pressure ulcers remained unhealed by the 5/15/14 "Skin Integrity Update" report. Three of five new pressure ulcers in April 2014 were resolved, according to the 5/15/14 "Skin Integrity Update" report. Data were not tracked to determine the number of pressure ulcers that originated at ABSSLC, and the number originating elsewhere (hospitalization, new admission, etc.).

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Month	Number of New Decubiti	Month	Number of New Decubiti
November 2013	0	February 2014	2
December 2013	3	March 2014	3
January 2014	0	April 2014	5

Month	Total Pressure Ulcers	# Ulcers Stage 1	# Ulcers Stage 2	# Ulcers Stage 3	# Ulcers Stage 4	# Ulcers Unstageable
November 2013	8	1	3	0	1	3
December 2013	10	1	4	0	1	4
January 2014	10	1	4	0	1	4
February 2014	10	1	4	0	1	4
March 2014	10*	2	6	0	1	2
April 2014	11	2	6	1	1	1

*Note the total does not equal the # of ulcers listed by stage.

Separately, data was submitted for "absolute numbers of new cases of decubitus ulcers for the prior year." In comparing the data to the above information, several discrepancies were noted:

Data Source	November 2013	December 2013	January 2014	February 2014	March 2014
Morning report	0	3	0	2	3
Absolute numbers of new cases submitted document	3	4	0	5	3

On 3/18/14, the PT Department provided an in-service to PCPs and RNs concerning "Pressure ulcer review." Additionally, the Facility had developed a "Clinical Pathway/Guideline for Pressure Ulcer

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		Prevention as well as Pressure Ulcer Care," dated February 2014. On 3/20/14, in-service training was provided to the PCPs. *Seizure Management* A list was submitted indicating that approximately 291 individuals had a diagnosis of a seizure disorder at the time of the Monitoring Team's visit. The Facility submitted information concerning antiepileptic medication usage. From submitted data, 263 individuals were prescribed antiepileptic medication. ▪ Of these, 144 (55%) were prescribed one antiepileptic medication, 73 (28%) were prescribed two antiepileptic medications, 37 (14%) were prescribed three antiepileptic medications, eight (3%) were prescribed four antiepileptic medications, and one (0.7%) was prescribed five antiepileptic medications. Additionally, 28 individuals had a VNS implant. ▪ Twenty-eight individuals with a diagnosis of seizures were on no antiepileptic medications. ▪ The Facility defined an individual with a "refractory seizure disorder" as an individual that had two antiepileptic drug failures, a seizure per month was recorded for each of the prior 18 months, or the seizure-free period did not exceed three months during the prior 18 months. Based on these three criteria, 75 individuals were considered to have a refractory seizure disorder. ▪ There was no individual with a refractory seizure disorder who was currently being evaluated for a VNS. ▪ In the prior six months, seven individuals had a total of 10 ER visits for an uncontrolled/prolonged/ new onset seizure. ▪ There were 14 individuals with status epilepticus. Status epilepticus occurred 20 times in these 14 individuals. A list was submitted indicating the percentage of all individuals on anti-epileptic medication that were prescribed older antiepileptic medications. A total of 30 (11%) of individuals were prescribed Dilantin, nine (3%) were prescribed Primidone, 63 (24%) were prescribed Phenobarbital, and four (2%) were prescribed Felbamate. On 3/13/14, in-service training was provided to the PCPs concerning the DADS "Seizure management instructions for the PCP." <u>Do Not Resuscitate Orders</u> A total of 28 individuals at the Facility had DNR orders in place. The date of the DNR was submitted for each. DNR orders were initiated for 14 individuals in 2014, for one individual in 2013, for zero individuals in 2012, for two individuals in 2011, for one individual in 2010, for two individuals in 2009, and for eight individuals in years prior to 2009. From 2010 to 2013, 20 individuals had their DNR status rescinded. For 12 of 28 individuals with current DNR orders, clinical justification was provided for the DNR. Clinical	

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		justification included the following: one individual had neurodegeneration, four had cardiac diagnoses, one had morbid obesity, four had severe osteoporosis, and two had gastrointestinal diagnoses. Sixteen listed no reason for medical justification. For some diagnoses listed as clinical justification, review by the State Office or a second opinion is indicated to ensure the State Office guidelines were followed in determining terminal condition. It was noted that 14 had DNR orders written in 2014. This was due to a Facility and/or State Office policy, which reduced the choice(s) offered to guardians/families concerning treatment options. Previously, an individual was ordered to be full code but without chest compressions due to severe osteoporosis which would result in flail chest, or due to abnormal anatomic location of the heart in which chest compression would not be effective. However, IV medication, intubation, bagging, and oxygen were permitted. The Facility policy no longer allowed for such options. The rationale for the new policy was not provided. However, families made the decision to institute the DNR for 13 of the 28 individuals based on the change in policy. These individuals will now be offered less medical treatment if they have a cardiac or respiratory arrest, than prior to the implementation of the new policy in which they remained full code with some restrictions determined by family/guardian. It is theoretically possible that conservative measures such as ambu bagging, oxygen administration, and IV medication that potentially could be successful in reviving an individual with a DNR order will no longer be provided during such a circumstance. There were 11 Ethics Committee meetings ordered based on changes in DNR status, but no information was submitted to determine whether these committee meetings were held, the individuals discussed, and/or outcome. The Ethics Committee minutes that were submitted at times agreed with a DNR status despite no qualifying condition. This area of Facility care and administrative oversight required further review to ensure the health and safety of the individuals. The State Office should review the practice of writing DNR orders without qualifying conditions (i.e., lack of aggressive treatment when there was no terminal illness). For the 13 individuals with a DNR order based on removal of the option for "no chest compression," the PCP discussed the two choices of DNR or full code with the families or guardians, but there was no evidence of the Ethics Committee guiding these discussions. It is recommended the Facility review the role of the Ethics Committee at ABSSLC, especially when confirming DNR status without a qualifying condition. <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	<u>Non-facility Physician Case Reviews</u> During the prior six months (November 2013 through April 2014), the Facility completed one non-facility physician audit reviews (Round #9). The following represents a synopsis of the information the Medical Department provided: ▪ For the one external peer review, dated April 3 to 4, 2014, PCP compliance in essential areas was	Noncompliance

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	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.	100 percent. For areas considered non-essential, compliance ranged from 97 to 100 percent. o Areas that appeared to need improvement from the external peer review included answers to the following audit probe questions: (9) "Has the MMR immunization been given?" and (27) "Is the 180 day physician order present in the record, and does it document the indication for each medication/order for medication to be discontinued?" ▪ From the external peer review audit, there were eight corrective action plans generated. Eight of eight were corrected within 60 days. ▪ An external medical management audit for Round #9 was also completed April 3 to 4, 2014. The three areas of clinical focus were: aspiration pneumonia, diabetes mellitus, and osteoporosis. ▪ Compliance for each diagnosis was 100 percent for all PCPs. There were no identified areas that appeared to need improvement from the external medical management peer review audit. ▪ From the external medical management audit for Round #9, there were no corrective action plans generated. ▪ As this external audit had been recently completed, no follow-up reports of progress for corrective actions had been completed. External medical peer review audit of October 24 to 25, 2013: ▪ An external medical peer review general medicine audit also was completed six months prior, (i.e., October 24 to 25, 2013). ▪ Twenty-two active records were reviewed (i.e., 8% random sample of each PCP caseload). An additional random sample of nine records was reviewed for the medical management audit, three records for each of three diagnoses of seizures, constipation, and urinary tract infection (UTI). ▪ The general medical audit included 46 indicators. Indicators required 80 percent as a compliance threshold. ▪ The external medical peer reviewer provided an exit summary. ▪ Strengths identified included organization of the records, appropriateness of consultations, and close follow-up of consultant recommendations. The medical staff had prompt response to any acute medical problem. Abnormal lab and diagnostic results were documented in the IPN and followed through to resolution. ▪ The Facility identified weaknesses through a review of specific record findings. Trends were not discussed. ▪ For areas considered essential, compliance among PCPs ranged from 95 to 100 percent. For areas considered non-essential, compliance ranged from 94 to 100 percent. ▪ Thirty-five corrective action plans were created from the general medical quality assurance audit. The clinical indicator with the most noncompliance was (14) "Has the varicella (titer or vaccine) been given." Another clinical indicator that identified need for improvement was (9) "Has the MMR immunization been given?" ▪ For the external peer review medical management audit, five corrective action plans were generated. The most common clinical indicators that identified areas needing improvement included: seizures – (4) "Quarterly review of seizures documented by the PCP with recommendations?" (2) "Did the PCP complete appropriate labs at least every 6 months?"	

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		▪ The constipation monitoring audit results reached the 80 percent compliance threshold. ▪ The UTI monitoring audit results reached the 80 percent compliance threshold. ▪ It was noted that the Round #8 external general medical quality assurance audit had expanded to 46 indicators from the prior 30 indicators during Round #7 of the audit. ▪ The QA Department tracked corrective action plans. The December 20, 2013 QA report indicated 18 of 35 general medical corrective action plans had been resolved, although a 1/8/14 report entitled "External Medical Audits" indicated that the audit of 1/4/14 confirmed that 18 of 35 general medical corrective action plans had been resolved. The reason for the discrepancy in dates was not identified. For the medical management corrective action plans, two of five had been resolved. ▪ From the 1/8/14 QA Department report, 21 of 40 (53%) action plans remained open. ▪ A 2/19/14 QA report on follow-up of action plans identified the number of outstanding action plans per PCP. ▪ As of 3/5/14, all 40 action plans had been closed. ▪ Results and progress of the external medical peer review audit action plans was reported at the 11/20/13 and 1/13/14 ABSSLC Leadership Council/QA/QI meeting. On 11/13/13, results of the external/internal medical audit results for Round #8 were discussed at a PCP in-service training. On 12/3/13 and 12/10/13, the PCPs received in-service training concerning "external/internal medical audits October 24-Nov 5, 2013." On 2/25/14, the PCPs received in-service training on "External QA medical audits." On 3/11/14, the PCPs received in-service training on "QA Department and Medical Department Review Meeting." <u>Mortality Reviews</u> At the time of the Monitoring Team's onsite review, the Facility submitted seven clinical death reviews and seven administrative death reviews. There were two additional deaths in February 2014 for which clinical and administrative death reviews were not submitted. It was not known if these reviews had occurred. A total of nine deaths were reviewed from September 2013 through March 2014. ▪ The average age was 65 (range 24 to 93). ▪ Six died under the age of 65, and three died at age 65 or greater. ▪ Of the deaths, five were females, and four were males. ▪ The causes of death were: septic shock, respiratory disorder, cancer, pulmonary embolism, cardiac disease, seizure disorder, neurological disorder, and advanced dementia. ▪ An autopsy was performed in three of the seven. ▪ DNR status was ordered while residing at ABSSLC for six of the seven, and ordered for six while in the hospital. ▪ Three died in a hospital setting or at the ER. ▪ Five died at the Facility. ▪ One died at another site (hospice). ▪ Two had feeding tubes. ▪ Nine included documentation indicating they were aggressively treated or aggressively treated	

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		until a decision of DNR was made. ▪ Seven were enrolled in hospice. ▪ Two were considered ambulatory or mobile with adaptive equipment (either independently or with assistance). Since the Monitoring Team's last visit, seven clinical death review investigations and seven administrative death reviews were completed for the seven reviews submitted. 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. ▪ Of these death reviews, seven of seven administrative death reviews had follow-up recommendations. ▪ Administrative death reviews included from six to 22 recommendations per review, for a total of 91 recommendations for seven death reviews. ▪ Systemic issues related to potential improvements in medical care were 21 of the 91 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in nursing care were 67 of the 91 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in transition of care to the ER, hospitalization, rehabilitation or nursing home, or hospice were zero of the 91 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in pharmacy services were zero of the 91 recommendations from the administrative death reviews. ▪ Systemic issued related to potential improvements in dental services were zero of the 91 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in habilitation therapies services were two of the 91 recommendations from the administrative death reviews. ▪ Systemic issues related to need for collaborative work between nursing and Medical Departments were three of the 91 recommendations. ▪ Systemic issues related to potential improvements in meaningful day activities (i.e., work, leisure programs, etc.) were zero of the 91 recommendations from the administrative death reviews. ▪ Systemic issues related to documentation/medical records oversight were eight of the 91 recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in other departments (i.e., maintenance, housekeeping, furlough, etc.) were zero of the 91 recommendations from the administrative death reviews. ▪ The Facility submitted follow-up documentation for three deaths with 60 recommendations. Of these 60 recommendations, the Facility administration determined the recommendations from the administrative death reviews were unnecessary, process already in place, or other rationale for nine of 60 recommendations. For 51 recommendations Facility Administration accepted, evidence was provided for tracking and closure of 49 of 51 (96%). The remaining deaths had	

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		recommendations, but these recommendations continued to be implemented and had not been completed, as these were more recent deaths. For two deaths, no information was available concerning clinical death reviews or administrative death reviews. In-service training to PCPs related to follow-up recommendations from administrative death reviews included the following: ▪ Chronic Obstructive Pulmonary Disease (COPD), on 11/19/13 ▪ Deep Vein Thrombosis (DVT) prophylaxis and treatment; pulmonary embolism, on 11/19/13 ▪ Urosepsis, on 11/20/13 ▪ Post menopausal uterine bleeding, on 11/20/13, and ▪ Congestive heart failure, on 12/12/13. The Facility had made significant progress in tracking recommendations resulting from mortality reviews through to completion. The reason for not submitting death reviews for two individuals was not determined. For the external medical peer review process, medical management clinical indicators needed to be expanded to other common diagnoses.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action;	<u>Internal Medical Provider Quality Assurance Audit of April 3 to 4, 2014</u> The audit questions were identical to those used in the external medical peer review audit. Compliance for PCPs in essential areas ranged from 72 to 94 percent. Compliance for PCPs in non-essential areas ranged from 91 to 97 percent. The QA Department had tracked action plans each month. Areas that appeared to need improvement included answers to the following audit probe questions: (4) "Is the annual physical exam complete, including past medical history, family history, and plan of care?" (9) "Has the MMR immunization been given?" (11) "Has the influenza immunization been given?" (17) "Have the appropriate preventive screenings for mammograms been provided?" (25) "Have the appropriate preventive screenings for vision been provided?" (26) "Was the preventive care flow sheet updated at the time of the last annual assessment?" (31) "Do the medication orders for chronic conditions include indication and duration for all the medication prescribed?" (32) "Are the diagnostic tests and/or therapeutic procedures medically appropriate?" (33) "Are responses to significant lab values documented in the integrated progress note by the provider?" (34) "Are all diagnostic test results and consults initialed and dated?" (42) "Did the provider indicate resolution and closure of acute problems in the integrated progress note?" (43) "Has the provider ordered appropriate consultations for identified need and diagnosis?" Also, an internal medical management audit was completed from April 3 to 4, 2014, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: aspiration pneumonia, diabetes mellitus, and osteoporosis. Additionally, there was a medical management audit for GERD. Compliance among PCPs ranged from 50 to 100 percent. Areas that appeared to need improvement included answers to the following audit probe questions: ▪ Aspiration pneumonia - (5) "Did the provider order a GI consult or a pulmonary consult if	Noncompliance

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	and monitors to ensure that remedies are achieved.	indicated?" (7) "Did the provider refer the individual to the QIDP or the PNMT nurse after the last dx [diagnosis] of aspiration pneumonia?" (10) "Did the PCP review the risks and interventions for the individual for aspiration pneumonia and recommendations made [sic]?" (11) "Did the provider review the medications to see if any changes or addition needed to reduce the risk of aspiration pneumonia?" ▪ Diabetes mellitus - (3) "Did the provider order appropriate diagnostics and consults if warranted?" ▪ Osteoporosis: no areas of noncompliance identified. ▪ GERD - (4) "Is the individual on an anti-reflux diet if fed orally?" (6) "Is the individual on the appropriate diet/calorie level if BMI is 25 or above?" (7) "Has an EGD, 24 hour pH probe study or upper GI series been done in the past?" (8) "Is the individual receiving drug therapy?" (9) "Have the individual's GERD symptoms been reassessed at least annually to determine whether the drug therapy is still needed?" (10) "Did the PCP assess the individual for the presence of alarm symptoms?" (11) "Did the PCP consider a GI referral or evaluation of fundoplication if the individual has been having recurrent "COPD," "asthma," "reactive airway disease," or "wheezing" exacerbations despite maximum medical therapy?" For the internal medical management peer review audit, there were 13 corrective action plans identified. Additionally, there were 17 corrective action plans for GERD. Four of 13 corrective action plans were outstanding at 30 days, and the remainder continued to be followed to closure. For the 17 corrective action plans for GERD, 17 of 17 remained outstanding at 30 days, and these continued to be followed to closure. <u>Internal Medical Provider Quality Assurance Audit (Round #8) of January 13 to 17, 2014</u> A second internal peer review medical management audit was completed January 13 to 17, 2014. A five percent random sample of each PCP's caseload was audited. This totaled 22 records, and an additional nine randomly selected charts were chosen, three for each of three diagnoses: seizures, constipation, and UTI. Compliance for PCPs in essential areas ranged from 92 to 100 percent. Compliance for PCPs in non-essential areas ranged from 98 to 100 percent. Clinical indicators needing improvement included: (13) "Has the PPD been given?" (26) "Was the preventive care flow sheet updated at the time of the last annual assessment?" (This is considered an essential clinical indicator.) (32) "Are the diagnostic tests and/or therapeutic procedures medically appropriate?" An internal medical management audit was completed January 13 to 17, 2014 for the following clinical concerns: constipation, seizures, and UTI. Compliance among PCPs ranged from 75 to 100 percent. Compliance for constipation was 83 percent, for seizures was 83 percent and for UTI was 100 percent. Clinical indicators needing improvement included: ▪ Constipation - (3) "Is there evidence that the PCP documented follow-up effectiveness of the treatment plan including side effects?" (4) "Is there evidence that the PCP ordered non-pharmacological treatments?" ▪ Seizures - (4) "Quarterly review of seizures documented by the PCP with recommendations?"	

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		▪ UTI – all clinical indicators met compliance. There were eight corrective action plans identified from the internal general medical peer review audit. There were 18 additional informal corrective action plans identified. These were tracked every 30 days. Of the eight formal corrective action plans, three of eight remained outstanding at 30 days, one of eight remained outstanding at 60 days, and all received closure by 90 days. For the 18 additional informal corrective action plans, six of 18 remained outstanding at 30 days, and all received closure by 60 days. The QA Department provided a report dated 2/19/14, listing the incomplete action plans per PCP caseload. There were four corrective action plans from the internal medical management peer review audit of January 13 to 17, 2014. Three of four were outstanding at 30 days, and all received closure by 60 days. On 2/25/14 and 3/11/14, the PCPs received in-service training on the internal QA medical audit of January 13 to 17, 2014. <u>Internal Medical Provider Quality Assurance Audit (Round #8) of October 24 to November 5, 2013</u> A five percent random sample of each PCP's caseload was chosen for the general medical audit. This totaled an audit of 22 records. An additional nine records were randomly selected based on diagnoses: three records for each of three diagnoses, including seizures, constipation, and UTI. Of 46 indicators in the general medical audit, 10 fell below the threshold of 80 percent compliance. PCP compliance in essential areas was 71 to 100 percent. PCP compliance in non-essential areas was 88 to 93 percent. Compliance for the medical management audit was: 83 percent for constipation, 92 percent for seizures, and 80 percent for UTIs. The internal general medical audit resulted in 79 action plans. The clinical indicators most frequently missed were (14) "Has the varicella (titer or vaccine) been given?" and (32) "Are the diagnostic tests and/or therapeutic procedures medically appropriate?" For the internal medical management audit, there were five action plans generated. The constipation audit clinical question (3) indicated need for improvement: "Is there evidence that the PCP documented follow-up effectiveness of the treatment plan including side effects?" Combined, there were 84 action plans to be completed. From a 1/8/14 QA Report, zero of 84 were closed by December 5, 2013. Fifty-three (63%) were closed by 1/4/14, and 31 (37%) remained without closure as of 1/8/14. A QA Medical audit report of 2/19/14 documented specific incomplete action plans per PCP. The last remaining action plan was completed 3/6/14. This information was provided at the ABSSLC Leadership Council/QAQI meeting of 11/20/13 and 1/13/14. In addition to resolving these specific action plans, several systemic processes were changed. Preventive screening for pap smears and colonoscopies resulted in a system-wide corrective action plan. Several additional Quality of Medical Care Indicator audit tools were developed. Additional areas included preventive care, completing initial consultation reports, and constipation, based on results of the internal	

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		peer review audits. On 1/21/14 and 3/11/14, the PCPs received in-service training for the internal audit results of October to November 2013. Inter-rater reliability for the internal medical peer review general medical audit of October 2013 was 90 percent. For the medical management audit, the inter-rater reliability for the constipation audit was 92 percent, for the seizure audit was 81 percent, and for the UTI audit was 90 percent. <u>Medical Department Initiatives Based on External and Internal Medical Peer Review Findings</u> For the internal medical peer review findings, there was evidence the Medical Department completed medical staff meetings to discuss results. These were held at the "Lunch and Learn" sessions, which became a forum for review of the findings of the peer review audits and steps to be taken to resolve the areas of need. Follow-up meetings for these audits were also conducted to review progress. Topics included: "Quality of Medical Care Indicators for Aspiration Pneumonia Monitoring," held January 21 to 22, 2014, and "Quality of Medical Care Indicators for Diabetes Monitoring Report," held December 5 to 6, 2013. The medical staff meeting minutes documented identification of areas needing improvement. Each CAP was reviewed in detail with examples of resolution steps. The medical staff meetings documented development of a plan of improvement. Each PCP received a list of deficiencies from the clinical indicators that needed closure. Follow-up required orders to be written or IPNs as part of the closure. <u>Medical Department Internal Reviews/Initiatives and Improvement Projects</u> The Medical Department has implemented the following additional processes for internal peer reviews: ▪ Quality indicators were identified for eight clinical areas, independent of the audit tools utilized in the external and internal medical peer review and medical management peer review process. Topics included: Diabetes mellitus, aspiration pneumonia, annual medical assessments, transfer to the ER and not admitted to the hospital for respiratory distress, and hospitalizations for respiratory distress, GERD, constipation, and preventive care. Evidence was provided that several of the "quality of medical care" audit tools had been implemented. Several reports were generated summarizing findings from these audits. ▪ A "Monitoring Report," dated 1/8/14, reviewed an internal Medical Department audit of 12/5/13 to 12/6/13 concerning diabetes mellitus that consisted of 16 indicators. A 100 percent sample of 18 records for individuals with this diagnosis was reviewed. Instructions for completing the audit were developed to improve/ensure inter-rater reliability. The Settlement Agreement Compliance Physician reviewed 18 records. The Medical Director reviewed one record for inter-rater reliability. A document entitled: "Guidelines for Completion of the Monitoring Tool Quality of Medical Care Indicators for Diabetes" provided instructions for auditors. Inter-rater reliability was 94 percent. Nineteen corrective action plans were identified. Thirteen of 16 indicators achieved compliance, a 57 percent improvement from a prior internal audit completed in September 2013. Corrective actions were tracked to completion. All corrective action plans were completed by	

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		1/29/14. On 1/7/14 and 2/6/14, PCPs received in-service training on "Quality of Medical care Indicators for Diabetes Monitoring." ▪ A "Monitoring Report," dated 1/23/14, reviewed an internal Medical Department audit concerning aspiration pneumonia. There were 15 indicators within the audit tool. Seven active records (100% sample) of individuals diagnosed with aspiration pneumonia from September 2013 through December 2013 were audited. The Settlement Agreement Compliance Physician and the Medical Director were the auditors. Instructions for completion of the monitoring were created to potentiate inter-rater reliability. The Settlement Agreement Compliance Physician reviewed seven records and the Medical Director completed a review of one of these seven records. Inter-rater reliability was 93 percent. Sixteen corrective action plans were generated. Ten of 15 clinical indicators met the established threshold for compliance. Several steps were taken to improve clinical practice. This included completing corrective action plans, creating and implementing an "Aspiration Infirmary Admission Assessment Template" as of 1/21/14, in-servicing the PCPs on indicators that fell below the compliance threshold, ongoing in-service on aspiration pneumonia during morning medical meeting discussions, "Lunch and Learn" sessions, and review of the most recent "At Risk Individual" section of the most recent Monitoring Team report for ABSSLC. On 2/6/14, a follow-up report was generated indicating 16 of 16 (100%) CAPs had been closed. On 1/23/14 and 2/6/14, the PCPs received in-service training on "Quality of Medical Care Indicators for Aspiration Pneumonia Monitoring." ▪ A "Monitoring Report," dated 2/5/14, reviewed the results of an internal Medical Department audit concerning annual medical assessments, which occurred 1/29/14 to 1/30/14. Twelve indicators had been created for monitoring. The Settlement Agreement Compliance Physician reviewed eighteen (5% sample) of the most recently completed annual medical assessments. Additionally, a PCP reviewed one of these annual medical assessments for inter-rater reliability. Inter-rater reliability was 100 percent. There were seven (or eight as separate reports did not agree) corrective action plans. Eleven of 12 indicators met the established threshold for compliance. Steps were taken to improve clinical outcome. Corrective action plans were tracked to closure. Additionally, the annual medical assessment template was revised to include prompts for the PCPs as they complete assessments. A follow-up of closure indicated that six of eight plans had been completed by 2/2/14, and the remainder by 3/6/14. On 2/6/14 and 3/13/14, the PCPs received in-service training on "Quality of Medical Care Indicators for Annual Medical Assessment." ▪ A "Monitoring Report" dated 2/25/14 reviewed the results of an internal Medical Department audit concerning ER transfers for respiratory concerns not admitted to the hospital. Ten indicators were created for the audit tool. A 100 percent sample (four active records) was identified for the time period October through December 2013. The Settlement Agreement Compliance Physician reviewed four records and the Medical Director reviewed one record to determine inter-rater reliability. Inter-rater reliability was 90 percent. Results indicated five of 10 clinical indicators met compliance. There were 11 corrective action plans. Steps taken for improvement included tracking corrective action plans to closure, revising the "GERD monitoring tool" for future implementation, and revising the annual medical assessment template to include prompts for a diagnosis of GERD and reactive airway disease/wheezing/COPD/asthma. A follow-up report, dated 3/13/14,	

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		indicated 11 of 11 corrective action plans were completed prior to 3/6/14. On 2/13/14 and 2/25/14, PCPs received in-service training on "Quality of Medical care Indicators for ER visits monitoring tool." On 3/13/14, the PCPs received in-service training on "Quality of medical care indicators for ER transfers due to respiratory concerns monitoring." ▪ A "Monitoring Report," dated 3/4/14, reviewed the results of an internal Medical Department audit concerning hospital admissions due to respiratory distress. There were seven indicators in the audit tool. A 100 percent sample of 12 records for the time period October 2013 through December 2013 was audited. The Settlement Agreement Compliance Physician reviewed 12 records and the Medical Director reviewed one record to determine inter-rater reliability. Inter-rater reliability was 100 percent. Seven of seven indicators achieved compliance. There were three CAPs. The CAPs were tracked to completion. All three were completed prior to 3/11/14. Additionally a "Hospital Discharge Procedure" was implemented as of 10/10/13. A "Hospital Admission Medical Chart Review Procedure" was to be developed by 3/31/14. On 2/13/14, 3/4/14, and 3/13/14, the PCPs received in-service training on "Quality of Medical Care Indicators for Hospital Admissions monitoring tool." As a follow-up to the internal Medical Department audits, an in-service was provided during medical staff "Lunch and Learn" meetings. Minutes indicated the following training, with dates, action plans, and follow-up to resolution: ▪ "Quality of Medical Care Indicators for Annual Medical Assessment Monitoring," held 1/29/14 to 1/30/14; ▪ "Quality of Medical Care Indicators for ER transfers Monitoring Report," held 2/21/14; and ▪ "Quality of Medical Care Indicators for Hospital Admissions Monitoring," held 2/24/14. Additionally, on 2/13/14, the PCPs had in-service training on "Quality of Medical Care Indicators for GERD monitoring tool." This was a monitoring tool with 11 clinical indicators. The Medical Department also demonstrated an analysis of data with development and maintenance/revision of audit tools. From a 3/31/14 report "The Top 6 diagnoses for the ER transfers 4th Calendar Quarter Report Oct-Dec 2013," the results highlighted the need for creation and continuation of several Quality of Medical Care Indicators monitoring tools (i.e., ER transfers for respiratory distress, hospital admissions for respiratory distress, and aspiration). The annual medical assessment and plan template was expanded to include further prompts for aspiration pneumonia, reactive airway disease, wheezing, asthma, COPD, and GERD. An additional template was created, the "Aspiration Infirmary Admission Assessment" form. A follow-up meeting with PCPs occurred on 4/1/14 and 4/24/14. It was noted that the diagnoses of aspiration pneumonia/pneumonia/respiratory distress caused 51 percent of the six top diagnoses being transferred to the hospital. Data was also analyzed by the Medical Department for quarterly medical review completion. From a monthly report of 2/25/14, overall completion in January 2014 was 17 percent. The corrective action included providing graphs showing the completion rate per PCP and Facility total. Training of PCPs	

#	Provision	Assessment of Status	
		occurred on 2/25/14. The February 2014 data indicated a Facility compliance of 38 percent. This was discussed with PCPs on 3/20/14. A meeting on 4/24/14 with the PCPs reviewed completion data for quarterly medical reviews. The Facility completion rate had increased to 72 percent. A report entitled "Incomplete Medication Orders 1/7/14 monthly database report" tracked incomplete orders, incomplete verbal orders, and total number of incomplete medication orders over the year of 2013. The PCPs received in-service training on 1/7/14, 4/8/14, and 4/24/14. Except for one locum tenens, this concern appeared to have a downward trend. The Medical Department had clearly taken a number of steps towards to development of a robust medical quality assurance system. Some of the improvements included: ▪ A number of problems were identified, baseline data was obtained, information was analyzed, new templates were created or revised with expansion of prompts to ensure completeness of clinical review, training was provided, and continual periodic monitoring occurred to assess the impact of corrective actions. ▪ With the introduction of a template, there was improvement in the content and timeliness of the quarterly medical reviews. ▪ Similarly, the evaluations to determine aspiration expanded the differential diagnosis, and reviews required interpretation by the PCP, with which the template assisted. Evidence of these reviews prompted by the contents of these templates was evident at discussions at the morning medical meetings. Although the Medical Department QI system had matured, and work was being done to continually improve clinical practices of the PCPs, the following were areas requiring further work: ▪ With regard to the internal medical audits, clinical indicators determining the effectiveness of treatment need to be added, which are clinically focused rather than documentation focused. ▪ Health outcome measures were an additional component of health status measurement that Facility staff needed to develop. Examples would include: the percentage of individuals within ideal body weight, as well as those less and those over that range for each quarter, the percentage of individual with osteoporosis for whom the last two DEXA scans indicated improvement, or stabilization of the T score, the number of individuals with a seizure disorder with no seizures in the past quarter, one seizure in the past quarter, etc., the number of individuals with a diagnosis of chronic constipation that required additional intervention beyond routine daily medication (i.e., PRN medications), and for those with fall prevention plans, the number of individuals that had no falls, versus falls without injury, versus falls with injury in the past quarter. Tracking the actual health status would allow determination of effectiveness of systems in place [i.e., medical treatment, and risk plans). It would allow determination of the health of individuals residing at ABSSLC, and assist in identifying areas of medical care that required focused attention. ▪ In general, more of the clinical data needed to be used to identify areas requiring changes in medical practice. For instance, if a Dilantin level was returned as abnormally high or low, was the PCP response appropriate and timely? If the database indicated five abnormal Dilantin levels across campus in the month, was there a quality improvement process in place to track the PCP	

#	Provision	Assessment of Status	
		response and timeliness to the abnormalities? When data was reviewed related to acute care interventions to abnormal Dilantin levels, was there a trend, and what were the steps taken (i.e., training, etc.) to improve care, followed by further tracking of this information for indications of resolution? Similarly, if a CBC result indicated abnormally high or low hemoglobin, did the PCP modify the treatment or order additional tests? Were the treatments or tests appropriate (as based on specific standards), and was the response timely? This approach answers a different set of clinical questions than many of the current clinical indicators. The Facility remained out of compliance with this provision. However, it is important to note that the Facility had taken a number of important steps towards substantial compliance, and the internal quality assurance efforts were beginning to play an important role in the identification and remediation of concerns with medical care at ABSSLC.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing	Since the Monitoring Team's last visit, the following policies/procedures/protocols were approved and/or implemented: ▪ Hospital Admission Medical Chart Review Procedure, implemented 3/21/14; ▪ ABSSLC Quarterly Medical Review Procedure, implemented 1/23/14; ▪ ABSSLC Aspiration Infirmary Admission Assessment Procedure, implemented 1/20/14; and ▪ ABSSLC Clinical pathway/Guideline for pressure ulcer prevention as well as pressure ulcer care, dated February 2014. A Medical Department Policy and Procedure Manual that included all pertinent aspects of medical services was not provided. The Facility had an ongoing process to create and update needed policies, procedures and protocols, and this is to be encouraged. The Medical Department Policy and Procedure Manual should include the following clinical and administrative areas: ▪ Staffing and administration (i.e., caseloads, categories of topics for CME, CPR certification, etc.); ▪ Organizational procedure and role of the morning medical meeting; ▪ Routine care and documentation standards; ▪ Updating diagnoses using IDC and DSM nomenclature; ▪ Preventive care; ▪ Acute care; ▪ Utilization of clinical guidelines and national standards as part of practice pattern; ▪ Tracking missed appointments; ▪ External peer review; ▪ Internal peer review and inter-rater reliability; ▪ Role of QA/QI Department in monitoring/guiding the Medical Department; ▪ Internal QI monitoring initiatives; ▪ Mortality review recommendations; ▪ Role of ethics committees; and ▪ Others as indicated.	Noncompliance

#	Provision	Assessment of Status	
	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Additionally, the Manual should have a calendar with updating/review of all policies on a frequency to be determined by Facility guidelines. The Medical Department had focused considerably on training of PCPs in the new and ongoing policies and procedures. The following are some of the in-service trainings on several policies which occurred in the Medical Department:	

Name of Policy	Date of Training on Policy
Integrated Neurology Clinic Policy	3/11/14
Periodic Cervical Cancer Screening	3/11/14
DADS Medical Care Policy 009.2 Section II.A.4	3/13/14
ABSSLC antiepileptic and psychotropic medications: Surveillance studies and drug levels policy	3/13/14
DADS 009.2 Medical Care Policy Section IX prevention Subsection B and C 1 and 2	2/11/14
DADS Medical Care Policy, documentation requirements, active problem list, properly updating the active problem list	12/12/13
DADS Medical Care Policy, documentation requirements, regarding proper documentation of agreement/disagreement and plan related to consultation recommendations	12/12/13
DADS Medical Care Policy, documentation of acute medical problems	12/10/13
DADS Medical Care Policy, IDT referral and appropriate documentation if IDT meeting is cancelled	12/10/13
Clinical Death Review Process	11/26/13
Reducing the Risk for aspiration pneumonia for the PCP	11/19/13
DADS Medical Care Policy - PCP orders	11/19/13
DADS Medical Care Policy	10/1/13
Medical Peer Review	10/1/13
Minimum common elements of clinical care	10/1/13
Medical/dental restraint process and sedation plans	10/1/13
Hospital Admission Medical Chart Review Procedure	3/20/14
Quarterly Medical Review Procedure	1/23/14
Aspiration Infirmary Admission Assessment Procedure	1/14/14
Medical Assessment/Summary/Plan of Care procedure	10/10/13
Hospital Discharge Procedure	10/10/13

#	Provision	Assessment of Status				
			Participation in Morning Medical Meeting Procedure	10/8/13		
			Use of Physician Order Sheet procedure	10/8/13		
			Use of consultation report form procedure	10/8/13		
			DADS Anticoagulation Therapy management guidelines	3/26/14		
			DADS guidelines Prader-Willi syndrome	3/26/14		
			DADS guidelines Tuberous Sclerosis	3/25/14		
			DADS Guidelines Clostridium difficile infection and treatment	3/25/14		
			ABSSLC Clinical pathway/guideline for pressure ulcer prevention as well as pressure ulcer care	3/20/14		
			Seizure management instructions for the PCP guideline	3/13/14		
			DADS Enteral Feeding Clinical Guidelines for the PCP	3/6/14		

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 At-Risk Individuals list; o ABSSLC's Nursing Department Presentation Book; o ABSSLC's Infection Control Presentation Book; o ABSSLC's Nursing Monitoring Tools raw data; o ABSSLC's lists of individuals who were seen in the emergency room, Infirmary, and hospital; o ABSSLC's Nursing Staffing data; 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 Infection Control Committee meeting minutes, dated 10/17/13, and 1/16/14; o Immunization auditing process and tool; o Administrative Follow-Up Meeting minutes related to home 6521, dated 1/27/14 and 1/30/14; o Medication Variance Committee meetings minutes, dated 11/6/13, 1/22/14, 2/26/14, and 3/26/14; o ABSSLC Medication Variance Graphs; o ABSSLC's Infection Control overall summary report list; o ABSSLC's Immunization Database examples; o Drug Utilization Discrepancy data; o Medication Administration Observations data; 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; o Pharmacy and Therapeutics Committee meeting minutes, dated 11/6/13 and 2/19/14; o Medical records for the following individuals: Individual #250, Individual #540, Individual #27, Individual #441, Individual #368, Individual #290, Individual #247, Individual #3, Individual #369, Individual #541, Individual #261, Individual #463, Individual #70, Individual #296, Individual #417, Individual #366, Individual #538, Individual #255,

	Individual #241, Individual #191, Individual #333, Individual #2, Individual #452, Individual #394, Individual #385, Individual #281, Individual #162, Individual #9, Individual #285, Individual #126, Individual #483, Individual #165, Individual #381, and Individual #509; o Infection Control Data Spreadsheet; o ABSSLC Bedbug Protocol; o Emergency Code Drill Trend Report; o Emergency Response Monitoring Data reports; o Emergency Drills Incident Management Review Team Meeting report; o Emergency Response Trend Report 1st Quarter FY 2014; o 911 Calls and Transport log; o Recruitment Activities; and o Emergency Response Committee meeting minutes, dated 2/20/14, 3/24/14, and 4/17/14. ▪ **Interviews with**: o Mary White, RN, MSN, Chief Nurse Executive (CNE); o Amy Jo Bramlett, LVN, At-Risk Coordinator; o Elizabeth Mendoza, RN, Nurse Operations Officer (NOO); o Jo Gloyd, RN, Quality Assurance; o Stephanie Richey, RN, Case Manager Supervisor; o Krista Hamilton, RN, Infection Control Manager; o Mary Willingham, RN, Program Compliance Nurse (PCN); o Marla Knight, PharmD, Clinical Pharmacist; o David Daniel, Quality Assurance Director; o Debbie Taylor, Assistant Director, Facility Competency Training/Development (CTD); and o Barbara J. Marrow, Director, Facility Competency Training/Development. ▪ **Observations of**: o Medication Variance Committee meeting, on 5/14/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. 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 M, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Since the last review, the Facility continued to use the Health Monitoring Tools for Nursing. At the time of the review, the methodology used to select some of the samples that the Quality Assurance Nurse was monitoring had resulted in very small sample sizes with little to no data being generated for some items. In addition, the Facility reported that due to a leave of absence, some of the quality assurance monitoring activities had not been consistently conducted. Although the Facility had made improvements regarding the presentation of data regarding inter-rater reliability percentages by item for some of the monitoring nursing tools (i.e., Real Time Infection Control Audit and the Nursing Assessments audit), there were a number of not applicable (NA) scores found in the Facility inter-rater

	reliability data and monitoring data that did not seem appropriate for the item being scored. However, no explanation was provided in the Facility's Self –Assessment regarding these odd scores. o Although it was evident that the Facility was continuing to make improvements in the presentation of its data, some of the data presented in the specific subsections for Section M did not consistently address the requirements of the subsection. In addition, the Self-Assessment did not consistently identify the specific criteria for compliance for the different areas audited or reflect the proactive use of nursing protocols when assessing the quality of the nursing services and documentation. As the Facility continues to review and use 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 Although the Self-Assessment included the inter-rater reliability percentages for each item for some of the nursing monitoring tools, the variability reported for some of the items did not include any explanation. ▪ At the time of the review, the Facility had made significant improvements regarding the consistency of presenting the data in a meaningful/useful way. However, some problematic issues persisted as noted in previous reports regarding the Self-Assessment. 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, 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 some of the scoring for compliance made some of the information confusing and it was unclear what it reflected. In some cases, more information was needed to explain the data so that the Facility's findings could make sense. o Did not adequately address the quality of the supports provided or documentation audited. o Did not consistently identify how samples were selected and presented data for some very small sample sizes, which could not be considered representative of the population being audited. ▪ The Facility rated itself as being in compliance with none of the subsections of Section M. This was consistent with the Monitoring Team's findings. However, the efforts the Facility made to demonstrate how their data supported their self-ratings were hampered by the lack of explanation regarding question marks or "NAs" for some compliance ratings in the data tables. The Facility's data identified some of the areas that were in need of improvement, but overall, did not provide specific information regarding the analysis of the information, identifying some potential causes for the issues, and the barriers to improvement. Continued 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, changes that ABSSLC had experienced regarding the Nursing Department and nursing positions included: ▪ Seven Registered Nurse (RN) Case Managers positions were filled; and ▪ In February 2014, the Hospital Nurse Liaison position was filled. In addition, at the time of the review, the Nursing Department had a total of 181.5 allotted positions, including 77 for RNs and 100.5 for Licensed Vocational Nurses (LVN). The current nursing vacancies included six RN positions and 22 LVN positions. The Nursing Department had continued to experience staffing challenges, which warranted the use of 14 agency nurses. In addition, since the last review, the 10 to 6 shift had lost five nurses due to retirement. Although since the last review, the Facility had engaged in a number of recruitment activities, such as posting positions on social media, meeting with graduating nursing classes, and advertising on the radio and television, filling the needed nursing positions had remained challenging. Some of the Facility's positive steps forward included: ▪ The Facility continued to create a stellar Presentation Book addressing the data and activities related to Infection Control. The Presentation Book included a significant amount of organized and detailed information regarding the Facility's infection control activities, but also demonstrated the increased depth of knowledge regarding infection control practices the Infection Control Nurses have gained since the review process was initiated. ▪ An incident regarding the identification of a bed bug showcased the Facility's prompt action to implement the appropriate treatment and prevent an infestation. In response to this incident, the Facility developed an instruction sheet in the event this situation was to reoccur, and added education regarding bed bugs to the Infection Control new employee training and refresher classes. ▪ In addition, since the last review, the Nurse Managers began collecting and reporting medication variances by unit during the monthly Medication Variance Committee meetings. This had enabled the Facility to promptly trend errors and implement interventions. Although the Facility had made some positive steps forward in the areas noted above, there continued to be a significant overall lack of progress found regarding the integrated health care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Nursing Assessments, and the actual implementation of nursing protocols. It was very troubling to find that nursing was still not implementing regular, proactive, and individualized nursing assessments for individuals who had clear histories of repeated hospitalizations, Infirmary admissions, multiple orders for treatments addressing their chronic health issues, and whose teams had assigned high and medium health risk ratings indicating the need for such interventions related to existing health conditions. There is no clinical justification for nurses or IDTs to wait for an individual to experience a change in his/her status to implement proactive and individualized nursing assessments in alignment with nursing protocols, especially when the individual has known health conditions. From discussions with ABSSLC's Nursing Leadership, a candid yet very alarming barrier was raised

	regarding the implementation of nursing protocols and the associated nursing assessments. The Chief Nurse Executive indicated that there was a concern amongst nursing staff regarding their ability to consistently implement regular nursing assessments in alignment with the nursing protocols for individuals that warranted these assessments for existing health issues due to resources and staffing issues. Although these concerns were clearly articulated during this review, they might be relevant within other SSLC Nursing Departments and should be openly discussed with Facility Administration and the appropriate State Office staff for prompt remediation to ensure individuals are provided the clinical services that they require. Given the significant nursing resources currently available, discussions should include consideration of the realignment of responsibilities within the Nursing Department and/or for individuals with higher acuities, as identified through the at-risk system.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>M1</td><td>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.</td><td>Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the Settlement Agreement. Information and recommendations addressing nursing documentation regarding restraints is included above with regard to Section C.

In assessing its progress, ABSSLC indicated in the Facility's Self-Assessment that the following data was generated since the last review regarding this requirement of the Settlement Agreement:

<table>
<tr><th>Urgent Care/ Hospitalizations</th><th>Sept 2013</th><th>Oct 2013</th><th>Nov 2013</th><th>Dec 2013</th><th>Jan 2014</th><th>Feb 2014</th></tr>
<tr><td>Population</td><td>40</td><td>46</td><td>44</td><td>52</td><td>36</td><td>48</td></tr>
<tr><td>% of population selected for audit</td><td>5%</td><td>6.52%</td><td>6.81%</td><td>5.77%</td><td>5.56%</td><td>6.25%</td></tr>
<tr><td>Sample size for PCM</td><td>2</td><td>3</td><td>3</td><td>3</td><td>2</td><td>3</td></tr>
<tr><td>Sample size for QA</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Overall Average per Report</td><td>80%</td><td>75%</td><td>92%</td><td>43%</td><td>76%</td><td>86%</td></tr>
<tr><td>There is documentation in the Integrated Progress Notes relating to circumstance/reason</td><td>100%</td><td>100%</td><td>100%</td><td>67%</td><td>100%</td><td>100%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status							Compliance
		that led to the urgent/emergency visit and/or hospitalization							
		The SSLC Hospital Transfer Form is completed and filed in Chart 1	NA	NA	NA	0%	0%	100%	
		There is a pre-transfer physical assessment SOAP note	100%	50%	100%	50%	100%	100%	
		Chief complaint/presenting problem and system review documented legibly and accurately documented, on the SSLC Hospital Transfer Form	NA	NA	100%	0%	0%	50%	
		There was a pre-transfer diagnosis	100%	100%	100%	100%	100%	100%	
		There is documentation that the medical provider and/or the nurse either provided a verbal report or telephone report to the infirmary or telephoned the off-site receiving facility to notify them of the individual's transfer and health status	100%	0%	100%	100%	100%	100%	
		The date, time, and method of transfer were included in the Integrated Progress Notes	50%	100%	50%	50%	0%	100%	

#	Provision	Assessment of Status							Compliance
		If an individual was admitted to the hospital, the hospital liaison includes current diagnosis of person's problem, the type of treatment received and clinical status during visitations, any discharge planning, including any special needs for the person	NA	NA	NA	0%	NA	100%	
		Hospital liaison form completed on weekends/holidays and filed in IPN	NA	NA	NA	0%	NA	0%	
		There is documentation on the Hospital Liaison Report and/or the IPN that the Hospital Liaison has visited the individual in the hospital daily (or made phone contact)	NA	0%	NA	100%	NA	50%	
		On discharge from the urgent/emergency room care and/or hospital, a complete nursing assessment (RN Post Hospital Assessment Form) was performed by an RN within two hours (to include subjective information, a full set of vital signs with SaO2 [oxygen saturation rates], physical assessment	NA	100%	NA	0%	100%	100%	

#	Provision	Assessment of Status							Compliance
		An individualized Acute Care Plan has been implemented within 12 hours	NA	NA	100%	0%	NA	50%	
		There is a PNMT Nurse Post Hospital Assessment/Evaluation completed on individuals who were hospitalized for aspiration pneumonia, respiratory concerns, GI issues, skin integrity issues, fractures, and seizures	NA	NA	NA	NA	NA	100%	
		There are hospital H&P [history and physical], lab, diagnostics, etc. reports and orders in the record	NA	NA	NA	0%	100%	100%	
		D/C [discharge] summary is available at time of chart review	0%	NA	NA	100%	100%	100%	
		There is documentation of nursing assessments and progress notes completed at the frequency indicated by the individual's plan of care and health status or Nursing Protocols	100%	NA	100%	0%	NA	50%	
		Nursing progress notes were written in the S.O.A.P format	NA	NA	NA	0%	100%	100%	

- Below is the Facility's monitoring data regarding Hospital Transfers and Post Hospital admissions:

Urgent Care/ Hospitalizations	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014

#	Provision	Assessment of Status							Compliance
		Population	40	46	44	52	36	48	
		% of population selected for audit	5%	6.52%	6.81%	5.77%	5.56%	6.25%	
		Sample size for PCM	2	3	3	3	2	3	
		Sample size for QA	1	1	1	1	1	1	
		Overall Average per Report	80%	75%	92%	43%	76%	86%	
		There is documentation in the Integrated Progress Notes relating to circumstance/reason that led to the urgent/emergency visit and/or hospitalization	100%	100%	100%	67%	100%	100%	
		The SSLC Hospital Transfer Form is completed and filed in Chart 1 of the record	NA	NA	NA	0%	0%	100%	
		There is a pre-transfer physical assessment SOAP note	100%	50%	100%	50%	100%	100%	
		Chief complaint/presenting problem and system review documented legibly and accurately documented, on the SSLC Hospital Transfer Form.	NA	NA	100%	0%	0%	50%	
		There was a pre-transfer diagnosis	100%	100%	100%	100%	100%	100%	
		There is documentation that the medical provider and/or the nurse either provided a verbal report or telephone report to the infirmary or telephoned the off-site receiving facility to notify them of the individual's transfer and health status	100%	0%	100%	100%	100%	100%	

#	Provision	Assessment of Status							Compliance
		The date, time, and method of transfer were included in the Integrated Progress Notes	50%	100%	50%	50%	0%	100%	
		If an individual was admitted to the hospital, the hospital liaison includes current diagnosis of person's problem, the type of treatment received and clinical status during visitations, any discharge planning, including any special needs for the person	NA	NA	NA	0%	NA	100%	
		Hospital liaison form completed on weekends/holidays and filed in IPN	NA	NA	NA	0%	NA	0%	
		There is documentation on the Hospital Liaison Report and/or the IPN that the Hospital Liaison has visited the individual in the hospital daily (or made phone contact)	NA	0%	NA	100%	NA	50%	
		On discharge from the urgent/emergency room care and/or hospital, a complete nursing assessment (RN Post Hospital Assessment Form) was performed by an RN within two hours (to include subjective information, a full set of vital signs with SaO2, physical assessment	NA	100%	NA	0%	100%	100%	

#	Provision	Assessment of Status	Compliance

An individualized Acute Care Plan has been implemented within 12 hours	NA	NA	100%	0%	NA	50%
There is a PNMT Nurse Post Hospital Assessment/Evaluation completed on individuals who were hospitalized for aspiration pneumonia, respiratory concerns, GI issues, skin integrity issues, fractures, and seizure	NA	NA	NA	NA	NA	100%
There are hospital H&P, lab, diagnostics, etc. reports and orders in the record	NA	NA	NA	0%	100%	100%
D/C summary is available at time of chart review	0%	NA	NA	100%	100%	100%
There is documentation of nursing assessments and progress notes completed at the frequency indicated by the individual's plan of care and health status or Nursing Protocols	100%	NA	100%	0%	NA	50%
Nursing progress notes were written in the S.O.A.P format	NA	NA	NA	0%	100%	100%

- Below is the Facility's monitoring data regarding precautions and hand washing with isolated acute infections:

Real Time Infection Audits	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
Population	0	4	1	5	10	18

#	Provision	Assessment of Status						Compliance
		% of population selected for audit	100%	100%	60%	100%	100%	
		Sample size for PCM	4	1	3	10	18	
		Sample size for QA	4	1	3	10	16	
		Overall Average per Report	72%	39%	47%	68%	59%	
		Proper standard and/ or Isolation Precautions are included in care plan	50%	100%	0%	63%	61%	
		The protocols for proper use of personal protective equipment and subsequent training have been included in the care plan	50%	0%	0%	63%	33%	
		Sufficient and appropriate supplies necessary for adherence to ordered Precautions	100%	100%	100%	NA	NA	
		Signs posted outside resident's room notating type of isolation	100%	100%	67%	100%	100%	
		Isolation cart positioned outside the resident's room containing PPE [personal protective	100%	100%	100%	100%	100%	

#	Provision	Assessment of Status	Compliance

equipment]						
Red Trash bin and laundry hamper positioned in ill resident's room with appropriate contaminated trash/linen bags	100%	100%	100%	100%	100%	
Soap and/or hand sanitizer available for staff use in hand hygiene.	100%	100%	100%	100%	100%	
Observable staff adherence to proper Standard and Isolation Precautions:	100%	0%	100%	NA	NA	
Staff observed properly washing/sanitizing hands	100%	NA	100%	100%	100%	
Staff observed properly donning and removing PPE when entering or exiting isolation room	75%	0%	100%	100%	89%	
Observation of cleaning/disinfection of shared equipment by staff	75%	NA	100%	100%	100%	

- Below is the Facility's monitoring data regarding preventative measures to limit the transmission of real time infections:

IC Audits	Sept	Oct	Nov	Dec	Jan	Feb

#	Provision	Assessment of Status							Compliance
		Sample = 100% of population	**2013**	**2013**	**2013**	**2013**	**2014**	**2014**	
		Population	0	4	1	5	11	19	
		% of population selected for audit	100%	100%	100%	60%	100%	100%	
		Sample size for PCM	0	4	1	3	11	19	
		Sample size for QA	0	4	1	3	10	16	
		Education/training for resident as applicable related to preventing mode of transmission for illness has been included in care plan		33%	0%	0%	0%	0%	
		Education/Training for staff related to the infectious process and preventing mode of transmission for illness, as well as, the appropriate clinical indicators to be monitored with the s/s [signs and symptoms] to report to nursing have been included in the care plan		75%	0%	0%	63%	39%	
		If applicable, the resident was treated with appropriate antibiotic in alignment with culture and sensitivity results of		100%	100%	100%	NA	NA	

#	Provision	Assessment of Status	Compliance

labs	[redacted]					

Although the Facility had made improvements in its presentation of data, the Self-Assessment did not include any additional information regarding what the data reflected or how it was being used in relation to nursing practices.

Self Rating
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. 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 Chief Nurse Executive indicated that since the last review, the Facility had continued to experience staffing challenges, but had initiated some positive steps forward. The Facility indicated that since the last review, the Facility had hired and trained seven new RN Case Managers, and had revised and expanded the training modules that had been used in the past regarding RN Case Managers. In addition, training for the RN Case Managers as well as the Direct Care RNs also was implemented during quarterly workshops. Also, although not implemented at the time of the review, in June 2014, the Facility planned to establish a Care Plan Review Workgroup and had developed a promising written procedure describing this process.

In addition, since the last review, the Skin Integrity Committee had finalized a Clinical Pathway and Guidelines addressing pressure ulcers and had completed training with Habilitation Therapies staff and the Medical Department staff. The CNE indicated that training for nursing was to begin in June 2014, initially with the RN Case Managers. Also, the Facility had developed a tracking database for pressure ulcers, but planned to expand the database to include other issues related to skin integrity.

Staffing
At the time of the review, ABSSLC had a census of 361 individuals. Since the last review, changes ABSSLC experienced regarding the Nursing Department and nursing positions included:

- Seven RN Case Managers positions were filled; and
- In February 2014, the Hospital Nurse Liaison position was filled.

In addition, at the time of the review, the Nursing Department had a total of 181.5 allotted positions, including 77 for RNs and 100.5 for LVNs. The current nursing vacancies included six RN positions and 22 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 continued to experience staffing challenges that warranted the use of 14 agency nurses. The CNE reported that since the last review, the 10 to 6 shift had lost five nurses due to retirement. Although the

#	Provision	Assessment of Status	Compliance
		Facility had participated in a number of recruitment activities since the last review, such as posting positions on social media, meeting with graduating nursing classes, and advertising on the radio and television, filling the needed nursing positions had remained challenging. 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 Program Compliance Nurse and the Quality Assurance 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; ▪ Medication Administration Observation Tool; and ▪ Nursing Protocols for the following: o Aspiration/Respiratory; o Constipation; o Seizures; o Vomiting; and o Abdominal Distention/Pain. Interviews with the QA Nurse indicated that since the last review, there were some months when her monitoring activities had not been completed due to a leave of absence, which was indicated on some of the data graphs contained in the Self- Assessment for Section M. However, it was noted that several of the sample sizes the QA nurse completed were very small and only consisted of a sample of one. The CNE indicated that since the Facility had only recently hired a new QA Director, a meeting was scheduled after the review to discuss monitoring issues, such as sampling methodology and sample size in order to generate more meaningful data. Since the last review, the Facility had continued to add instructions to the nursing monitoring tools and had referenced nursing protocols as the standard for assessing the quality of the nursing care provided or related documentation when determining compliance. However, as discussed in more detail with regard to Section M.4, the Facility was only monitoring the reactive initiation of nursing protocol assessments (after an acute event or illness occurred), and not the proactive use of nursing protocols for existing diagnoses or health conditions. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Although the Monitoring Team found there had been an increase in the use of the Nursing Protocols in the Integrated Health Care Plans for individuals with high and/or medium risk levels, the IHCPs indicated that the nursing assessments contained in the nursing protocols were only to	

#	Provision	Assessment of Status	Compliance
		be implemented after the individual demonstrated a change in status. According to the IHCPs reviews, nurses were only to complete nursing assessments in response to an acute issue. This meant that an individual with existing health conditions or diagnoses had to become ill in order for nursing staff to implement assessments. Consequently, the addition of the nursing protocols did not increase the clinical care the individuals' warranted. A review of nine individuals' IPNs (i.e., Individual #2, Individual #452, Individual #394, Individual #385, Individual #281, Individual #162, Individual #9, Individual #285 and Individual #126) 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 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 and only then were nursing protocols implemented. ▪ 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. The Monitoring Team did note that there were more IPNs that contained an adequate nursing assessment than found during previous reviews. However, the lack of consistency of the nursing assessments rendered the overall care of the individuals insufficient to address their specific needs. Although the IPNs indicated that some nursing protocols had been implemented, although not consistently, after the individuals demonstrated symptoms of an acute illness, no nursing protocols were implemented regarding the existing high and medium health risks these individuals already had experienced and continued to experience. There was no indication that nursing protocols were being used consistently to guide nursing assessments and documentation. As noted in several previous reports, due to the number of individuals with complex medical needs at ABSSLC, this area should be considered a priority. As noted in previous reports, the	

#	Provision	Assessment of Status	Compliance
		Facility should continue to implement and expand the use of nursing protocols to guide nursing practices for existing health conditions. The Facility's Self-Assessment indicated that it was not in compliance with these elements of this requirement, which was consistent with the Monitoring Team's findings. <u>Availability of Pertinent Medical Records</u> From a review of records while on site, it was noted that 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: ▪ The Facility continued to create a stellar separate Presentation Book addressing the data and activities related to Infection Control. It clearly presented a significant amount of organized and detailed information regarding the activities of the IC Nurses since the last review, but also demonstrated the depth of knowledge regarding infection control practices that the IC Nurses have gained since the review process was initiated. ▪ The Facility continued to monitor the process addressing data reliability, to accurately identify the Facility's trends related to infectious and communicable issues. From data generated by comparing the Infection Control Reports, Infection Control Logs from the residences, and the Pharmacy reports for the utilization of antibiotics, the following represented the number of discrepancies that were found and corrected regarding acute infections representing data reliability checks for Infection Control: 18, 28, 20, 25, 25, 18, 16, and 26, from September 2013 through April 2014, respectively. These data reflected that the Facility continued to conduct consistent data reliability checks to ensure the accuracy of the overall IC data. ▪ Data from the Presentation Book for Infection Control indicated that at the time of the review, 100% of the individuals and 100% of the Facility's staff at ABSSLC were current regarding Tuberculosis (TB) screenings. ▪ The documentation regarding an incident where a bed bug was identified in Residence 6690 demonstrated the Facility took immediate action regarding inspecting the entire home for the presence of bed bugs (no others were found) and implemented the appropriate treatment for the entire home. In addition, the Facility developed an instruction sheet in the event this situation was to reoccur. Also, education regarding bed bugs was added to the Infection Control New Employee Orientation training and	

#	Provision	Assessment of Status	Compliance
		refresher class. ▪ The documentation contained on the Outbreak Reports since the last review continued to be detailed, included specific clinical information regarding the individuals' status and progress, as well as any treatments initiated and precautions implemented. In addition, the documentation contained on the Facility's Infection Control Progress Note form indicated the IC Nurses provided a number of timely in-service training sessions to staff in response to the outbreaks and followed all cases reported to resolution. ▪ 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. Data were provided for the specific items that were found to be in compliance, as well as for those items that reflected problematic issues. This provided some valuable findings regarding the strengths and weaknesses of the Facility's practices related to acute infectious illnesses. ▪ Overall, the content of the minutes of the Infection Control Committee meetings continued to improve regarding the information and data presented, the analysis of data, and actions implemented in response to problematic issues. ▪ At the time of the review, the Facility was able to aggregate some infection control data by individual through the Avatar database. ▪ Since the last review, the Facility had developed and implemented a very comprehensive written Immunization Auditing Process and an associated Immunization Audit Tool to confirm the immunization status and immunizations for all the individuals as outlined in the Health Care Guidelines. At the time of the review, the IC Nurses reported that approximately 182 individuals had had their immunization information brought up to date, and that the remaining individuals would be completed by the next review. Although the IC Nurses clearly continued to make significant positive steps forward, the Monitoring Team noted some continued problematic areas regarding infection control that were in need of further attention, including: ▪ The minutes of the Administrative Meeting Related to Residence 6521, dated 1/27/14 and 1/30/14, indicated that in response to the onset of respiratory symptoms for seven individuals on 1/25/14 and 1/26/14, Housekeeping conducted a Sanitation Detail and an administrative walk-through of the home also was conducted. The minutes indicated that a significant number of problematic issues regarding the cleanliness of the environment were found, and interventions such as cleaning the wheelchairs and replacing cracked mattresses and pillows were implemented. Although these were positive actions implemented, it was unclear why these issues had not been previously identified during Environmental Surveys. It is recommended that the Facility continue to thoroughly monitor and clean the homes and equipment on a routine basis. ▪ Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated 39 individuals had 41 incidents of an acute infection (i.e., MRSA: Individual #199, Individual #122, and Individual #156; and	

#	Provision	Assessment of Status	Compliance
		Influenza: Individual #215, Individual #322, Individual #281, Individual #88, Individual #321, Individual #127, Individual #293, Individual #174, Individual #312, Individual #213, Individual #23, Individual #469, Individual #166, Individual #323, Individual #7, Individual #270, Individual #361, Individual #452, Individual #385, Individual #119, Individual #492, Individual #497, Individual #432, Individual #146, Individual #386, Individual #24, Individual #94, Individual #285, Individual #255, Individual #23, Individual #513, Individual #368, Individual #500, Individual #65, Individual #83, and Individual #110). Of the 41 incidents, 37 (90%) were found to have had Care Plans addressing the infectious issue. Of the 37 Nursing Care Plans reviewed, none (0%) were found to be clinically adequate. Although the care plan template addressing Influenza A and B included clinically sound information, the care plans reviewed were generally not individualized, did not consistently include stopping the spread of the infection as a goal, and did not consistently include measurable interventions. In addition, some of the care plans had different individual names listed throughout the plan. However, there was improvement found in the baseline assessment findings/data section of the plans. A review of the Facility's Real Time IC data also indicated that the Facility continued to find similar problematic issues regarding the development, implementation, and individualization of care plans addressing acute infectious illnesses. ▪ At the time of the review, the Facility was in the midst of an Influenza outbreak. The homes that were placed on isolation during the review week included: 6480, 6510, 6500, 6720, the Infirmary, 6522, and 6710. Although the Facility appeared to timely implement isolation procedures with restrictions regarding entering and leaving the affected buildings, the continual and rapid spread of the infection indicated that there might have been breeches in these procedures. It is recommended that the Facility review and analyze the documentation from the Outbreak Timelines as well as other critical factors such as staffing assignments, staff floating to other buildings, consistency of implementation of precautions, when the flu shots were administered, environmental issues, and other possible factors that might have contributed to the ongoing transmission of Influenza in an attempt to identify additional preventative strategies for future infectious outbreaks. The Facility continued to make a number of positive steps forward in the area of Infection Control. However, more work was needed, 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. <u>Mock Code Drills and Emergency Response Systems</u> Positive steps ABSSLC made regarding this area since the past review included:	

#	Provision	Assessment of Status	Compliance
		▪ The Facility continued to review the daily Emergency Cart Checklists verifying that the daily Emergency Cart checks were consistently being done ensuring that the equipment was available in case of an emergency situation. ▪ Emergency Mock 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. ▪ In addition, since the last review, the Facility had initiated conducting Emergency Mock Drills at the Laundry and the Housekeeping Department. However, a number of significant problematic issues were found that need to be promptly addressed in order for additional progress to be made: ▪ Again, 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 meetings were canceled in October, November, and December 2013, and the minutes for January 2, 2014 indicated that no members from the Nursing Department were present and that the meeting was ultimately canceled, since there were not enough committee members present. In addition, the minutes for February and March 2014 contained very little content or indication regarding on what issues the committee planned to focus its attention. Consequently, there was no evidence the Facility's Emergency Response Committee reviewed, analyzed, or discussed issues regarding the Mock Drills. ▪ Although there were no Emergency Response Committee Minutes for December 2013, January, February, March, and April 2014 with data regarding the number of passed and failed drills, it was particularly concerning that the minutes of the Leadership Council/QA/QI Council Notes on 1/6/14 noted an increasing trend in failed drills for the first quarter of 2014 in comparison with the past year's data, and yet there had not been a review of this issue by the Emergency Response Committee. ▪ The Facility's review of data regarding failed drills by new and tenured staff indicated that 20 drill failures from September through November 2013 were associated with tenured staff, while new employees were associated with only four failed drills. ▪ No information was provided in the Facility's Self-Assessment indicating if the Emergency Equipment Competency Checklist that should be conducted at least every quarter for each nurse had been conducted. Due to an active outbreak of Influenza	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>during the review week, the Monitoring Team was not able to observe emergency equipment use.

The data from the Emergency Mock Drills conducted since the last review were as follows:
▪ 90 drills conducted in October 2013 – 83 passed (92%);
▪ 96 drills conducted in November 2013 – 80 passed (83%);
▪ No aggregated Mock Drill data was provided for December 2013, January, February, March, or April 2014.

Clearly, there were a number of significant problematic issues found regarding the Facility's Mock Code Drills and Emergency systems. 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.</td><td></td></tr>
<tr><td>M2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.</td><td>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 Comprehensive Nursing Assessments from September 2013 through February 2014 found the following:
<table>
<tr><th>Comprehensive Nursing Assessment Audits</th><th>Sept 2013</th><th>Oct 2013</th><th>Nov 2013</th><th>Dec 2013</th><th>Jan 2014</th><th>Feb 2014</th></tr>
<tr><td>Population</td><td>39</td><td>35</td><td>42</td><td>38</td><td>22</td><td>24</td></tr>
<tr><td>% of population selected for audit</td><td>10.26%</td><td>5.71%</td><td>7.14%</td><td>10.53%</td><td>13.64 %</td><td>20.83 %</td></tr>
<tr><td>Sample size for PCM</td><td>4</td><td>2</td><td>2</td><td>4</td><td>4</td><td>5</td></tr>
<tr><td>Sample size for QA</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Annual Nursing Assessment is a scheduled, documented review that assesses the individual's health status</td><td>75%</td><td>100%</td><td>100%</td><td>75%</td><td>100%</td><td>100%</td></tr>
<tr><td>Annual Nursing Assessment is</td><td>50%</td><td>100%</td><td>100%</td><td>75%</td><td>100%</td><td>80%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status							Compliance
		completed by the RN							
		Individual's Annual Nursing Assessment was completed within 10 working days prior to the annual PSP.	50%	100%	100%	50%	67%	100%	
		Demographic Data (individual's name, home, date of birth, age, home, date of last annual physical by physician)	75%	100%	100%	75%	100%	80%	
		General Data (height, weight, weight since last year, IDW/DWR, Temperature, Pulse, Respirations, Blood Pressure, advance directive status)	75%	100%	100%	50%	100%	100%	
		Immunizations (including TB screening status)	75%	100%	100%	67%	100%	80%	
		Allergies/Adverse reactions (including food and environmental allergies)	75%	100%	100%	75%	100%	75%	
		Medical Diagnoses/Conditions	25%	0%	0%	0%	0%	60%	
		Current Medications/Treatments and related Diagnoses for each	50%	50%	100%	50%	33%	40%	
		Standing Orders for Labs (including frequency and dates due)	50%	100%	100%	67%	100%	40%	
		Dates	0%	100%	100%	67%	67%	80%	

#	Provision	Assessment of Status							Compliance
		Results	0%	100%	100%	67%	67%	80%	
		Dates of each	0%	0%	0%	67%	33%	100%	
		Diagnoses of each	0%	0%	0%	67%	33%	100%	
		Date	0%	NA	NA	0%	0%	100%	
		Medication and dose	0%	NA	NA	0%	0%	100%	
		Route	0%	NA	NA	0%	0%	100%	
		Reason	0%	NA	NA	0%	0%	100%	
		Response	0%	NA	NA	0%	0%	100%	
		Recovery time	0%	NA	NA	0%	0%	100%	
		Effectiveness	0%	NA	NA	0%	0%	100%	
		Information documented on sedation log	0%	NA	NA	0%	0%	0%	
		Date	NA	NA	NA	0%	0%	NA	
		Medication and dose	0%	NA	NA	0%	0%	NA	
		Route	0%	NA	NA	0%	0%	NA	
		Reason	0%	NA	NA	0%	0%	NA	
		Response	0%	NA	NA	0%	0%	NA	
		Effectiveness	0%	NA	NA	0%	0%	NA	
		Eyes	50%	50%	100%	75%	100%	100%	
		Ears	25%	100%	100%	75%	100%	100%	

#	Provision	Assessment of Status							Compliance
		Nose	75%	50%	100%	75%	67%	100%	
		Throat	75%	50%	100%	75%	100%	100%	
		Respiratory	75%	100%	100%	50%	100%	100%	
		Genito-Urinary	75%	100%	100%	75%	67%	100%	
		Dental	75%	100%	100%	75%	100%	100%	
		Podiatry	75%	100%	100%	75%	67%	100%	
		Orthopedic	50%	100%	100%	75%	100%	100%	
		Neurological	75%	100%	100%	75%	100%	100%	
		Cardiovascular	75%	100%	100%	75%	100%	100%	
		Gynecological	0%	NA	NA	0%	100%	50%	
		Gastrointestinal	75%	50%	100%	50%	100%	100%	
		Endocrine	67%	50%	0%	67%	100%	100%	
		Integumentary/Dermatological	75%	100%	100%	75%	100%	100%	
		Psychiatric/Behavioral	75%	100%	100%	50%	100%	60%	
		Health Risk Assessment	0%	0%	0%	0%	33%	60%	
		Pain Assessment	67%	100%	NA	50%	100%	73%	
		Dates of falls	0%	NA	NA	0%	NA	0%	
		Injuries associated with falls	0%	NA	NA	0%	NA	0%	
		Date of injuries	0%	NA	NA	0%	NA	0%	

#	Provision	Assessment of Status							Compliance
		Description of type of injuries	0%	NA	NA	0%	NA	0%	
		Mobility	75%	100%	100%	75%	100%	100%	
		Sleep Patterns	50%	50%	0%	75%	100%	20%	
		Communication	75%	100%	100%	75%	67%	80%	
		Self-Care Activities	0%	0%	0%	50%	67%	20%	
		Medication Administration (including ability to Self-Administer Medication)	33%	100%	100%	50%	100%	100%	
		Individual needs	0%	0%	0%	0%	33%	40%	
		Each nursing problem/diagnosis was identified and the reason for the diagnosis	0%	50%	0%	0%	33%	40%	
		General approaches and interventions are summarized and incorporated into section XI Nursing Summary in the annual form.	0%	50%	0%	0%	33%	40%	
		Nursing Interventions are Problem focused	0%	0%	0%	0%	0%	0%	
		Nursing Interventions are individualized	0%	50%	0%	25%	33%	20%	
		Nursing Interventions are documented in the care plan	0%	50%	0%	25%	0%	0%	
		Date completed	50%	100%	100%	75%	67%	80%	
		Name of the RN completing	50%	100%	100%	75%	100%	80%	

#	Provision	Assessment of Status	Compliance

the assessment						
Comprehensive Nursing Review and Nursing Physical Assessment is saved in correct format in personal folder	[redacted]	100%	75%	67%	100%
Current Quarterlies 1, 2, 3 along with nursing physical assessment filed in individual's record		100%	0%	33%	100%
Current Quarterlies 1, 2, 3 along with nursing physical assessment correct format in personal folder		100%	50%	67%	100%

- A review of the Presentation Book for Section M.2 found that ABSSLC had developed a very promising training curriculum addressing Comprehensive Nursing Assessments. However, the information addressing the analysis of data needs to be significantly expanded and should include the analysis of the high and medium health/mental health 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.2. Since the self-assessment time period, the annual nursing assessment has been modified per state office requirements for standardization with all assessments. Due to the multiple changes in assessment forms utilized for annual nursing assessments and guidelines, confusion has led to the results of lack of progress in this provision."

The Facility's finding of noncompliance was consistent with the Monitoring Team's findings. However, the Monitoring Team's finding of noncompliance as noted below was based on specific findings related to problems regarding the quality of the content of the Annual and Quarterly Nursing Assessments Reviews. Such a review of the quality of the information included in the documentation was demonstrated in only a few items in the Self- Assessment for this section. In addition, the Facility did not identify the specific criteria used in determining compliance.

The Quarterly/Annual Nursing Reviews for 21 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #250, Individual #540, and Individual #27 for gastrointestinal issues; Individual #441, Individual #368, and

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		Individual #290 for constipation; Individual #247, Individual #3, and Individual #369 for weight issues; Individual #541, Individual #261, and Individual #463 for urinary tract infections; Individual #70, Individual #296, and Individual #417 for aspiration; Individual #366, Individual #538, and Individual #255 for skin integrity issues; and Individual #241, Individual #191, and Individual #333 for fractures. ▪ Of the 21 individuals' quarterly nursing 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 Quarterly/Annual Nursing reviews. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Annual/Quarterly Nursing Reviews reviewed. Although far from consistent, the Monitoring Team found that since the last review, there had been more attempts made regarding the use of data from the current quarter as compared to the previous quarter in the analysis of the high and medium health/mental health indicators. However, overall, none of the Annual/Quarterly Nursing Review summaries reviewed included an adequate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving, maintaining, or getting worse. In addition, due to the ongoing lack of implementation of the nursing protocols for existing conditions/diagnoses, appropriate clinical nursing assessments were not consistently being conducted for the individuals, and this resulted in an absence of objective clinical data generated to even allow analysis to occur. The Monitoring Team noted in the last report that there appeared to be an increase in understanding regarding the use of the nursing protocols in guiding nursing assessments and the associated nursing documentation. However, from interviews with Nursing Department staff and review of nursing documentation, the nursing assessments contained in the nursing protocols were only initiated after changes in status occurred and then discontinued, rather than conducted on a regular basis for existing health issues such as aspiration and constipation. Consequently, the data generated from the nursing assessments contained in the nursing protocols reflected only indicators of illness, not indicators of periods of stability. Thus, only using these data for analysis offers little in determining the individuals' healthy baselines compared to data during their changes in status. In addition, it did little to identify changes in status early, so that they could be addressed and/or reported to medical staff to potentially avoid acute periods of illness. The lack of consistent progress found regarding the quality of the Comprehensive Nursing Assessments continued to be very concerning due to the potential impact it had on the health and wellbeing of individuals residing at the Facility.	

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		As noted in several past reports, it is absolutely essential that the nurses responsible for completing the quarterly/annual Nursing Reviews and Physical Assessments have the ability and understanding to document, analyze, and summarize health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health/mental health status. Although the Facility has implemented some promising training curricula for nursing, clinically appropriate competency-based training and mentoring should be provided from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Regarding the nursing documentation for four discharges/individuals transitioning to the community, a review of the nursing notes and nursing discharge assessment summaries for four individuals including: Individual #483, Individual #165, Individual #381, and Individual #509 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 all (100%) 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. On a positive note, as noted above, the Facility had made solid progress regarding conducting a nursing assessment prior to the individuals' discharge from the Facility as found in the IPNs. Also, since the last review, the Facility had added more documents to the transitions packets such as the immunization records, the IHCPs, and any Acute Care Plans. However, the poor quality of the added nursing documentation did not add to the information the community provider needed. The problems found during previous reviews persisted regarding the nursing documentation, such as the Annual/Quarterly Nursing Reviews, the IHCPs, and the IRRFs, and Acute Care Plans, which was not specific and detailed enough to ensure appropriate clinical care upon transition. 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	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 of Acute Care Plans was conducted to determine if they were individualized to meet individuals' unique needs. The	Noncompliance

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	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.	following Facility data was presented in the Self-Assessment:	

Real-Time Infection Audits	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
Population	[redacted]	4	1	5	10	18
% of population selected for audit		100%	100%	60%	100%	100%
Sample size for PCM		4	1	3	10	18
Sample size for QA		4	1	3	10	16
Appropriately personalized the Care Plan specifically for the resident		25%	0%	0%	?	?
Care plan refers to the resident throughout		50%	0%	0%	13%	33%
Care plan includes a personalized goal to include the prevention of the spread of the illness		75%	0%	0%	0%	6%
Care plan includes the resident's behaviors, preferences, and functional abilities as they may relate to interventions or teaching		25%	0%	0%	0%	0%
Care plan includes specific details related to the resident's current acute infectious process (Example: specific signs and symptoms of the infection)		50%	0%	0%	63%	33%
Care plan included appropriate interventions to limit the spread of infection		50%	0%	0%	NA	NA

Although the data regarding the Care Plans addressing real time infections was important, it was unclear what the question marks represented in the data graph and why there were items scored "NA" regarding interventions addressing the spread of infection. In addition, no other information or data was presented regarding the status of the Facility's Integrated Health Care Plans that were also of significant importance since they address interventions addressing high and medium health issues. In addition, no data were provided addressing whether care plans

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		were in alignment with the nursing protocols for the specific health issues, which is crucial to the quality of care provided to the individuals. <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 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. Facility processes are constantly changing as results of facility self-assessments provide evidence of lack of progression." The records of 21 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #250, Individual #540, and Individual #27 for gastrointestinal issues; Individual #441, Individual #368, and Individual #290 for constipation; Individual #247, Individual #3, and Individual #369 for weight issues; Individual #541, Individual #261, and Individual #463 for urinary tract infections; Individual #70, Individual #296, and Individual #417 for aspiration; Individual #366, Individual #538, and Individual #255 for skin integrity issues; and Individual #241, Individual #191, and Individual #333 for fractures. Of the 21 individuals' Integrated Health Care Plans reviewed: ▪ All 21 (100%) were found to have a care plan addressing the high or medium risk health/mental indicators. ▪ None (0%) of the care plans contained nursing interventions that were to be regularly conducted addressing specific existing health issue in alignment with the nursing protocols. Nursing Protocols that were found in the IHCPs were only to be conducted in response to an acute event. ▪ None (0%) of the 21 care plans was found to be clinically adequate. 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. The overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. ▪ None (0%) of the 21 care plans contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 21 care plans were adequately individualized. ▪ Due to the nonspecific interventions contained in the 21 care plans reviewed 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 the Facility RN Case Manager Supervisor and the Risk Coordinator had implemented	

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		joint random reviews of IHCPs since the last review, and had recently established a Care Plan Review Workgroup that was to begin reviewing Acute Care Plans in June 2014, the results of these reviews had not yet impacted the quality of the documentation found in the IHCPs the Monitoring Team reviewed. Although there was an increase in the use of nursing protocols found in some of the IHCPs, the nursing assessments contained in the nursing protocols were only to be implemented after the individual demonstrated a change in status. As these processes continue, the Facility should ensure that any improvements discussed during the reviews are made to the IHCPs through the appropriate Facility avenues (i.e., ISPAs to integrate new interventions into existing ISPs). 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. ▪ Most of the goals listed in the IHCPs reviewed did not address the etiology of the health problem as an objective clinical area of focus to assist the team in developing 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, none of the nursing action steps found in the IHCPs reviewed were in alignment with the clinical assessments required by the nursing protocols for the specific existing health issues. ▪ The action steps contained in the IHCPs 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; consistent notation of 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 generic, not measurable, and non-specific to the individual's health care needs. ▪ At the time of the review, the IHCPs 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 contained in the IHCPs prohibited validation that the steps were actually being implemented. It was very troubling that nursing was still not implementing regular, proactive and individualized nursing assessments for individuals who had clear histories of repeated hospitalizations, Infirmary admissions, multiple orders for treatments addressing their chronic health issues, and whose teams had assigned high and medium health risk ratings indicating the need for interventions to attempt to prevent or minimize the occurrence of acute changes in status regarding existing health conditions. There is no clinical justification for nurses or IDTs to	

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		wait for an individual to experience a change in his/her status to implement proactive and individualized nursing assessments in alignment with nursing protocols, especially when the individual has known health conditions. Consequently, the increased reactive use of nursing protocols in the IHCPs yielded no increase in the clinical care provided to individuals with high and medium health risks. In fact, it only reinforced the inadequate reactive care that already existed at ABSSLC. From discussions with the CNE, a candid yet alarming barrier was raised regarding nursing protocols and the associated nursing assessments. The CNE indicated that there was a concern amongst nursing staff regarding their ability to consistently implement regular nursing assessments in alignment with the nursing protocols for individuals that warranted these assessments for existing health issues due to resources and staffing issues. Although the Monitoring Team appreciated the identification and acknowledgement of this issue, it urgently needs to be brought forward to Facility Administration and State Office for prompt discussion and reconciliation to ensure individuals are provided the clinical services that they require. Given the significant nursing resources currently available, discussions should include consideration of the realignment of responsibilities within the Nursing Department and/or for individuals with higher acuities, as identified through the at-risk system. Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated 39 individuals had 41 incidents of an acute infection (i.e., MRSA: Individual #199, Individual #122, and Individual #156; and Influenza: Individual #215, Individual #322, Individual #281, Individual #88, Individual #321, Individual #127, Individual #293, Individual #174, Individual #312, Individual #213, Individual #23, Individual #469, Individual #166, Individual #323, Individual #7, Individual #270, Individual #361, Individual #452, Individual #385, Individual #119, Individual #492, Individual #497, Individual #432, Individual #146, Individual #386, Individual #24, Individual #94, Individual #285, Individual #255, Individual #23, Individual #513, Individual #368, Individual #500, Individual #65, Individual #83, and Individual #110). ▪ Of the 41 incidents, 37 (90%) were found to have had Care Plans addressing the infectious issue. The individuals without a Care Plan addressing the infectious issue included: Individual #215, Individual #281, Individual #88, and Individual #285. ▪ Of the 37 Nursing Care Plans reviewed, none (0%) were found to be clinically adequate. Although the care plan template addressing Influenza A and B included clinically sound information, the care plans reviewed were generally not individualized, did not consistently include stopping the spread of the infection as a goal, and did not consistently include measurable interventions. In addition, some of the care plans had different individual names listed throughout the plan. On a positive note, improvement was found in the baseline assessment findings/data section of the plans. Considerably more work was needed to ensure that individuals with infectious diseases were	

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		being tracked, monitored, and provided care plans that included the appropriate infection control measures, and clinically appropriate interventions to prevent the spread of infections. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. 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.	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 to validate compliance with the Nursing Protocol Cards addressing abdominal distention, constipation, respiratory distress, seizures, and vomiting. However, the data contained in the Self-Assessment indicated that there were months during the review period (September 2013 through February 2014) when no auditing took place without explanation. Although the sample sizes were noted to be small (ranging from 5% to 6%), there was no information provided as to how samples were chosen. In addition, the procedure describing how the auditing was conducted regarding nursing protocols indicated that only the reactive implementation of nursing protocols were being monitored (only after an acute health event occurred) rather reviewing samples of individuals who were at high or medium risk for a specific existing health issue and auditing to ensure that nursing protocols were initiated to prevent the occurrence of the acute health event. As noted in previous reports, 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. <u>Self-rating</u>: Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance. The facility began a new process for creating population [sic] for auditing nursing protocols. The process was fully implemented March 1, 2014. Future data will reflect audits from random sample of new population process." From discussion with the CNE and Risk Coordinator during the review, the Facility had initiated a tracking system addressing when nursing protocols were initiated. Since no additional information was provided in the Facility's Self- Assessment regarding the "new process for creating population [sic] for auditing nursing protocols," the Monitoring Team was unclear if the recently developed nursing protocol tracking system was part of the new process noted in the	Noncompliance

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		Facility's Self-rating. Although the nursing protocol tracking system was a promising step in generating data regarding acute health events that had taken place, at the time of the review, the Facility continued to only implement nursing protocols reactively rather than in alignment with individuals' current and existing health needs. Regarding nursing documentation, although there continued to be more nursing entries found in the IPNs than during previous reviews, ongoing adequate clinical nursing assessments in alignment with the nursing protocols for the particular health issues the individuals were experiencing were not found in the documentation. Unfortunately, the additional documentation that was found did not actually result in an improvement in clinical care. Although the Monitoring Team found an increase in the use of nursing protocols in the IHCPs that were reviewed, the nursing assessments listed in the nursing protocols in the IHCPs were interventions that were to be implemented only after an acute health event had occurred rather than on a regular basis for individuals who had known high and medium health risks to attempt 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. Waiting for an individual to experience a change is their status in order to implement nursing assessments in alignment with nursing protocols, especially when the individual has repeated Infirmary admissions and hospitalizations related to existing health conditions and diagnoses defies sound clinical logic and practice. Consequently, the increased use of reactive nursing protocols found in the IHCPs did not result in an improvement in clinical care. In addition, these major concerns, especially those related to individuals with high/medium risk health indicators and their changes in status warranting hospital admissions, were exemplified in a review of nine individuals who had been hospitalized since the last review: Individual #2, Individual #452, Individual #394, Individual #385, Individual #281, Individual #162, Individual #9, Individual #285, and Individual #126. Specific details are provided with regard to Section M.1. In summary, a review of these individuals' records indicated the following: ▪ There was no indication that nursing was actually using nursing protocols as part of a structured system to guide nursing practice and the associated documentation; ▪ Clinically appropriate nursing assessments were not conducted for significant existing health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data had not been established to quickly recognize changes in health status; ▪ Timely communication had not occurred with practitioners/physicians or other disciplines regarding changes in status; and ▪ Appropriate and clinically adequate care plans had not been developed and implemented that outlined specific nursing interventions for specific health issues.	

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		As noted with regard to Section M.3, discussions with Nursing Leadership while on site regarding the continued lack of regular nursing assessments in alignment with nursing protocols illuminated a perceived barrier. As described, the perceived barrier was not having the resources as a result of staffing issues to actually consistently implement regular nursing assessments in alignment with the nursing protocols for individuals warranting such assessments. Given the numbers of nursing positions, such a barrier should not exist. However, the root of the problem might be the allocation of those positions, job duties assigned, and/or accountability issues. Although these concerns were clearly articulated during this review, they might be relevant within other SSLC Nursing Departments and should be openly discussed with Facility Administration and the appropriate State Office staff for prompt remediation to ensure individuals are provided the clinical services that they require. When evaluating where clinical resources and staff should be deployed to meet the individuals' clinical needs, the Facility is encouraged to utilize its At Risk List and data in determining acuity levels for individuals in order to determine the clinical intensity regarding the types and frequency of nursing assessments each individual warrants. The problematic findings found in the nursing documentation reviewed for Section M.1 regarding nursing care for individuals admitted to a community hospital, Section M.2 regarding the nursing assessments, Section M.3 regarding nursing care plans, and Section M.5 related to individuals with high-risk health indicators demonstrated that the Facility clearly was not implementing nursing protocols sufficiently to address the health status of the individuals served as required by this provision of the Settlement Agreement. Consistent with past reviews, the problematic findings from this review indicated that ABSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility indicated that it was not in substantial compliance with this requirement, which was consistent with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health	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 since the last review, the Facility had operationalized the At-Risk policy, which the Facility's Policy Committee had approved. In addition, the Facility had reviewed and defined the Change of Status process and integrated this information into the Facility's Risk Policy. Also, a Lead QIDP Facilitator was identified to coordinate and facilitate training and mentoring of the QIDP Facilitators. In addition, since the last review, in January 2014, the Facility began observations of the ISPs and reviewing the IRRFs and IHCPs. In the next six months, the Facility planned to begin to review the data collected and implement follow up interventions in response to these findings.	Noncompliance

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	status of the individual.	<u>Self-rating</u> The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance. The facility is in the process of officially implementing the Operationalized At Risk Policy due to results of self-assessment that demonstrate IDT members lack of understanding of the procedure of the risk process. Facility processes are constantly changing as results of facility self-assessments provide evidence of lack of progression." Consistent with past reviews, the findings from the Monitoring Team detailed below indicated the documentation reviewed did not adequately address individuals' health/mental clinical health risks in alignment with the requirements of this provision. A review of records for 21 individuals determined to be at risk (i.e., Individual #250, Individual #540, and Individual #27 for gastrointestinal issues; Individual #441, Individual #368, and Individual #290 for constipation; Individual #247, Individual #3, and Individual #369 for weight issues; Individual #541, Individual #261, and Individual #463 for urinary tract infections; Individual #70, Individual #296, and Individual #417 for aspiration; Individual #366, Individual #538, and Individual #255 for skin integrity issues; and Individual #241, Individual #191, and Individual #333 for fractures) found that none (0%) included adequate nursing risk assessments including individual-specific information to clearly justify the risk ratings assigned. However, from a review of these nursing assessments, it was clear the Facility was in the process of improving the documentation contained in the Comprehensive and Quarterly Nursing Reviews. Although not consistently found in many of the assessments the Monitoring Team reviewed, improvements included using some of the past quarterly or annual information and providing an update regarding the current status of the health risk indicators. However, considerable more work was needed regarding the analysis of the information. In addition, regarding the Integrated Risk Rating forms, a review of these 21 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. Although the Monitoring Team found that there continued to be 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 from the previous year that made it difficult to determine the accuracy of the risk rating that was assigned. In addition, a review of the 21 records for these individuals determined to be at risk found there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). Although all 21 individuals (100%) were found to have a care plan addressing their high or medium	

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		health/mental risk indicator, none sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 21 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some IHCPs addressing, for example, the need to encourage adequate fluids, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the IHCP into the ISPs in 21 of the 21 cases (100%). ▪ None (0%) of the plans reviewed showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) consistently included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability, or it was not addressed. ABSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate IHCPs. The nursing protocols that were found in the IHCPs were noted to be implemented only in the event of an acute issue related to the high/medium health risk indictor. It was very troubling at this juncture of the compliance review process no nursing protocols were included in the IHCPs reviewed that designated nursing to conduct regular nursing assessments for high and medium health risks that the individuals were already experiencing which warranted the elevated risk rating from the IDTs. 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.	

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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.	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 data contained in the Facility's Self-Assessment indicated that the total number of medication variances from September 2013 through February 2014 was 389, 334, 249, 309, 265, and 155 respectively. In addition, the compliance data presented regarding Medication Administration Observations for the same time frame included 95%, 92%, 89%, 93%, 93%, and 91% respectively. However, based on the Monitoring Team's observation of the Medication Variance Committee meeting on 5/14/14, discrepancies were noted between the data presented at the meeting and the data contained in the Self-Assessment for Section M.6. Regarding the total number of medication variances for January 2014, the data from the committee meeting indicated there were 259. In addition, the overall compliance percentages for the Medication Administration Observations for January and February 2014 were reported in the committee meeting as 88% and 74%, respectively. Although the Facility's data indicated an overall decrease in medication variances, no additional information was provided in the Self-Assessment addressing what actions might have contributed to the decreasing trend reported. Additional information should have been provided in order for the Monitoring Team to fully understand and, most importantly, for the Facility to have a clear record of what actions had been implemented, the resulting outcomes, and the plan for future actions addressing this requirement of the Settlement Agreement. Should trends begin to increase again in the future, such a record would be important to provide the Facility with information about what had worked, and what had not worked. ▪ In addition, no additional information was provided regarding the Medication Administration Observation data such as how many observations were completed each month and what the specific findings were for each item on the observation tool. This would be important in order for Facility staff to be able to determine areas of strength and weakness, and the progress of these areas over the course of the review period. ▪ As noted in the previous report, the Facility continued to have some limitations regarding aggregating and trending some data addressing medication variances. These limitations were stemmed from the Avatar Electronic Medical Record System. <u>Self-rating</u>: 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." From discussions with the Facility staff while on site, since the last review, the Facility had implemented a number of actions addressing this area. In addition to the information that was provided in the Facility's Self-Assessment, interviews with the CNE and the Clinical Pharmacist	Noncompliance

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		indicated that since the last review, the Facility had initiated the following steps regarding the Facility's overall medication administration system: ▪ On a positive note, since the last review, the Nurse Managers had begun collecting and reporting medication variances by unit during the monthly Medication Variance Committee meetings. This had enabled the Facility to promptly trend errors and implement interventions. The minutes of the Medication Variance Committee, dated 3/26/14, included good information regarding medication variances that Case Managers reviewed and presented by building. ▪ The Facility had implemented reporting the unknown medication returns to the pharmacy during the morning meetings in order to alert the physicians to potential clinical issues. ▪ Pharmacy and Nursing had jointly developed a written process and guidelines regarding conducting medication room audits. ▪ Since the last review, both Technicians and Pharmacists now counted for the auto-fill process to ensure accuracy of the medication count at the Pharmacy level. ▪ All individuals' drug allergies had been verified to ensure the accuracy of the information in the Active Records. ▪ The Facility had developed an Access database for medication variances for nurses and pharmacists in order to easily identify trends. ▪ The Facility continued to include excesses and shortages of medications, medical, pharmacy, and dental errors in the medication variance data. ▪ The auditing data from the Medication Administration Observations continued to be discussed and integrated into the minutes of the Medication Variance Committee meetings. 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: ▪ As noted in previous reports, the Facility's data continued to indicate a high percentage of compliance regarding the Medication Administration Observations conducted. However given that the Facility's data indicating a number of unexplained and omitted medications were being returned to the pharmacy and a decrease in Medication Administration Record blanks (i.e., it appeared from the MARs that medications were being administered as prescribed, but unexplained returns were still occurring), the high compliance scores regarding the Medication Administration Observation data continued to be suspect. However, there was no indication at the time of the review that the Nursing Department was analyzing these obvious discrepancies between data and practice, or reviewing how the medication observations were being conducted in order to better identify how such omissions occurred. ▪ Although at the time of the review, data regarding unreconciled medication variances	

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		was being discussed in the medical morning meeting in relation to individuals' health status, the outcomes of any follow-up actions taken were not found consistently documented in the minutes provided. Closing the loop regarding all the outcomes from the follow-up regarding possible medication omissions and clinical issues should be consistently documented in the minutes of the morning medical meetings. ▪ From review of the Medication Variance Committee Meeting minutes, there continued to be problematic issues regarding having two nurses verify the medication count sheets to ensure the accuracy of the count. ▪ Although the Facility initiated the promising process of having the Nurse Managers collect and report on the medication variances by unit during the monthly Medication Variance Committee meetings, the process was noted to be very time-consuming, it conflicted with other managerial duties, and it was difficult to research since medication variance reports were not always completed the date discovered on auto-fill days. At the time of the review, it was unclear to the Monitoring Team what actions the Facility planned to put in place in order to maintain this new procedure. ▪ Also, since the last review, the Facility had implemented a system of "bagging" medications by individual by shift in all buildings in order to timely identify excess or shortages of medications. Although the Facility indicated that since this process was initiated, the data demonstrated that the number of excess/short medications had decreased, this Facility-wide process was very time-consuming and had been viewed as a short-term solution. Although the Facility's data from January 2013 through February 2014 indicated a significant (69%) overall decrease in the number of medication variances, it was unclear how the Facility would be able to maintain the current labor-intensive yet effective procedure. At the time of the review, there was no indication that the Facility had an alternative plan in place in the event the current procedure was not sustainable. ▪ Although the Facility's data indicated there had been a significant decrease in the overall number of medication variances since January 2013, it was unclear to the Monitoring Team if the medication variances had been "counted" in the same manner from January 2013 to the current time. Throughout the review process, changes had been made regarding how medication variances were tallied. For example, some Facilities counted each pill when aggregating medication variance data, while others counted the total dosage as one medication variance. Thus, through procedural changes, the actual number of medication variances could have increased or decreased depending on how the data was aggregated. It is recommended that the Facility clearly identify such changes when presenting it longitudinal medication variance data to ensure its accurate interpretation. ▪ Although the Facility began entering data regarding medication variances into the Avatar system since August 2013, there continued to be limitations regarding accessing and extracting certain queries from this database in order to analyze these data to identify	

#	Provision	Assessment of Status	Compliance
		trends. To the Facility's credit, in an attempt to not lose pertinent medication variance data, the Facility had been maintaining an additional Excel database so they could access and aggregate the needed data to accurately identify trends and outcomes. During the past two reviews, this issue was discussed at the Medication Variance Committee meetings the Monitoring Team observed while on site. Hopefully, the problematic issues involving Avatar can be ameliorated through joint collaboration between Facility staff and State Office staff. ▪ Although the Facility had made considerable progress regarding implementing processes directed at reconciling excesses and shortages of medications, the number of medication variances involving the wrong patient, the wrong time, the wrong dose, wrong medication, and the wrong route suggested that the Facility continued to have a significant problem regarding the under-reporting of medication variances, which was also noted in the Facility in the Medication Variance Committee minutes, dated 11/6/13. In addition, as noted during previous reviews, the Clinical Pharmacist candidly reported that issues continued regarding the reliability of the Facility's medication variance data, which the Facility was continuing to identify and work on at the time of the review. ▪ As noted in previous reports, although the Facility had implemented strategies, such as converting many of the stock medications to unit doses to be able to better track if medications were given as ordered, it continued to be very concerning that the underlying problem associated with the number of excess medications reflected that nursing was not administering medications appropriately as required. This issue was illustrated in the minutes of the Medication Variance Committee meeting, dated 1/22/14. The minutes noted that since Medicare Part D did not reimburse the cost of unit dosages of Carafate suspension (a medication used to treat conditions such as Gastroesophageal Reflux Disease and Peptic Ulcer Disease), the medication would have to be dispensed from stock bottles. The concern noted in the meeting minutes was that the use of stock bottles would render it impossible to determine if individuals were receiving their full doses of the medication. Thus, the minutes indicated that discussions would be initiated with the Medical Director regarding the use of Carafate dissolvable tablets, mainly to allow tracking of whether nursing staff had administered the medication as ordered. A review of the medication variances (Category A-E) reported by the Facility indicated the following: ▪ October 2013 – 334 variances, (including 188 unreconciled); ▪ November 2013 – 249 variances, (including 108 unreconciled); ▪ December 2013 – 309 variances, (including 128 unreconciled); ▪ January 2014 – 265 variances, (including 92 unreconciled); and ▪ February 2014 – 155 variances, (including 80 unreconciled). Regarding medication administration observations, due to the active outbreak of Influenza at	

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		ABSSLC during the week of the review, the Monitoring Team could not conduct observations of medication administration. Since the last review, the Facility clearly had made positive forward movement regarding analyzing, reviewing, and implementing very promising steps in efforts to strengthen the systems and practices addressing medication administration. However, the Monitoring Team's findings indicated that problematic issues continued to be noted regarding the medication administration systems at ABSSLC. 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 develop and implement strategies to increase the reliability of the medication variance data. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a format and structure to continue 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. This 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 Monitoring Team's last 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 Any follow–up studies completed for any prior Drug Utilization Evaluation (DUE) reports; o Minutes of Pharmacy and Therapeutics Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o For Quarterly Drug Regimen Reviews (QDDR) one 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 #17, Individual #327, Individual #83, Individual #232, Individual #305, Individual #215, Individual #205, Individual #354, Individual #222, Individual #196, Individual #538, Individual #297, Individual #335, Individual #359, Individual #423, Individual #74, Individual #52, Individual #139, Individual #184, Individual #115, and Individual #181; o For five most recent QDRRs in which recommendations were made and accepted, copies of physician orders for: Individual #184, Individual #431, Individual #308, Individual #307, and Individual #405. For two 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 #266 and Individual #199; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team's visit; o Since the last review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o 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 (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 (i.e., 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 QDDR are conducted by residence/unit; o Any trend analysis of chemical restraint use (i.e., 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 five new 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 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 five individuals: Individual #514, Individual #156, Individual #74, Individual #365, and Individual #196; o For five new 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 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 #544, Individual #23, Individual #30, Individual #63, and Individual #315; o For three new 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 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 #144, Individual #156, and Individual #71;

	○ 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 #226, Individual #147, Individual #538, Individual #307, and Individual #541; ○ 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 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 #285, Individual #373, Individual #159 1/24/14, Individual #332, and Individual #159 3/8/14; ○ For the self-assessment process: list of monitoring/audit tools used and 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; ○ 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; and ○ Presentation Book for Section N. ▪ **Interviews with**: ○ Bonnie Burroughs, RPh, PharmD, Chief Pharmacist; and ○ Marla Knight, RPh, PharmD, Clinical Pharmacist. ▪ **Observations of**: ○ Pharmacy and Therapeutics Committee Meeting, on 5/14/14; and ○ Medication Variance Committee meeting, on 5/14/14.
	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: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: Lab order monitoring, intervention logs from the WORx reports, QDRR monitoring tool, and new order audit tracking tool.

	○ These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. ○ The monitoring tools included adequate methodologies, such as review of Pharmacy Department records. ○ 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). These sample sizes were adequate to consider them representative samples. ○ The following staff/positions were responsible for completing the audit tools: pharmacists. ○ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. Not all audit tools appeared to have inter-rater reliability data. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement are 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: ○ Provided graphs with accurate trend information over months to years. ○ Presented findings consistently based on specific, measurable indicators. ○ Consistently measured the quality as well as presence of items. ○ Distinguished data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following subsections 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 data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example the need for additional system action plans to reduce medication variances.
	Summary of Monitor's Assessment: The Pharmacy resolved an important issue related to medication prescribing and dispensing, specifically the consistent documentation of allergies across various reports and forms. This will increase the safety of medications being prescribed. This area was added to the Quarterly Drug Regimen Reviews as an ongoing clinical indicator. The QDRRs remained an important periodic review that continued to guide the PCPs. QDRRs remained timely. Adverse drug effect training was well documented, both as part of new employee training and as refresher courses for clinical staff. The new order process documentation appeared to need further review. The patient intervention reports were not always sufficiently complete. The accuracy of the Pharmacy's review of new orders in relation to review of significant laboratory findings or follow-up with lab findings needed further focus, as well as demonstration of the related impact on prescriber practice. The Monitoring Team's findings did not agree with the Pharmacy Department self-assessment of the same submitted information. Medical variances continued to occur and the Pharmacy will need to be aggressive in developing system

	approaches to ensure the Medical and Nursing Departments reduce medication variances. In addition, there should be continued focus on medication variances internal to the Pharmacy Department.

<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: Pharmacy Director, one Clinical Pharmacist, two Pharmacists, and four Pharmacy Technicians.

New pharmacy policies included: "Guidelines for Potassium chloride infusion," (undated), and "Controlled Substance Wastage Procedure," (3/17/14).

"Patient intervention" entries for new orders entered into the WORx software program were submitted for review. A two-month sample (February 22, 2014 to April 22, 2014) of activity was submitted. The following lists the number of patient intervention entries generated per month, along with whether the order was included in the patient intervention report to determine whether minimum information required for interpretation of the intervention report was included:

<table>
<tr><th>Month</th><th># Interventions by Pharmacy Staff</th><th># Orders with Complete Information: Name of Drug/Strength/Dosage/ Frequency</th><th># Interventions with Incomplete Information</th></tr>
<tr><td>February 2014</td><td>6</td><td>6</td><td>0</td></tr>
<tr><td>March 2014</td><td>47</td><td>39</td><td>8</td></tr>
<tr><td>April 2014</td><td>36</td><td>34</td><td>2</td></tr>
</table>

Interventions were broken down into several different categories. The categories and numbers of patient interventions for each category follows:

<table>
<tr><th>Category of Intervention</th><th>February 2014</th><th>March 2014</th><th>April 2014</th></tr>
<tr><td>Renally excreted drug monitoring</td><td>0</td><td>4</td><td>1</td></tr>
<tr><td>Patient care</td><td>4</td><td>5</td><td>4</td></tr>
<tr><td>Interaction/ compatibility intervention</td><td>1</td><td>24</td><td>28</td></tr>
<tr><td>Order clarification/confirmation</td><td>0</td><td>10</td><td>2</td></tr>
<tr><td>Therapeutic consultation</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>Allergy/disease state contraindication</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Adverse drug reaction</td><td>0</td><td>2</td><td>0</td></tr>
<tr><td>Total per month</td><td>6</td><td>47</td><td>36</td></tr>
</table>

A sample of 23 new prescriptions was reviewed. The following summarize the results:</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		▪ Five new orders were submitted in which the Pharmacy found concerns with **drug-drug interactions** with the current drug regimen. A copy of the order was submitted in five of five. A computer screen shot of the order process, label, or MAR was submitted for four of five. In one order, the order was subsequently discontinued and there was no label or MAR. Evidence for correct entry of the order was documented on the patient intervention form. For five of five, a copy of the patient intervention form was submitted. A change in the order occurred in four of five orders. Additional testing was ordered for two orders. Evidence indicated compliance in five of five new orders. ▪ Five new orders were submitted in which **allergies** were reviewed and determined by Pharmacy as a concern. A copy of the order was submitted in five of five. A computer screen shot of the order process, label, or MAR was submitted for five of five. For five of five, a copy of the patient intervention form was submitted. A change in the order occurred in three orders and evidence indicated compliance in five of five orders. ▪ Five new orders were submitted in which **significant side effects** were reviewed by Pharmacy and determined to be a concern. A copy of the order was submitted in five of five. A computer screen shot of the order process, label, or MAR was submitted for five of five. For five of five, a copy of the patient intervention form was submitted. A change in the order occurred in three orders and evidence indicated compliance in five of five orders. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by Pharmacy during initial review. A copy of the order was submitted in four of five. A patient intervention form did provide the order details for the medication that had no copy of the order. A computer screen shot of the order process, label, or MAR was submitted for four of five new orders. For one new order, there was no computer screen shot, label or MAR, and the patient intervention form did not provide a dosage regimen. It could not be determined if the order was processed correctly. In a different individual with a new order of 2/11/14, the label was placed on the order sheet and covered prior orders dated 2/3/14 and 2/4/14. The reason for placing a label unrelated to underlying orders was not determined. For five of five, a copy of the patient intervention form was submitted. However, for a new order in a different individual, the patient intervention form documented the wrong drug regimen. The screenshot documented the correct regimen. New lab was ordered for three of five. Based on these discrepancies and irregularities, evidence indicated compliance in two of five orders. ▪ Three new orders were submitted in which Pharmacy had concerns about the potential need for **dosage adjustments**. A copy of the order was submitted in three of three. A computer screen shot of the order process, label, or MAR was	

#	Provision	Assessment of Status	Compliance
		submitted for three of three. For three of three, a copy of the patient intervention form was submitted. A change in the order occurred in one order Evidence indicated compliance in three of three orders. In summary, there was adequate documentation of the new order process in 22 of 25 (88%) submitted new orders. The Pharmacy Department completed an internal QA review of the new order process. Copies of 20 new orders from the prior month were randomly chosen for review. Two pharmacists each reviewed 10 of these new orders. Clinical indicators indicated whether the order entry included the correct patient, correct drug, correct label: dosage or frequency, correct start and stop dates, indications of medication, correct PCP, and correct route of administration. A third pharmacist reviewed half the new orders already reviewed by each of the original two pharmacists. Compliance was 100 percent except for the category of whether the indication for the order was listed. In this category, the score was 95 percent. The Facility maintained its finding of substantial compliance. However, the new order process documentation appeared to need further review. Specifically, the accuracy of the Pharmacy's review of new orders in relation to review of significant laboratory findings or follow-up with lab findings needed further focus, as well as demonstration of the related impact on prescriber practice. In order to maintain substantial compliance for the next review, it will be important for the Facility to correct issues impacting these deficiencies.	
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.	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
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	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 indicated there had been no emergency chemical restraint use in the past six months. The last emergency chemical restraints occurred in October 2013, shortly after	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	the Monitoring Team's last review. A graph was submitted for "Emergency Chemical Restraints October 2012 – March 2014." This indicated a trend line, which had been continuously downward since October 2012, representing the decreased use of emergency chemical restraints. The "Audit Report: Crisis Intervention Restraint Entries" showed different types of restraint were entered into AVATAR for each month. For instance, in March 2014, the form indicated that 16 physical restraints and two mechanical restraints occurred during this time period, but no chemical restraint. These monthly reports were submitted from October 2013 through March 2014. The Clinical Pharmacist reviewed these reports monthly to ensure emergency chemical restraint use was not missed through other communication channels. <u>Polypharmacy</u> Of the 21 QDRRs reviewed, polypharmacy was noted in 10 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 10 of 10 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in 10 of 10 (100%). Examples included date of meeting and name of meeting. ▪ Potential interactions with other drugs or food/side effect risk was reviewed in 10 of 10 (100%) ▪ For 10 of 10 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred and the effectiveness and appropriateness of the drug regimen. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in five of the 21 QDRRs. ▪ Of these, five (100%)documented justification with appropriate diagnoses; and ▪ Five of five (100%) QDRRs indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 21 QDRRs, 21 (100%) were screened for medications associated with potential significant anticholinergic side effects. Thirteen QDRRs identified anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ Thirteen of 13 (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect (i.e., the clinical burden of the side effects was less than the benefit). ▪ 13 of 13 (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 21 reviewed, five QDRRs listed atypical antipsychotic medication. Of these, five (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate).	

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		The Pharmacy Department had an internal, quality assurance monitoring tool in place for reviewing the content of the QDRR. Ten reviews were randomly selected each month from reviews completed the prior month. Two QDRRs were reviewed from each of five residences. Areas of the QDRRs that were audited included labs (i.e., significantly abnormal lab values were noted and addressed), benzodiazepine use (i.e., justification of use, effectiveness, side effects/drug interactions reviewed), anticholinergics (i.e., total anticholinergic burden documented, justification for use, effectiveness, side effects/drug interactions), polypharmacy (i.e., identified when present, justification of use, effectiveness, side effects/drug interactions), and metabolic risk reviewed for those on atypical antipsychotics (i.e., weight, BMI abdominal girth, blood glucose, and lipids). Inter-rater reliability was established by a sample of five of the 10 QDRRs also reviewed, each by a second pharmacist and the QA Department. Results from October 1, 2013 through March 31, 2014 indicated 100 percent compliance in each area reviewed (i.e., labs, benzodiazepine use, anticholinergic use, polypharmacy, and metabolic risk).	
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 21 QDRRs showed the following: ▪ Of the 21, 21 (100%) QDRRs had the PCP signature. ▪ Of the 21, 21 (100%) had the date the PCP reviewed the document. ▪ There were seven recommendations from the 21 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 21 of 21 (100%). o Agreement was documented in 21 of 21. o There was disagreement by the PCP for zero QDRRs. o The PCP responded within 14 days of the QDRR being completed by Pharmacy in 21 of 21 (100%) QDRRs. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication or psychotropics were prescribed. A psychiatrist reviewed 14 of 21 QDRRs. o Agreement was documented in 14 of 14. o The psychiatrist responded within 14 days of the QDRR being completed by Pharmacy in 14 of 14 (100%) QDRRs. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted five active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of five, five (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility submitted two active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. In two of two cases (100%), the response, rationale, and plan were written on the QDRR. The	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Pharmacy could not locate any other QDRRs in the prior six months in which there was disagreement with the PCP or psychiatrist concerning Pharmacy recommendations.	
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.	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 DISCUS and the monitoring of more general systemic side effects related to psychotropic medication with the MOSES, 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 physician. The review of the sample of the records for 23 individuals prescribed psychotropic medication showed that the MOSES evaluation was current (i.e., completed within the last six months) and had been performed at least every six months for the prior year for 21 of the 23 (91%) individuals. The documentation for Individual #278 indicated that the most recent MOSES in the record was dated 9/11/13. The information for Individual #478 indicated a gap of greater than six months between 2/5/13 and 10/8/13. The records of 20 of the 23 (87%) individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner, which had been defined as 14 calendar days. The individuals whose MOSES documentation was not reviewed in a timely manner (i.e., latency between dates) were those of the following individuals: Individual #320 (11/7/13 to 1/21/14), Individual #168 (11/15/13 to 12/3/13), and Individual #518 (11/1/13 to 1/14/14). 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 23 individuals indicated that the Facility carried out quarterly evaluations with the DISCUS, 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. Within this sample of 23 individuals, 10 individuals were not prescribed antipsychotic medication. Thus, the parameters related to the administration of the DISCUS were only evaluated for the 13 individuals who were prescribed an antipsychotic agent. The DISCUS had been performed quarterly for seven of the 13 (54%) individuals who	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		were prescribed antipsychotic medication in this sample. The exceptions were Individual #46 (for whom there was a gap between 8/30/13 and 12/20/13), Individual #4 (only one DISCUS in the record, dated 7/7/13), Individual #481 (7/11/13 to 1/10/14), Individual #324 (10/9/13 to 2/12/14), Individual #242 (10/25/13 to 3/5/14), and Individual #61 (10/10/13 to 2/20/14). 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. This review found that for these 13 individuals, the DISCUS had been reviewed in a timely manner for 10 of the 13 (77%) individuals. Those for whom there was a delay were: Individual #518 (11/1/13 to 1/14/14), Individual #320 (11/7/13 to 1/24/14), and Individual #421 (1/10/14 to 2/10/14). 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 five 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 and eight at the time of the November 2013 review. The following sample included all five (100%) individuals who fit the above criteria, including: Individual #19, Individual #21, Individual #226, Individual #385, and Individual #261. Review of the records of these five individuals related to the MOSES indicated that the examination had been performed at least every six months for all (100%) of the individuals. The evaluations also were reviewed with regard to the elapsed time between when the nurse completed the evaluation and the PCP reviewed. This analysis indicated the review by the prescriber had been completed in a timely manner for none (0%) of the five individuals. The individuals for whom there was a delay of greater than 14 calendar days between the completion of the evaluation and the review by the Provider were as follows (interval between exam and review): Individual #19 (3/6/14 to 4/1/14, and 12/16/13 to 1/7/14), Individual #21 (11/12/13 to 1/7/14), Individual #385 (11/6/13 to 1/10/14), Individual #26 (12/2/13 to 1/3/14), and Individual #226 (4/3/14 to 4/24/14). With regard to the completion of the DISCUS for the individuals in the sample, these evaluations were completed as specified for three of the five (60%) individuals. The two	

#	Provision	Assessment of Status	Compliance
		individuals for whom there were deficits were: Individual #261 (there was only one evaluation in the record, dated 12/2/13), and Individual #226 (there was a gap greater than three months between the 10/30/13 and 4/3/14 exams). Once completed, the prescribing physician had reviewed the DISCUS evaluations in a timely manner for none of the five (0%) individuals in the sample. The individuals for whom there was a gap of greater than 14 days between the evaluation and the review by the prescriber were (interval between exam and review): Individual #19 (3/6/14 to 4/1/14, and 12/16/13 to 1/7/14), Individual #21 (11/12/13 to 1/22/14), Individual #385 (2/10/14 to 3/27/14), Individual #261 (12/2/13 to 1/21/14), and Individual #226 (4/3/14 to 4/24/14). During the Monitoring Team's current onsite review, a request was made for the documentation related to the training provided to the nurses regarding the administration of the DISCUS. 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 12/13/13 and 12/20/13, for the PCPs on 12/20/13, and for the Psychiatric Providers on 12/18/13. The Monitoring Team's prior review found that 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, and ABSSLC was found to be in substantial compliance with this provision at the time of the prior two reviews. However, following the Monitoring Team's 11/13 review, the Facility transitioned to electronic medical records for the MOSES and DISCUS. Difficulties in the implementation of this system in the electronic filing of both the MOSES and DISCUS evaluations contributed to the significant deficits in the completion of these evaluations, as well as the timely review by the prescriber. The data that illustrates the impact of this change to electronic records was reviewed in the self-assessment prepared by the Clinical Pharm.D. for Section N.5 and is reproduced below: 1. *For the 6 month [sic] time period: 100% of MOSES assessments were timely, 61% of DISCUS assessments were timely, and 72% of MOSES and DISCUS assessments were reviewed in a timely manner by the Prescriber. The most current data (January 2014 through March 2014) is reflective of notable improvement after implementing a new process which required campus-wide training:* *October 2013: MOSES 100% DISCUS 67% Timely review 100%* *November 2013: MOSES 100% DISCUS 67% Timely*	

#	Provision	Assessment of Status	Compliance
		review 67% *December 2013: MOSES 100% DISCUS 38% Timely review 67%* *January 2014: MOSES 100% DISCUS 67% Timely review 33%* *February 2014: MOSES 100% DISCUS 67% Timely review 67%* *March 2014: MOSES 100% DISCUS 67% Timely review 72%* During the onsite review, the Clinical Pharm.D. presented data derived from her recent Quarterly Drug Reviews, for 4/1/14 to 5/14/14. A total of 86 individuals (of the 204 reviews) required MOSES evaluations every six months, DISCUS evaluations every three months, and timely review by the Prescriber within 14 days of completion of the evaluations. The results indicated that 70 individuals (81%) were in compliance for one or more parameters. This data substantiates both the deficits that followed the transition to electronic medical records and the subsequent adaptation to the new system. However, as with the current review, the deficits were primarily related to the completion and review of the DISCUS evaluations. The review of the 23 records contained in the current sample described above, indicated that the MOSES was competed as scheduled for 21 of the 23 individuals (91%); the corresponding rate for timely review by the prescriber was 20 of 23 individuals (87%). Only 13 of the individuals in the sample were receiving an antipsychotic agent, and seven of these 13 individuals (54%) had been evaluated with the DISCUS every three months. The corresponding analysis regarding the timely review by the prescriber indicated that for 10 of the 13 individuals (77%), the review by the prescriber had occurred within the allotted time. For those five individuals who were prescribed Reglan and were not also receiving a psychotropic medication, the MOSES had been completed as scheduled for all five (100%), but the timely review by the prescriber was deficient for all of them. The corresponding completion rate for the DISCUS was three of the five (60%), but all of these had deficits regarding the timely review. The visual inspection of raw data indicated that many of the deficiencies occurred during the time period that corresponded to the aforementioned problematic implementation of the electronic medical record system. The corresponding data collected by the Pharm.D. also documented a decline in completion rates following the implementation of the new system, followed by a return to the historically high rates of completion. The Settlement Agreement recognizes that compliance can be continued for provisions that have been in	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>compliance for repeated reviews, and then develop deficiencies related to a one-time event. Both the historical and current data indicate that the Facility had developed successful strategies for ensuring that these evaluations were completed and reviewed in a timely manner. This system was adversely impacted by the problematic implementation of the electronic medical record for the MOSES and DISCUS, but the Facility had now adapted to that system and appeared to be returning to their historic high levels of compliance. Accordingly, the finding of substantial compliance was carried forward for this review. In order to maintain substantial compliance for the next review, the Facility will need to demonstrate that the problems are fully resolved.</td><td></td></tr>
<tr><td>N6</td><td>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.</td><td>The Facility continued to train new employees on the curriculum for “Observing and Reporting Clinical Indicators of Health Status.” This curriculum included information concerning drug reaction signs and symptoms. The submitted information included training rosters. A document dated 4/4/14 entitled: “Course Delinquency List - Observing and Reporting Clinical Indicators of Health Status” indicated that 774 employees had completed the course and there were no employees delinquent in training (100% attendance).

According to the “Active Employee Course Participation Report 10/1/13 - 3/31/14” for the Course: “Observing and Reporting Clinical Indicators of Health Status,” 168 of 168 (100%) new direct support professional employees completed ADR training.

Evidence was submitted indicating training for the following new nursing staff had occurred on the subject of adverse drug reactions (document entitled “Adverse Drug Reaction”):

<table>
<tr><th>Month</th><th># Nurses Trained</th><th>Month</th><th># Nurses Trained</th></tr>
<tr><td>October 2013</td><td>12</td><td>January 2014</td><td>2</td></tr>
<tr><td>November 2013</td><td>4</td><td>February 2014</td><td>8</td></tr>
<tr><td>December 2013</td><td>5</td><td>March 2014</td><td>7</td></tr>
</table>
The nurse educators provided this training to a total of 38 nurses.

Separately, the Pharmacy Department provided in-service training information for annual refresher training of clinical staff that were not new employees:

<table>
<tr><th>Department</th><th># Staff Trained</th><th>Month Trained</th><th>Department</th><th># Staff Trained</th><th>Month Trained</th></tr>
<tr><td>Pharmacy</td><td>7</td><td>March 2014</td><td>Dental</td><td>6</td><td>March 2014</td></tr>
<tr><td>Psychiatry</td><td>6</td><td>March 2014</td><td>Medical</td><td>7</td><td>July 2013</td></tr>
</table>
Total clinical staff completing the annual refresher training by pharmacy was 26.</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Nurses separately completed a refresher course at the time of their annual competency training review.

The following table represents data extracted from the ADR reports submitted:

<table>
<tr><th>Date</th><th>Medication</th><th>Reaction</th><th>Date Notified Pharmacy</th><th>ADR Reported to Med Watch</th><th>Added to Allergy Profile/Drug Alert</th></tr>
<tr><td>11/23/13</td><td>Testosterone topical</td><td>Rash</td><td>11/25/13</td><td>N</td><td>Y</td></tr>
<tr><td>1/5/14</td><td>MMR vaccine</td><td>Rash</td><td>1/7/14</td><td>Y*</td><td>Y</td></tr>
<tr><td>2/16/14</td><td>Lamictal</td><td>Vomiting</td><td>2/26/14</td><td>N</td><td>Y**</td></tr>
<tr><td>3/10/14</td><td>Bactrim</td><td>Increase in creatinine and enzymes</td><td>3/12/14</td><td>N</td><td>Y</td></tr>
</table>
*Reported to Vaccine Adverse Event Reporting System
**Added to Active Problem List

The Facility remained in substantial compliance with this provision.</td><td></td></tr>
<tr><td>N7</td><td>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.</td><td>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.</td><td>Substantial Compliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances.</td><td>
<u>Pharmacy Review of Categorization of Errors</u>
The Pharmacy Department was active in verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy's interpretation of the medication error categorization.

The Monitoring Team requested a sample of the 10 most recent completed medication error forms and categorized them by severity. Eleven forms were submitted. Of these, the Facility had categorized them as two Category A errors, three Category B errors, five Category C errors, and one Category D error. The Monitoring Team member categorized one medication variance as Category C that the Facility had scored as Category B. Follow-up was indicated with specific nurses in 10 of 11 medication variances. Ten of 10 (100%) medication errors had follow-up. Error types included PCP error in writing the order (three variances), missing documentation on the MAR (one variance), known omission of medication (four variances), and unknown excess return (three variances). These 11 medication errors included pain medication, antibiotic, anxiolytics, plaquenil, eardrops, and seizure medication. In one case, four doses of medication were missed.

<u>Committee Monitoring of Medication Errors/Variances</u>
The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Variance Committee meetings, which the CNE chaired. Since the Monitoring Team's last visit, the committee met on 1/22/14, 2/26/14, and 3/26/14. This committee also met on 5/15/14, the week of the Monitoring Team's visit. The following tables describe some of the findings of this committee:

The number of medication variances, per department was provided per month.
<table>
<tr><th>Month</th><th>Pharmacy Department</th><th>Nursing Department</th><th>Medical Department</th><th>Dental Department</th><th>Total</th></tr>
<tr><td>October 2013</td><td>46</td><td>287</td><td>1</td><td>0</td><td>334</td></tr>
<tr><td>November 2013</td><td>61</td><td>187</td><td>1</td><td>0</td><td>249</td></tr>
<tr><td>December 2013</td><td>77</td><td>229</td><td>3</td><td>0</td><td>309</td></tr>
<tr><td>January 2014</td><td>80</td><td>177</td><td>1</td><td>1</td><td>259</td></tr>
<tr><td>February 2014</td><td>18</td><td>134</td><td>3</td><td>0</td><td>155</td></tr>
<tr><td>March 2014</td><td>31</td><td>187</td><td>5</td><td>0</td><td>223</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Total	313	1201	14	1	1529

The number of medication variances per month was categorized.

Month	Category A	Category B	Category C	Category D	Category E
October 2013	48	202	82	2	0
November 2013	62	117	67	3	0
December 2013	76	149	83	1	0
January 2014	87	108	61	3	0
February 2014	21	81	52	1	0
March 2014	35	130	55	3	0
Total	329	787	400	13	0

A description of major categories of medication variances per month included the following:

Month	Excess Unknown Returns (doses)	Unknown Shortage (doses)	MAR Not Initialed	Documented Omission
October 2013	202	25	0	30
November 2013	117	33	0	26
December 2013	130	51	0	39
January 2014	90	27	0	43
February 2014	80	21	0	23
March 2014	128	25	2	34
Total	747	182	2	195

At the 1/22/14 meeting, there was discussion to review the agenda/format of the

#	Provision	Assessment of Status	Compliance
		meeting. Due in part to success at another SSLC, as of the February 2014 meeting, the nurse managers were asked to provide a summary of medication variances from their unit. At this meeting, it was noted that there had been a 73.2 percent decrease in nursing variances over the prior 12 months. This was believed due to a combination of nursing education, re-training during medication administration observations, pharmacy assistance with decreasing medication workloads, and a stabilized nurse staff. The Nursing Department had taken several steps to reduce medication variances, and they were reflected in the minutes: ▪ An in-service was provided to nurses to double check the PCP orders for allergies and ensure such information was listed on the MARs. ▪ The excess/shortage form was changed to include two nurse signatures to ensure accurate completion of the form. ▪ Copies of the excess/shortage forms were to be given to the nurse managers. ▪ Nurse managers were to be trained to review timeline of seizures in relation to timeline of missed doses of anti-epileptic medication. The 5/14/14 Medication Variance Committee meeting minutes documented that there had been a drop of 39 percent in medication variances in the past year. It was noted that the Avatar system was unable to differentiate between true omissions and excess unknown returned medications. The Nursing Department had plans to track unreconciled medications separately. Noted was a decrease in the medication variance due to wrong dosage administered. According to the minutes, steps in place that may have improved this statistic were the intensive education focusing on medication administration, ensuring the MAR provides clarity on the number of tablets to be administered for a single dosage, and bagging of medications. For pharmacy systems in place, it was confirmed medications were checked once before leaving the pharmacy and a second time, between two nurses, prior to accepting the medications. It was noted that the nurse managers provided summary reports, trends, corrective actions, and follow through for medication variances on their assigned units. The committee reviewed numerous graphs, and the minutes reflected this information along with concise interpretations or comments in an easy-to-read format. Pharmacy and Therapeutics Committee meetings included a wide variety of concerns: drug utilization reviews, medication variance reports, adverse drug reaction investigations, use of psychotropics, anticholinergics, benzodiazepines, emergency chemical restraints, psychiatric polypharmacy, infection control, and new Pharmacy policies. A Pharmacy and Therapeutics Committee meeting was held 11/6/13. It was noted in the	

#	Provision	Assessment of Status	Compliance
		minutes that the Pharmacy Department inspected every medication station including the Treatment Room and Infirmary. Per calendar quarter, compliance ranged from 94 to 96 percent. At this meeting, several achievements of the committee from the prior three months were listed. These included the following: ▪ All nurses administering medication received additional training in medication administration for those with IDD and dysphagia. ▪ Nursing began to inspect all medication rooms effective September 1, 2013. ▪ There was monthly refresher training for nursing concerning medication administration. ▪ The proper wastage of medications was established. ▪ Nurse managers were provided in-service training on classification of medication errors. ▪ The nurse educators increased medication administration observations with reporting to the Medication Variance Committee. A P&T Committee meeting was held 2/19/14, and also on 5/14/14, during the Monitoring Team's visit. The Pharmacy Department was involved in a number of action steps and plans to reduce medication variances. ▪ In the Pharmacy, both technicians and pharmacists counted the auto-fill. Pharmacists had verified the medication in the past, but not counted the medications. ▪ Both nursing and pharmacy began to use a universal form for medication room inspections. ▪ Allergies for each individual at ABSSLC that were recorded in the pharmacy computer system were verified for consistency with the most current annual medical assessment. ▪ To obtain controlled substances, the nursing staff must go to the Pharmacy. The medication count was to be verified at that time. Additional steps taken were that nurses were required to count controlled medications at every shift change in residences with 24-hour onsite nursing. At residences where staffing did not have this ability, a count was to be done daily at the afternoon change of shift. <u>Medication Observation Monitoring</u> Medication Pass Observations occurred according to a schedule to ensure all nurses are observed once per quarter. The results of the monitoring were included in a monthly report provided to the Medication Variance Committee. In January 2014, 18 observations were completed. Three inter-rater reliability observations were performed, and two follow-up medication pass observations were completed. For	

#	Provision	Assessment of Status	Compliance
		February 2014, five medication pass observations were completed, and one follow-up observation. The report reviewed each question with less than 90 percent compliance. The Medication Variance Committee of 5/14/14 indicated that the medication administration observation compliance rate was 79 percent in December 2013, 88 percent in January 2014, 74 percent in February 2014, 98 percent in March 2014, and 93 percent in April 2014. Listed were seven steps taken as part of corrective action when noncompliance with medication administration was observed. Observations were considered random and spontaneous, and completed by one of two nurse educators. Although the Pharmacy Department and the Nursing Department had taken many actions, the number of medication variances remained significant. The Pharmacy Department will need to continue to develop and implement system changes that focus on reduction of Category D errors, excess unknown returns, and medication variances originating in the Pharmacy Department.	

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 #392, Individual #253, Individual #145, Individual #51, Individual #285, Individual #468, Individual #193, Individual #409, Individual #478, Individual #349, Individual #124, Individual #83, Individual #2, Individual #215, and Individual #9) including: list of IDT members required for attendance at annual ISP, PNMT referral form, OT/PT/SLP consultations from the past year, 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 with color photographs; PNMT Post Hospitalization assessment; IPNs for the last six months; and ISPAs for the last calendar year; o For Sample O.2, the following documents for five individuals (i.e., Individual #484, Individual #266, Individual #392, Individual #344, and Individual #167) on the PNMT caseload, who were assessed or reviewed in the last six months; and a sample of two individuals who had been discharged by the PNMT (i.e., Individual #541 and Individual #74): PNMT referral form, PNMT assessment, HOBE assessment, individual-specific PNMT meeting minutes since the last review, annual ISP including IRRF and IHCP, and ISPAs for the past calendar year, COS IRRF and IHCP, PNMP and dining plans with supporting written and pictorial instructions, PNMT discharge summary, list of IDT members required to attend the annual ISP meeting, and last six months of IPNs; o Facility physical and nutritional management (PNM)/Physical and Nutritional Management Team policies and/or procedures; o List of all PNMT core members including titles, license numbers, curriculum vita, and date of assignment to the PNMT; o List of PNM back-up team members, if applicable, including titles, license numbers, curriculum vita, and date of assignment to the PNMT; o List of medical providers/consultants assigned or identified as consultants to the PNMT; o List of continuing education and/or other training completed by PNMT members during the past 12 months including name of each training session, agenda, curriculum, attendance rosters for state-sponsored clinical instruction, certificate(s) of completion for each staff member who attended, and CEUs/contact hours completed; o All PNMT meeting minutes since the last review, including attendance sheets; o Lists of individuals seen by the PNMT to date; current individuals on caseload of the PNMT, including the referral date of and the reason for the referral to the PNMT; individuals assessed by the PNMT since the last review, including the date of the assessment; individuals with PNMT consults since the last review; and individuals discharged by the PNMT since the last review and the date of the discharge;

	○ List of completed PNMT Nursing Post-Hospitalization Assessments/Evaluations; ○ Facility PNMT assessment format and any additional assessment formats utilized by the PNMT with changes made since the Monitoring Team's last review highlighted; ○ Copy of the Facility PNMT referral form; ○ List by home of individuals in alphabetical order who have PNM needs (i.e., those with a PNMP/dining plan), and a similar list of individuals who it has been determined do not have PNM needs; ○ Dining Plan template with any changes made since the Monitoring Team's last review highlighted; ○ PNMP template with any changes made since the Monitoring Team's last review highlighted; ○ List of individuals on modified/thickened liquids; ○ List of individuals who require mealtime assistance; ○ List of individuals who receive nutrition through non-oral methods; ○ List of individuals whose diets have been downgraded or changed to a modified texture or consistency; ○ List of individuals with Body Mass Index (BMI) equal to or greater than 30; ○ List of individuals with BMI equal to or less than 20; ○ List of individuals who have had an unplanned weight loss of 10 percent or greater over a six-month period; ○ List of individuals who have had a choking incident during the past six months; ○ List of individuals who have had an aspiration and/or pneumonia incident during the past six months; ○ List of individuals who have had a fall during the past six months; ○ List of individuals who have had a decubitus/pressure ulcer during the past six months; ○ List of individuals who have experienced a fracture during the past six months; ○ List of individuals who have had a fecal impaction during the past six months; ○ List of individuals who are non-ambulatory or require assisted ambulation; ○ List of individuals with poor oral hygiene; ○ List of individuals who received a feeding tube since the last review; ○ List of individuals who are at risk of receiving a feeding tube; ○ List of individuals who have received a Modified Barium Swallow Study or other diagnostic swallowing evaluation during the past year; ○ List of individuals who have received a video fluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review. ○ Incident reports, assessments, Facility investigations, and all follow-up documentation for any choking or near choking event; ○ Schedule of meals by home; ○ NEO training curricula for PNM foundational training with any changes made since the Monitoring Team's last review highlighted and copies of blank competency performance check-off forms new employees are required to complete; ○ Current PNM monitoring forms(s) with any changes made since the Monitoring Team's

	last review highlighted; date of implementation of the forms; monitoring form instructions with any changes made since the Monitoring Team's last review highlighted; list of staff (with titles) responsible for monitoring; monitoring schedule; and monitoring schedule for individuals at high risk; o Any documents identified in the Facility Self-Assessment or Provision Action Information for this Section as having been developed or revised as part of an action to comply with the Settlement Agreement, but not listed in this document request; o QA/QI meeting minutes related to PNM, PNMT, and the Habilitation Therapies (HT) Department; and o Minutes from the HT Department meetings. ▪ **Interviews with:** o Bobbie Holden, OTR, Director of Habilitation Therapies; o Amy Gleaton, PNMT Coordinator and PNMT OT; o Tammy Bayer, RN, PNMT RN; o Luke Palmer, Doctor of Physical Therapy (DPT), PNMT PT; o Donna Boulette, MS, CC/SLP/A, PNMT SLP; o Tricia Reyes, MS, RD, LD, PNMT RD; o Nicole Spalding, RD, LD, PNMT RD; o Jolene Willis, Assistant Director of Programs; o Patricia Hamblin, Assistant Mealtime Management Coordinator; and o Leslie Riggins, SLP Assistant. ▪ **Observation of:** o PNMT meeting, on 5/12/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, updated 4/28/14. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section O, in conducting its self-assessment: ▪ Based on a review of the Facility Self-Assessment, as well as interviews with the Director of HT, the following was found: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Facility Section O: Minimum and Comment Elements of Physical and Nutritional Management Monitoring tool, revised 1/13, and Facility-based audit tools (e.g., PNMP audit tool). o 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. o The monitoring tool and audits did not include adequate standards, and criteria. The audit tools were missing instructions to support consistency among monitors. o The Self-Assessment identified the sample sizes that 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 the 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, PNMPs); 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: At the time of the Monitoring Team's review, the Physical and Nutritional Management Team (PNMT) had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. With a few exceptions, the necessary members attended the meeting consistently. 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 physical and nutritional Management (PNM) monitoring. The PNMT members were identifying systemic issues in meeting minutes, but documentation was missing to show resolution had occurred of these issues, or actions were underway. In addition, 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. At times, IDTs were not referring individuals who met the PNMT referral criteria and/or their referrals were not timely. PNMT assessments did not include necessary elements. PNMT recommendations were not incorporated into individuals' IHCPs. In addition, PNMT meeting minute documentation did not consistently include information about action steps and their completion. The plans of individuals who were discharged from the PNMT did not provide objective clinical data to justify the discharge and did not include criteria for referral back to the PNMT if it differed from criteria included in policy. Individuals' Physical and Nutritional Management Plan (PNMP) content continued to improve. However, some PNMPs were missing important elements. Annual ISP meeting and/or ISPA documentation did not

	reflect that individuals' PNMPs were reviewed to determine their effectiveness and changes made, as appropriate. Every dining plan had been revised to include color photographs of individuals' primary and/or secondary mealtime position as well as assistive equipment. Individuals at high risk for aspiration and/or choking were identified with a red dot on their dining plan. 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. The Facility continued to implement the Mealtime Management System. At the time of the review, over 500 staff had been trained in Eating, Mealtime Management, and Nutrition Services, as well as Mealtime Coordinator Training. In addition, the Facility had developed and implemented Snack Time Management training for new employees and veteran staff, and competency-based training for food service managers, cooks, and food service workers to ensure correct diet textures and consistency. The Facility also retooled the mealtime management system in the Cottages. The ongoing implementation of a Mealtime Management System was a significant positive initiative in enhancing a safe environment for individuals during mealtimes and snacks. Unfortunately, due to an influenza outbreak, the Monitoring Team was not able to observe meals during the week of the onsite review.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary,	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 #392, Individual #253, Individual #145, Individual #51, Individual #285, Individual #468, Individual #193, Individual #409, Individual #478, Individual #349, Individual #124, Individual # 83, Individual #2, Individual #215, and Individual #9. ▪ **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 #484, Individual #266, Individual #392, Individual #344, and Individual #167. In addition, a sample of two individuals who the PNMT discharged was selected, including: Individual #541 and Individual #74. ▪ **Sample O.3** was not selected for this review, due to the reduced monitoring conducted for Section O.8.	Noncompliance

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	approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	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 4/28/14, reported the following for Section O.1: ▪ 11/15/13 – Draft PNMT policy completed; ▪ 1/3/14 – PNMT began collecting data concerning conversations with PCPs; ▪ 1/15/14 – Began analysis of self–assessment; ▪ 1/31/14 – Began revising PNMT meeting minutes shell; and ▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section O.1 included an action plan with the following action steps and completion status: ▪ Train IDTs on implementation of the revised PNMT policy at the unit meetings (not started); and ▪ Develop tracking list to ensure systemic issues are resolved (not started). These action steps appeared to be appropriate in working to achieve substantial compliance with Section O. However, additional work was needed to achieve substantial compliance as discussed within this section. **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 012.2 for Physical Nutritional Management, revised	

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		4/28/14; ▪ ABSSLC PNMT Process Flow Chart, revised 9/30/13; ▪ ABSSLC Skin Integrity Committee, Policy 03-05.02; revised 5/13; ▪ Clinical Pathway/Guideline for Pressure Ulcer Prevention As Well As Pressure Ulcer Care, dated 2/14; ▪ Policy for Safe Positioning During Vomiting, dated 2/28/14; ▪ ABSSLC – IDT Active Treatment: Meal Time Procedure, in process of modification; ▪ ABSSLC Snack Time Procedure, dated 3/25/14; ▪ Bed Rail Policy, revised 4/30/14; ▪ Lifting Policy, revised 5/8/14; ▪ Wheelchair Prioritization, undated; ▪ Draft Care and Cleaning of Wheelchairs, dated 5/12/14; and ▪ ABSSLC Dental Policy and Procedures, published and approved 3/4/14. ABSSLC had 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 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;	

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		▪ 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 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	

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		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** Since the Monitoring Team's last visit, there had been no changes to the PNMT membership. 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 illustrated multiple instances of conversations with the PNMT Physician Liaison, as well as other Primary Care Physicians. The Facility Self-Assessment for Section O.1 indicated: "the PNMT consulted with a medical provider 149 times." No additional information was provided to explain the process for calculating how the PNMT had met with medical providers at total of 149 times. For five of the five individuals in Sample O.2 (i.e., Individual #484, Individual #266, Individual #392, Individual #344, and Individual #167) (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 follow-up meetings and/or PNMT/IDT meetings, but RN Case Managers did attend these meetings for individuals on the PNMT caseload to provide updates. The PNMT meeting minutes provided updates related to completed medical appointments and consultations. If questions arose during the meeting that could not be answered, the RN Case Manager was able to communicate with the individual's primary care practitioner. In addition, the PNMT Nurse and/or a designee attended the daily morning medical meetings to receive updates on individuals who had experienced a change in status. Every Thursday morning, the PNMT Nurse also provided members of the morning medical meetings an update on the status of individuals on the PNMT caseload. For five of the five individuals in Sample O.2 (100%) (i.e., Individual #484, Individual #266, Individual #392, Individual #344, and Individual #167), evidence was provided of	

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		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. ▪ RN attended: 2013 Food and Nutrition Conference and Expo (10/19/13 – 10/22/13), Annual Habilitation Therapies Conference: Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/31/13 – 11/1/13), Eat, Breathe and Move (11/22/13 - 11/23/13), and Dementia Management –Advanced Skills for the Health Care Practitioner (4/1/14) for a total of 44 hours. ▪ OT attended: Annual Habilitation Therapies Conference: Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/31/13 – 11/1/13), Eat, Breathe, and Move (11/22/13 - 11/23/13), and Study of Mediation (1/6/14 – 1/10/14) for a total of 62.5 hours; ▪ RD #1 attended: 2013 Food and Nutrition Conference and Expo (10/19/13 – 10/22/13), Annual Habilitation Therapies Conference: Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/31/13 – 11/1/13), and Eat, Breathe and Move (11/22/13 - 11/23/13) for a total of 36.5 hours; ▪ RD #2 attended: 2013 Food and Nutrition Conference and Expo (10/19/13 – 10/22/13), Annual Habilitation Therapies Conference: Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/31/13 – 11/1/13), and Eat, Breathe and Move (11/22/13 - 11/23/13) for a total of 36.5 hours; ▪ PT attended: Annual Habilitation Therapies Conference: Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/31/13 – 11/1/13), Eat, Breathe, and Move) (11/22/13 - 11/23/13), Ethics and Your	

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		Professional Responsibility: What's It to You? (1/23/14), and Dementia Management –Advanced Skills for the Health Care Practitioner (4/1/14) for a total of 30.5 hours; ▪ SLP attended: Annual Habilitation Therapies Conference: Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/31/13 – 11/1/13), Eat, Breathe, and Move, (11/22/13 - 11/23/13), Low-Tech AAC Options and Practical Strategies for Classroom Use (1/12/14), Legal and Ethical Implications of Professional Practice (1/12/14), Dysphagia in Patients at the End of Life (1/12/14), Decision Making for Alternate Nutrition and Hydration: Part I and II (1/12/14), and Dementia Management –Advanced Skills for the Health Care Practitioner (4/1/14) for a total of 33.5 hours; **PNMT Meetings** From November 5, 2013 to March 25, 2014, the PNMT met 50 times. Attendance by core PNMT and back-up members, if available, for 50 meetings conducted during the time frame from November 5, 2013 to March 25, 2014 was: ▪ RN: 94% attendance by core member; ▪ RD: 90% attendance by two RD core members; ▪ PT: 72% attendance by core member; ▪ OT: 82% attendance by core member; and ▪ SLP: 82% attendance by core member, 14% for back-up member, 96% overall. None of the 50 (0%) PNMT meeting minutes (November 2013 to March 2014) consistently included documentation of appropriate topics, including all of the following: 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, and as a result, changes of status were not regularly addressed in the minutes;	

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		▪ The meeting minutes did not identify individual-specific triggers to be monitored by direct support professionals, the results of that monitoring, or actions the PNMP took in response; and ▪ Based on the information in the minutes, it was challenging to identify an individual's progress toward established goals. **<u>Resolution of Systemic Concerns</u>** PNMT meeting minutes identified systemic issues, but there was no documentation in PNMT the minutes to discern if these issues had been resolved. Some examples of systems issues that did not reach resolution included: ▪ PNMT meeting minute discussion, dated 11/20/13, stated that the PNMT OT, RN, and Director of HT would meet with the CNE to address RNs not making changes in IHCPs to reflect PNMT recommendations. There was no action step developed. The following fields were blank: person responsible, date due, and date done. ▪ PNMT meeting minute discussion, dated 11/6/13, indicated: "long-term strategies needed for those with diagnoses of aspiration pneumonia such as helping with a foundational checklist of items that must be pursued prior to PNMT referral." Action step stated: "goal would be for the home IDTs to do these basic steps to get their information before referring to the PNMT." However, the following fields were blank: person responsible, date due and date done. ▪ PNMT meeting minute discussion for whipped peanut butter trial, dated 11/12/13, specified: "OT to approve [whipped peanut butter] for individuals." There was no action step developed. The following fields were blank: person responsible, date due and date done. 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 PNMT had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. However, the PNMT OT's meeting attendance was 82% and the PNMT PT's attendance was 72%. Back-up team members for the OT and PT had been identified, but the back-up members were not in attendance for multiple meetings when the PNMT OT and/or PT were not present. The PNMT members had completed continuing education relevant to physical and nutritional supports that were transferrable to the population served during 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 did not show resolution of these issues, or status of the actions Facility staff were taking to try to resolve them. PNMT meeting minutes were missing important information. For	

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		example, the minutes did not consistently identify individualized clinical indicators, individuals' progress or lack thereof, and results of PNMT recommendations. Additional work was needed 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 4/28/14, reported the following for Section O.2: ▪ 12/15/13 – Began working on process for modified barium swallow studies; ▪ 2/15/14 – Began revising PNMT assessment shell to include all elements; and ▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section O.2 included an action plan with the following action steps and completion status: ▪ Develop process for modified barium swallow studies (in process); ▪ Develop policy/procedure to define criteria for development of list 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. A workgroup has met to begin the development of this policy/procedure; ▪ Meet with CNE to develop plan to integrate PNMT recommendations into the IHCP (not started); ▪ Meet with QIDP Coordinator to develop plan to integrate PNMT recommendations into the ISP write up (not started); and ▪ Develop tracking system to ensure implementation of PNMT action plans within 14 days or sooner (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 (i.e., dated 4/1/14), who required positioning assistance associated with swallowing activities (i.e., dated 4/1/14), who had a diagnosis of dysphagia (i.e., dated 4/1/14), or who were at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"). 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 noted above, there was an action step to develop a policy/procedures to define criteria for development of lists for individuals 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	Noncompliance

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		swallowing. This action step had not been started. 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. **Physical and Nutritional Management Team Referral Process** The PNMT Referral form, revision dated 11/2013, was to be used by the IDT for an initial referral and/or follow-up. 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). However, a review of individuals' PNMT referral forms did not show that they included this information. The draft Facility PNMT policy stated the IDT and primary care practitioner was to be use the PNMT consultation form to refer individuals to the PNMT. Individuals in Sample O.1 were reviewed to determine if they had been appropriately referred to the PNMT, based on the Facility policy. More specifically: ▪ Four of the 15 individuals (i.e., Individual #51, Individual #2, Individual #215, and Individual #349) did not meet the PNMT referral criteria. ▪ Four of the remaining 11 individuals (i.e., Individual #478, Individual #392, Individual #9, and Individual #253) were appropriately referred to the PNMT based on the referral criteria. However, as described below, the PNMT did not consistently respond appropriately to the referrals: o Although the State Office policy indicated referrals should be made after two choking incidents in a year, the Monitoring Teams have indicated that individuals should be referred after one choking incident in one year. Individual #478 experienced a choking incident on 11/16/13. The IDT referred her to the PNMT on 11/26/13 for the choking incident on 11/16, hypoxia on 11/17, and hospitalization with final diagnosis of aspiration. PNMT meeting minutes stated: "PNMT will not pick up on active caseload due to aspiration pneumonitis diagnosis." Individual #478 should have been evaluated by the PNMT. ▪ There were seven individuals who should have been referred to the PNMT, but had not been referred. As a result four of the 11 individuals (36%) that should have been referred to the PNMT were. More specifically: o Individuals experienced unplanned weight loss of 10% or greater over a six-month period. Individual #193, Individual #409, and Individual #83	

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		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 #145, Individual #285, and Individual #468. o Individuals had experienced skin breakdown that met the PNMT referral criteria, but had not been referred to the PNMT (i.e., Individual #124 and Individual #83). 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' IDTs had not referred individuals in a timely manner who were exhibiting clinical indicators that should have initiated an earlier referral. A secondary concern was the PNMT did not initiate assessments within five working days of the referral that resulted in a further delay for PNMT intervention. More specifically: ▪ Individual #392's PNMT assessment, dated 2/18/14, indicated she had been referred to the PNMT on 1/7/14 for multiple meal and fluid refusals and consideration of a gastrostomy tube placement. It was noted that she "began to have these problems during August 2013 when coughing increased as well as meal refusals." ▪ Individual #266 was referred to the PNMT on 12/30/13. The PNMT assessment stated: "consult received on 12/31/13 for remarkable increase in vomiting (39 episodes) since March 2013." ▪ The PNMT received a referral on 11/18/13 "to discuss the options of a Peg tube placement" for Individual #541. Individual #541's PNMT assessment indicated: "review of data and record review revealed the onset of this recent event appeared to occur staring in September 2013." ▪ Individual #74's PNMT assessment noted: "on July 24, 2013, [Individual #74] experienced a choking episode requiring the use of [abdominal thrust.]" He was not referred to the PNMT until 12/17/13 for "significant weight loss and refusal to eat (lost 23 lbs. [pounds] in the last 5 months)." The following was not applicable as no individual had received an emergency tube placement since the last review: ▪ ____ of ____ (%) individuals who received an emergency feeding tube placement	

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		since the Monitoring Team's last review had been referred to the PNMT after the emergency feeding tube placement. One of one individual (100%) (i.e., Individual #74) who received 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** For the 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). Five of five (100%) 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). 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; ▪ Five of five (100%) contained the date the assessment was initiated; ▪ Five of five (100%) contained evidence of review and analysis of the individual's medical history; ▪ None of five (0%) identified the individuals' current risk rating(s), including the current rationale; ▪ None of five (0%) 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; ▪ Five of five (100%) 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; ▪ Four of five (80%) (i.e., Individual #484, Individual #266, Individual #392, and Individual #344) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ 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;	

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		▪ None of five (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ None of one (0%) (i.e., Individual #266) identified residual thresholds, if enterally nourished. This was not applicable for four individuals at the time of the PNMT assessment (i.e., Individual #484, Individual #392, Individual #344, and Individual #167), because they ate orally; ▪ Three of five (60%) (i.e., Individual #266, Individual #392, and Individual #167) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. ▪ One of five (20%) (i.e., Individual #344) contained respiratory status; ▪ None of five (0%) contained evidence of review/analysis of lab work; ▪ None of five (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Five of five (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ One of five (20%) (i.e., Individual #344) 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; ▪ One of one (100%) (i.e., Individual #344) 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); ▪ Five of five (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and ▪ Four of the five (80%) (i.e., Individual #399, Individual #201, Individual #377, and Individual #395) contained signatures with dates.	

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		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 two of the five individuals for whom HOBE assessments were conducted (40%) (i.e., Individual #266 and Individual #344), 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 none of the five individuals' plans reviewed (0%), 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 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.	

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		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 methods for ongoing measurement of these indicators to enable the PNMT members to monitor the effectiveness of their recommendations. ▪ Individual-specific triggers were 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 **Individuals Discharged by the PNMT** Review of two individuals' PNMT discharge summaries (i.e., Individual #541 and Individual #74) and ISP/ISPAs found: ▪ One of the two individuals (50%) (i.e., Individual #541) had a meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ None of the two (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. ▪ None of the two (0%) individuals' discharge summaries included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. Additional work was needed in the following areas to achieve substantial compliance in this section: ▪ IDTs should refer individuals in a timely manner to the PNMT when they experience PNMT referral criteria; ▪ PNMT assessments should include the assessment elements presented in this section; ▪ PNMT meeting minutes/plans should incorporate elements presented in this section; ▪ PNMT recommendations should be integrated into IHCPs, as well as clinical	

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		indicators and methods for ongoing measurement of these indicators to enable the PNMT members to monitor the effectiveness of their recommendations; and ▪ Individuals discharged from the PNMT should have an ISPA meeting. The meeting documentation should include the elements included in this section. 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 4/28/14, reported the following for Section O.3: ▪ 11/15/13 – Continuing to review PNMP audit tool results; ▪ 11/18/13 – Entering improved pictures into the new dining plans; ▪ 12/15/13 – Continuing to add information to new dining plans; ▪ 1/30/14 – Finalizing new dining plans for 6480, 6521, and 6510 in preparation for issuance; ▪ 2/4/14 – Issued new dining plans for 6521; ▪ 3/25/14 – Dining plans issued for all homes with the exception of the cottages; and ▪ 4/24/14 - No other initiatives started since last visit. 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 PNMP (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) (in process); ▪ Develop protocol for eating evaluations (in process); ▪ Conduct observations/audits quarterly to ensure PNMP Coordinators and Habilitation Technicians are competent in performance of their duties (not started); ▪ Provide retraining or other appropriate follow-up, if problem areas are identified (not started); ▪ Meet with records coordinator to ensure that positioning pictures are always placed immediately following the PNMP in the Individual Notebook (not started); and ▪ Meet with QIDP Coordinator to ensure evidence is documented in the ISP/ISPA write-up that IDT members addressed the effectiveness of the PNMP and/or discussed specific updates and/or revisions to a PNMP. **<u>IDTs' Reviews of PNMPs</u>** Three hundred forty-one (341) of the 361 individuals (94%) living at ABSSLC had a	Noncompliance

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		PNMP. One of the 15 (7%) (i.e., Individual #409) 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 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. None of 15 (0%) PNMPs in Sample O.1 were adequately reviewed by the individual's IDT in the annual ISP meeting. ISP documentation should reflect that the PNMP was reviewed, effectiveness was discussed, and a summary is provided of changes required. **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. For example, PNMPs were missing photographs of individuals in their seating systems and pictures of prescribed adaptive equipment. ▪ Fifteen of 15 (100%) PNMPs listed the adaptive equipment required by the individual with rationale. ▪ In none of 14 (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. One individual did not use a wheelchair as their primary mobility (i.e., Individual #193); ▪ In 15 of 15 (100%) PNMPs, the type of transfer was clearly described, or the individual was described as independent.	

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		▪ In nine of 15 (60%) PNMPs (i.e., Individual #392, Individual #51, Individual #193, Individual #478, Individual #349, Individual #124, Individual #83, Individual #2, and Individual #215), bathing instructions were provided. For the remaining individuals, the bathing instructions did not specify strategies, independence level, and/or level of staff assistance required. ▪ In six of 15 (40%) PNMPs, (i.e., Individual #145, Individual #51, Individual #285, Individual #124, Individual #2, and Individual #215) 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 included 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. ▪ Seven individuals had feeding tubes with no oral intake (i.e., Individual #253, Individual #145, Individual #285, Individual #468, Individual #409, Individual #83, and Individual #9). Seven of seven (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In 15 of 15 (100%) PNMPs/dining plans, position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ Eight individuals ate orally within this sample (i.e., Individual #392, Individual #51, Individual #193, Individual #478, Individual #349, Individual #124, Individual #2, and Individual #215). o In eight of eight (100%) PNMPs/dining plans for individuals who ate orally, diet orders for food texture were included. o In eight of eight (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. o In eight of eight (100%) PNMPs/dining plans for individuals who ate orally, dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. ▪ In 15 of 15 (100%) PNMPs medication administration instructions were 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	

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		individual). The PNMT continued to complete the PNMP audit tool as a component of the PNMT assessment process. This audit produced a comprehensive review of individuals' PNMPs. 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 were in the process of memorializing this process in Facility policy. **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>** For the 14 individuals in Sample O.1 (i.e., Individual #392, Individual #253, Individual #145, Individual #51, Individual #285, Individual #468, Individual #193, Individual #478, Individual #349, Individual #124, Individual # 83, Individual #2, Individual #215, and Individual #9) with PNMPs for whom the IDT and/or PNMT identified changes needed to be made to the PNMP after the annual ISP meeting, three of the 14 individuals' records (21%) (i.e., Individual #392, Individual #285, and Individual #215) included ISPA meeting documentation to incorporate the changes into the ISP. For individuals for whom the PNMP was revised, there was supporting documentation that none of the 14 (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 and then implement them. To achieve substantial compliance with this section, IDTs need to review and document their decisions about PNMPs, changes in PNMPs should be reviewed in an ISPA meeting so they are officially incorporated into the existing ISP, 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,	The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section O.4: ▪ 2/1/14 – Personnel assigned to monitor for PNMT/follow-up monitoring as needed; ▪ 2/14/14 – Met with QA Director to discuss data and graphs regarding PNMP compliance monitoring shared at Program Implementation Meeting and moving that into the QA/QI Council; and ▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section O.4 included an action plan with the following action steps and completion status:	Not Rated

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	and other activities that are likely to provoke swallowing difficulties.	▪ 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 (not started). **<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u>** Due to an ongoing outbreak of influenza, the Monitoring Team was not able to complete observations of staff implementing individual's dining plans and PNMPs. As a result, the following could not be completed: Based on observations conducted by the Monitoring Team: ▪ ____ of ____ individuals' (%) dining plans were implemented as written. ▪ ____ of ____ (%) individuals' oral hygiene plans were implemented as written. ▪ ____ of ____ individuals' positioning plans were implemented as written. ▪ ____ of ____ individuals' transfer plans were implemented as written. ▪ In ____ of ____ observations of medication administration, the nurse followed procedures in the PNMP. ▪ ___ of ___ individuals' bathing plans were implemented as written. [Methodology: This will not routinely be observed due to privacy issues. However, if bathing is observed, this indicator will be completed.] The Facility was not rated for this subsection for this review.	
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. The noncompliance finding from the last review stands. **<u>Updates</u>** 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, and Facility therapists. The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section O.5: ▪ 11/20/13 – Began training and inter-rater reliability for the actual mealtime monitoring; ▪ 12/15/13 – Continuing competency based training with food service managers, cooks and food service staff to ensure textures are consistent; ▪ 1/31/14 – Continuing to work on updating the dietitian/OT portion of NEO; ▪ 4/4/14 – Training completed for mealtime management; and	Noncompliance

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		▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section O.5 included an action plan with the following action steps and completion status: ▪ Update the Dietitian/OT portion of NEO for diet/textures/feeding techniques to include specific diets, choice menu, reading menus and diet/dining plans (in process); ▪ Develop performance check offs for PNMPs (not started); ▪ Implement a training database to document the completion of core competency training for required veteran staff (not started). These action steps were appropriate in working towards 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; ▪ Aspiration Pneumonia; ▪ Mealtime Coordinator Training; ▪ Eating, Mealtime Management and Nutrition Services; and ▪ Snack Time Management and Coordination. 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 from 10/1/13 to 3/31/14, 256 of 256 (100%) new employees had successfully completed NEO for PNM core competencies. **<u>PNM Core Competencies for Current Staff</u>** Based on interview with the Director of HT, a training plan was to be implemented for veteran staff to complete competency-based training for PNM core competencies. The training was scheduled to begin in August 2014. 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.	

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		▪ ____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>** 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>** 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. ▪ ____ 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, PNMT Coordinator, and Assistant Mealtime Management Coordinator for an update on the ongoing implementation of the Mealtime Management System. More specifically: ▪ Snack Time Management training had been developed and implemented for new employees and veteran staff; ▪ Over 500 staff completed two courses: Eating, Mealtime Management and Nutrition Services, and Mealtime Coordinator Training; ▪ The Facility had developed and implemented competency-based training for food service managers, cooks and food service workers to ensure correct diet textures and consistency; ▪ Facility staff retooled the mealtime management system in the Cottages; ▪ There was a realignment of PNMP Coordinators and Habilitation Technicians that resulted in an assignment to one home. Their primary responsibilities were to provide coaching and mentoring to staff in PNMP implementation, and provide competency-based training on PNMP and dining plan revisions;	

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		▪ Campus-wide training has been completed to address safe positioning during vomiting; and ▪ A mealtime monitoring tool was developed and implemented. This tool was in the process of being revised, as the mealtime monitoring data was not sufficiently discrete to identify individual-specific concerns and/or system issues. On a positive note, the Mealtime Management workgroup and HT therapists had been begun the process of expanding their focus on bathing supports and had been assessing these environments for safety. Multiple initiatives had begun as a result of these bathroom assessments. Individual-specific bathing assessments and assessment of bathrooms in the residences had been completed. As a result of these assessments, bathing equipment had been ordered for individuals to support a safer environment for bathing. Bathing instructions in individuals' PNMPs were to be modified to address the new bathing equipment. Bathrooms were in the process of being remodeled to accommodate the new equipment. Monitoring of bathing was to begin to assess staff compliance with PNMP instructions. The implementation of a Mealtime Management System was a significant positive initiative in enhancing a safe environment for individuals during mealtimes and snacks. As noted above, based on the reduced monitoring, the Facility remained in noncompliance with this provision.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section O.6: ▪ 11/4/13 – Redistributed staff so there is one PNMP Coordinator or Habilitation Technician per home to ensure continuity of PNMP training and accountability to ensure timeliness of training; ▪ 2/21/14 – Developed spreadsheet to track follow-up for failed PNMP compliance monitoring; and ▪ 4/24/14 - No other 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,	Noncompliance

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		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). Based on interview with the Director of HT and Facility therapists, a Facility policy/procedure for PNM monitoring would be in place by the next onsite review. **<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 s will be reviewed: ▪ 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 three months prior to the review, ___ of the expected _____ monitoring sessions per policy or the individuals' assessments and/or plans (%) were completed timely. ▪ 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 ____ (%).	

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		As noted above, based on the reduced monitoring, the Facility remained in noncompliance with this provision.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section O.7: ▪ 12/10/13 – Began revising the Section O monitoring tool; ▪ 3/21/14 – Revised the Section O monitoring tool/instructions; and ▪ 4/24/14 – No other 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). Based on interview with the Director of HT and Facility therapists, a Facility policy/procedure for effectiveness monitoring would be in place by the next on-site review. **IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of Plans** 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 objective clinical data included in the plan. ▪ _____ of the _____ individuals' records showed a change of status based on the	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. As noted above, based on the reduced monitoring, the Facility remained in noncompliance with this provision.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection, because the Facility had made limited progress. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section O.8: ▪ 4/24/14 - No other 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). The Director of HT indicated policies from other Facility's had been reviewed and a policy would be in place for the next onsite review. **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	Noncompliance

#	Provision	Assessment of Status	Compliance
		of individuals who were enterally fed. ▪ ___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. **<u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u>** During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____ (%) individuals in Sample O.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);	

#	Provision	Assessment of Status	Compliance
		○ Time and schedule of interventions; ○ Specific triggers for when the plan should be stopped; ○ Milestones for progressing with the plan; ○ Documentation requirements (i.e., method for tracking progress); and ○ 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. As noted above, based on the reduced monitoring, the Facility remained in noncompliance with this provision.	

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 #462, Individual #348, and Individual #451; 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 Facility OT/PT assessment, assessment updates, or any other additional assessment templates used by OTs and PTs; o Wheelchair seating, PNM clinic assessment templates and related documentation (e.g., Facility protocols, instructions for use, etc.); o OT/PT comprehensive assessment and/or screening for individuals newly admitted to the Facility since the last review, including the date of admission; and o Copies of blank monitoring form(s)s that were used by OTs, COTAs, PTs, PTAs, and PNMP Coordinators. ▪ **Interviews with**: o Bobbie Holden, OTR, Director of Habilitation Therapies; o Luke Palmer, Lead PT, Doctor of Physical Therapy (DPT), PNMT PT; o Amy Gleaton, Lead OT, PNMT Coordinator and PNMT OT; and o Leslie Riggins, SLP Assistant. ▪ **Observations of**: o Observations were not completed during this review due to an influenza outbreak.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 4/28/14. 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: Section P Occupational and Physical Therapy Monitoring Tool, revised 1/14, and Facility-developed audit tools (i.e., OT/PT assessment and PNMP audit tool). o The data presented in the Self-Assessment indicated that multiple audits were conducted, including reviews of OT/PT assessments for individuals newly admitted, review of ISPs for incorporation of OT/PT assessment recommendations, implementation of the OT/PT assessment audit tool, analysis of PNM foundational training databases for NEO, and analysis of annual refresher training for PNM foundational training.

	○ The Self-Assessment identified the sample sizes used to complete audits, including the information necessary to determine the percent sample in comparison with the overall population. ○ The Facility-based audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tools: the Director of HT, therapists, and the PCM. ○ 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: ○ 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 not being in compliance with any of 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 provided minimal analysis of the information. Based on the limited analysis, the Facility connected some of 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. For example, the self-rating in the Self-Assessment for Section P.1 indicated OT/PT assessments did not include all of the essential elements. The P.1 action plan step two was to "revise OT/PT assessment shell to include all clinical indicators." Section P.2 self-rating noted that OT/PT assessment recommendations were not consistently integrated into SAPs. Section P.2 action step indicated a meeting would take place with the QIDP Coordinator to develop a plan to ensure OT/PT recommendations were implemented within 30 days.
	Summary of Monitor's Assessment: Review of the Facility-selected sample of three individuals' OT/PT assessments revealed that 14 of 20 applicable assessment elements being present in each of the assessments reviewed. A number of important elements were still missing from the assessments. Due to limited progress, the Monitoring Team conducted a streamlined review of most of Section P. However, the Facility's Provision Action Information, Presentation Book, and staff interviews indicated that two experienced PTs, who were former employees, began in January, 2014; competency-based training for PNMP coordinators and Habilitation Therapy Technicians had been completed; the Habilitation Therapies Director met with QA Director to implement a new database to show review of ISP documentation for adequate review of the PNMP, and auditing had begun of ISPs; competency-based training had been completed with Habilitation Therapy Technicians to conduct monthly wheelchair inspections, simple repairs, and document repairs; competency-based training had been provided to the PCPs regarding bedrail reduction; and effectiveness monitoring had begun of wheelchairs to develop a priority list for individuals without an adequate seating system and needing a comprehensive seating assessment. 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. The noncompliance finding from the last review stands. **Definition of Samples** ▪ **Sample P.1** consisted of the following three individuals the Facility selected: Individual #462, Individual #348, and Individual #451. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section P.1: ▪ 1/15/14 – Began analysis of self-assessment; and ▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section P.1 included an action plan with the following action steps and completion status: ▪ 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 (not started). ▪ Revise OT/PT assessment shell to include all clinical indicators (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** During the next review, the following will be reviewed for individuals newly admitted to ABSSLC: ▪ ___ of ___ admitted individuals since the last review (%) received an OT/PT screening or assessment within 30 days of admission or readmission. ▪ If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening, received a comprehensive OT/PT assessment	Noncompliance

#	Provision	Assessment of Status	Compliance
		within 30 days of identification. For one of three individuals in Sample P.1 (33%) (i.e., Individual #451), the OT/PT assessment and/or update was dated as having been completed at least 10 days prior to the annual ISP. 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. ▪ Three of three (100%) assessments included medical diagnoses. ▪ One of three (33%) (i.e., Individual #451) 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. ▪ None of three assessments (0%) included a comparative analysis 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. ▪ Three of three assessments (100%) 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. ▪ None of the three individuals in the sample used a wheelchair as their primary mobility. Consequently, the following was not applicable: ____ of ____	

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		assessment (%) 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. ▪ 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. ▪ One of three (33%) (i.e., Individual #451) 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. ▪ Three of three assessments (100%) 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 #462 and Individual #451) 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, interventions, and programs should be utilized throughout the day.	

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		Because of the limited review, the following was not 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 14 of the 20 applicable assessment elements.	
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. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section P.2: ▪ 11/22/13 – Hired two experienced PTs, who are former employees, to begin in January, 14; and ▪ 4/24/14 - No other initiatives started since last visit The Presentation Book for Section P.2 included an action plan with the following action steps and completion status: ▪ Meet with QIDP Coordinator to develop a plan to ensure recommendations of the OT/PT assessment are implemented within 30 days (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. **Direct OT/PT Interventions** 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 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ 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. **<u>Indirect OT/PT Programs</u>** The implementation of these plans is discussed with regard to Section O.4 for PNMPs and in Section S for skill acquisition plans. **<u>Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP</u>** 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 were 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 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	

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		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. The noncompliance finding from the last review stands. **Update** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section P.3: ▪ 11/18/13 – Completed annual competency-based training for PNMP Coordinators and Habilitation Technicians; ▪ 2/14/14 – Met with QA Director to implement new database to show review of ISP documentation for adequate review of the PNMP; ▪ 3/10/14 – Began auditing ISPs for adequate review of the PNMP; and ▪ 4/24/14 – No other initiatives started since last visit The Presentation Book for Section P.3 included an action plan with the following action steps and completion status: ▪ Conduct observations/audits quarterly to ensure PNMP Coordinators and Habilitation Technicians are competent in performance of their duties (not started). ▪ Develop individual-specific competency-based performance check-offs for the implementation of indirect OT or PT programs (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. **Competency-Based Training** Competency-based training for, and monitoring of continued competency and compliance of direct support professionals related to implementation of PNMPs are typically addressed in detail with regard to Section O.5. Substantial compliance with Section O.5 is the standard for compliance with this section.	Noncompliance

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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. The noncompliance finding from the last review stands. **Update** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section P.4: ▪ 11/5/13 – Completed competency-based training with Habilitation Therapy Technicians to conduct monthly wheelchair inspections, simple repairs and document repairs; ▪ 11/26/13 – Provided competency-based training for the PCPs regarding bedrail reduction; ▪ 12/15/13 – Began revising Section P monitoring tool; ▪ 12/15/13 – Began conducting effectiveness monitoring of wheelchairs to develop a priority list for individuals without an adequate seating system and needing a comprehensive seating assessment; ▪ 2/14/14 – Revision of Section P monitoring tool complete – to begin using March 1; ▪ 3/1/14 – Began using Section P monitoring tool along with the PCM; and ▪ 4/23/14 – Priority list developed for people without an adequate seating system. 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 that 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 that identify the responsible therapist, date of work order and delivery of equipment, and frequency of equipment monitoring (completion status – not started); ▪ Revise/update OT/PT policy (not started); ▪ 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	Noncompliance

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		(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. **<u>Monitoring System</u>** The Facility did not have defined procedures 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 for updated policies/ procedures/protocols, 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: ▪ Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain (yes or no), dentist documentation confirming pain (yes or no), and treatment documented; ▪ Have had preventative dental care; ▪ Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work; and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam; o List of abbreviations used in all dental records/reports; o List of those who have not seen dentist in one year and reason; o List of those who were edentulous at time of the last onsite visit, and those who have become edentulous since that time; 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 #159 12/6/13, Individual #159 1/24/13, Individual #123, Individual #215, and Individual #507; 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, IPNs on date of procedure, etc., for: Individual #136, Individual #469, Individual #427, Individual #519, and Individual #137; o For the past six months, copies of any correspondence concerning restraint and sedation

	use at time of office visit (i.e., to QDDP, team, psychologist, etc.); o For five individuals given dental pretreatment 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 pretreatment sedation sheets). Information was provided for the following individuals: Individual #527 10/25/13, Individual #127, Individual #527 3/18/14, Individual #242, and Individual #69; o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia; o Copy of any restraint and sedation tracking list/system used by the Dental Department (i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach such as 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 # 502, Individual #307, Individual #283, Individual #153, and Individual #543; 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 #53, Individual #403, Individual #73, Individual #488, Individual #178, Individual #497, Individual #423, Individual #302, Individual #237, and Individual #56; o Copy of nine most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #242, Individual #36, Individual #383, Individual #322, Individual #443, Individual #15, Individual #63, Individual #535, and Individual #361; 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 With regard to chair-side and in-home oral hygiene training for individuals or staff in past six months, the number of eligible individuals during this time and umber of eligible staff during this time, submitted per month; 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;

	○ List of individuals provided instructions on flossing with dates of training; ○ 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; ○ 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; ○ List of staff in the Dental Department, including names, title/role, and degrees; ○ 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 and 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; and ○ Presentation Book for Section Q. ▪ **Interviews with**: ○ Jerry Griffin, DDS, Dental Director; and ○ Pamela Acevedo, RDH.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment: ▪ The Facility used a monitoring/auditing tool. Based on a review of the Facility Self-Assessment, the monitoring/audit template 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 did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ The monitoring tools included adequate methodologies, such as dental record reviews. ○ The Self-Assessment identified the sample 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). These sample sizes were

	adequate to consider them representative samples. o The following staff/positions were responsible for completing the audit tools: dentist and QA Monitor. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used some other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the old dental database was noted to be complete and accurate. The Dental Care Tracking new database was suspended due to the inability to obtain accurate reports. Examples of databases/data sources that were not considered include: percentage of individuals with various levels of periodontitis and various levels of gingivitis. ▪ The Facility presented some data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Had some accurate complete data for various subsets (e.g., prophylaxis care, etc.). Some databases were incomplete (e.g., the date of the annual dental assessment and date of prior annual assessment for the prior six months) and some areas needed database development (e.g., tracking suction tooth-brushing training, tracking oral hygiene in the homes). o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. The quality of the transition information for the community dentist was not tracked for completeness, for instance. ▪ The Facility rated itself as being in compliance with Section Q.1. This was not consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example the need to track training in the home.
	Summary of Monitor's Assessment: The Dental Department maintained the progress it had made with regard to several components of dental services. The annual exams were timely. Many areas of dental care were tracked. Desensitization had a number of success stories. The data related to routine dental care appeared thorough and accurate, and was analyzed at intervals, which led to revisions. Individuals with poor oral hygiene were identified, and discussions with the IDTs were reflected in the ISPAs, as well as the dental section of the IRRF. The Dental Department was mostly limited by lack of staff. There was currently only one dentist in the Department. The successful desensitization program required increased hours from dental staff, but an expansion of hours was not possible. The lapse of time from the annual dental exam to completion of the annual dental summary for the ISP remained excessive for some individuals. Training and monitoring needed to occur in the home setting for individuals with poor oral hygiene ratings, who were at risk as a result. Focus was needed particularly for individuals who were responsible for self-brushing, but had poor or worsening oral hygiene. In addition, the Dental Department needed to track and analyze the cause for

	dental extractions (e.g., new admissions, trauma, etc.) to assist in determining common causes for which preventive strategies should then be developed, as appropriate.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	<u>Staffing</u> One Dentist, two Registered Dental Hygienists, one Registered Dental Assistant, an additional Dental Assistant, and an Administrative Assistant staffed the Dental Department. There was one vacancy in the Dental Department for a Staff Dentist position. CPR certification was submitted for the Dental Department staff. Four of five dental staff were listed and were current in CPR certification. A second Dental Assistant was not listed. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the prior twelve months in a document entitled "Scheduling AE (annual exams) and Recall Master all by Name." This was reviewed to determine timeliness of annual examination completion. The two most recent were taken from the list. The two most recent dates were only available for the months of January 2014 through entries in April 2014. Some December 2013 entries included the prior date of completion, and others did not. Compliance for timely completion was only calculated for the months of January 2014 through April 2014. During this period, 134 annual dental assessments were completed. One hundred twenty eight of 134 were completed within 365 days of the prior annual dental assessment. Compliance was 96 percent. The Dental Department documented that there were four individuals residing at ABSSLC who had not seen a dentist in the prior 365-day time period. For one individual, a "medical issue" delayed the annual dental exam. For three individuals, there was an internal Dental Department oversight. It is recommended that a second monitoring tier be developed to ensure timely assessments. Separately, copies of 10 annual dental assessments that were completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessments were submitted. For 10 of 10 (100%) of these individuals, an annual dental assessment had been completed within 365 days. The content of this submitted document (annual dental assessment) included the following components: ▪ Ten of the 10 (100%) submitted assessments had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 (100%) submitted assessments had entries for oral hygiene rating. ▪ Eight of eight (100%) submitted assessments for individuals with teeth had entries for	Noncompliance

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		periodontal condition. ▪ Of those with teeth, a periodontal chart or periodontal screening/probe record was completed/documented in eight of eight records. ▪ Two were edentulous. ▪ Ten of the 10 (100%) submitted assessments had entries for oral cancer screening (i.e., intra-oral exam and extra oral exam screening)/soft tissue exam. ▪ Ten of the 10 (100%) submitted assessments documented a summary of findings/treatment during the annual visit. ▪ Ten of the 10 (100%) submitted assessments included a dental treatment plan. ▪ Ten of the 10 (100%) submitted assessments documented oral hygiene recommendations. ▪ Zero of the 10 (0%) submitted assessments documented risk rating. ▪ Ten of the 10 (100%) submitted assessments documented community transition preparedness. Copies of nine annual dental summaries (i.e., the report submitted to the IDT for the ISP process) that had been completed in the 30 days prior to the Monitoring Team's visit were submitted for review. The document request was for a sample of 10 annual dental summaries. However, one individual's summary was copied twice. The content of this submitted document (annual dental summary) included the following components: ▪ Nine of nine (100%) submitted summaries had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Nine of nine (100%) submitted summaries had entries for oral hygiene rating. ▪ Six of seven (86%) submitted summaries for individuals with teeth had entries for periodontal condition. For one individual, the entry for periodontal categorization was a "?" without further explanation. This was unhelpful. ▪ Two were edentulous. ▪ Nine of nine (100%) submitted summaries documented a summary of findings/treatment during the annual visit. ▪ Nine of nine (100%) submitted summaries included a dental treatment plan. ▪ Nine of nine (100%) submitted summaries documented oral hygiene recommendations. ▪ Nine of nine (100%) submitted summaries documented risk rating. ▪ Nine of nine (100%) submitted summaries documented community transition preparedness. ▪ As one of the individuals had died, and the date of the annual dental summary was the date of death, the rationale for completing the recommendation and transition section was unclear. ▪ Completion of the annual dental summary occurred from the same day to 156 days following the annual dental assessment. Although a Facility goal was set to have an	

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		annual dental exam completed within the nine months prior to the ISP and the annual dental summary, the time lapse remained significant. The goal should be to have the annual dental examination completed as close as possible to the time of the annual dental summary submission for the ISP. The Dental Department was able to demonstrate that ability in two of the nine individuals, completing the annual dental summary on the same day as the annual dental examination. Had the annual dental summary been completed promptly following the annual dental assessment, all portions of the template for the individual that died would have been appropriate at that time. However, some aspects of the template became meaningless. It is recommended that the continued prolonged length of time from annual dental examination to annual dental assessment be reviewed further. A guideline of annual dental summary completion within 30 to 60 days of the annual dental examination would best meet the needs of the individuals. There were a number of other concerns noted with the annual dental summary. The form was completed in template format. However, there was abrupt change from a dental clinical review to a section approaching a page in length, which outlined the individual's preferences, strengths, and goals. This was followed by an abrupt change back to the dental template and a review of periodontitis. The purpose for this additional "preferences, strengths, and goals" in the middle of the dental summary was unclear. Based on direction from State Office related to Settlement Agreement requirements for Section F, the goal was for all assessors to incorporate the individual's preferences, strengths, and goals, as appropriate into the assessments. However, the intent was not merely to list them, but rather to use them meaningfully. A way in which they might be incorporated into dental assessments, for example, would be to recommend the use of some of the individual's preferences in developing desensitization plans or other strategies to minimize the use of sedation. However, as is, the template went from determining what dental treatments had been completed in the year (i.e., fillings, extractions, crowns, etc.) to listing of non-dental related preferences and goals: that an individual preferred long socks, that the IDT recommended the individual continue morning and afternoon sessions at the Activity Center, that the individual have visits with her mother weekly, etc. To ensure that the preferences and strengths information is meaningful to the clinical aspects of dental care at the Facility as well as to a community dentist, who would likely be puzzled by the additional information and may not read through the summary to the end where further important dental information was communicated, dental staff should distill down the preferences and strengths that they believe are necessary to attend to ensure success in the dental office at the Facility as well as in a community office setting. Selected preferences or strengths might be helpful in an office environment, because they would facilitate cooperation and calm the individual, but these statements should likely be placed towards the end of the dental report, after the clinical information. Section V of the dental template stated: "Evaluation/Assessment" followed by "present	

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		condition." Present condition appeared to refer to periodontal condition. It appeared there needed to be a review of the subsection headings of this part of the template. For instance, "present condition" was then followed by a single word in the template, but it was not clear to what "present condition mild" referred. There were inconsistencies in the "present condition" and the "periodontal type." One individual had a "periodontal type II," and this was listed next to "present condition mild." Another individual also had "periodontal type II," but "present condition moderate." The template did not provide further information as to the reason for the difference in "present conditions" with similar periodontal types. More information was needed in the template to resolve this concern. The periodontal type was in part based on periodontal probing, but there were no probe readings in any of the seven individuals with teeth. These might have been on the annual dental assessment, but it would have provided evidence of the determination of the level of periodontal type. There was a section simply stating 'Tissues," but the response was often confusing. For one individual, the statement was "tissues – mild" without further clarification (i.e., mild bleeding, mild hypertrophy, mild inflammation, etc.). For individuals with severe periodontitis listed in the Annual Dental Summary, there was a lack of specific plan to address this concern. The response was a standardized set of phrases used in many of the template reports. However, in these individuals, the current plan was not successful, and more information was needed concerning how the Dental Department was going to approach this challenge in the individual (i.e., increased frequency of office visits, increased frequency of home visits for teaching the individual or staff, or monitoring of dental hygiene in the home, need for expedited dental desensitization, etc.). <u>New Admissions</u> Additionally, according to a spreadsheet entitled: "ABSSLC Admission Tracking Worksheet – ABSSLC Dental," there were three new admissions in the prior six months. Two had an admission dental assessment completed within thirty days. A third admission was at ABSSLC briefly before being hospitalized, and had not returned to the Facility. Due to being hospitalized within the first 30 days of admission, the Dental Department was unable to complete an admission dental assessment at the time of the Monitoring Team's visit. It is uncertain whether this would be completed within the 30-day time period. Because the 30-day time period had not ended, this individual was removed from compliance calculations. Compliance for two of two applicable new admissions was 100 percent. <u>Oral Hygiene</u> 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	

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		"ABSSLC Oral Hygiene Values for All: 4-2013 to 3-2014 12 months." According to this document, for a census of 403 individuals during the year, this information was submitted as follows:	

	Good Oral Hygiene Rating (#/%)	Fair Oral Hygiene Rating (#/%)	Poor Oral Hygiene Rating (#/%)
All individuals	294 (73%)	75 (19%)	34 (8%)

As a comparison, the Dental Department was able to provide this same information for all individuals in the prior two years, to determine any trend.

Year	Good Oral Hygiene Rating	Fair Oral Hygiene Rating	Poor Oral Hygiene Rating
2012	76%	17%	7%
2013	73%	20%	7%

This information included both dentate and edentulous individuals. There were 147 individuals that were edentulous during the prior year, according to this submitted documentation. All 147 had good oral hygiene ratings. Separately, the Facility submitted a document entitled "ABSLC Oral Hygiene values for all with Teeth 4-2013 to 3-2014 12 months." According to this document, for a census of 256 dentate individuals during the year, the following information was submitted:

Good Oral Hygiene Rating (#/%)	Fair Oral Hygiene Rating (#/%)	Poor Oral Hygiene Rating (#/%)
147 (57%)	75 (29%)	34 (13%)

It was noted that four individuals with poor oral hygiene had left campus. This was concerning, as the dental services at ABSSLC were not able to improve the oral hygiene in these four individuals, and they were transitioned to the community or transferred elsewhere. No further information was reviewed or submitted for these four individuals to determine how the receiving environment was to meet this difficult challenge in providing needed dental supports.

As a comparison, the Dental Department was able to provide this same information for the dentate population in the prior two years, to determine any trend.

Year	Good Oral Hygiene Rating	Fair Oral Hygiene Rating	Poor Oral Hygiene Rating
2012	60%	28%	12%
2013	58%	31%	11%

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The Dental Department provided information concerning periodontal chart completion/updates in the dental record. The eligible population at ABSSLC for periodontal chart completion was individuals with six or more teeth. As of 4/24/14, 185 of 225 (82%) of the individuals had periodontal charts. For the immediate prior time period of 10/1/13 through 3/31/14, 181 of 224 individuals had periodontal charts (81%). For the prior year (10/1/12 through 9/30/13), 175 of 232 had periodontal charts completed (75%).

Oral Hygiene Training

The Dental Department provided information concerning the number of new employees trained in oral hygiene during orientation. The following indicates the training per month and department (i.e., # trained/# new employees). It was explained that the numbers do not match as some staff that start work one month may not be trained until the next, or some did not continue to work before the Intermediate Oral Hygiene class was provided:

Department	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014
Residential	51/45	17/47	39/14	40/47	26/31	22/26
Nursing	4/6	2/5	5/2	6/6	10/10	2/3
Other	9/3	0/0	2/2	2/1	1/1	0/1
Total	64/54	19/52	46/16	48/54	37/42	24/30

Additionally, the Dental Department was able to provide data concerning the number of direct support professionals that were current in the new employee training in-service entitled "Intermediate Oral Hygiene Training Program." Data was available per month for the prior six months:

Month	# Direct Support Professionals Trained in Oral Hygiene Program	# Direct Support Professionals	% of All Direct Support Professionals Employed during Month
October 2013	606	624	97%
November 2013	611	640	95%
December 2013	577	626	92%
January 2014	631	643	98%
February 2014	574	630	91%
March 2014	621	629	99%

The Dental Department provided information concerning the number of individuals receiving oral hygiene instruction at the dental office (i.e., chair-side).

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Dental Appointments with Oral Hygiene Instruction	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014
# individuals with brushing training	27	26	20	24	25	11
# individuals with flossing training	13	13	3	8	7	5

A total of 138 individuals had oral hygiene training.

The Dental Department provided information concerning the number of staff receiving oral hygiene instruction at the dental office (i.e., chair-side).

Dental Appointments with Oral Hygiene Instruction	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014
# staff with brushing training	59	49	59	58	43	27
# staff with flossing training	8	5	4	3	4	4

A total of 247 staff had oral hygiene training.

Oral hygiene instruction also occurred in the home via skill acquisition programs for tooth-brushing, flossing and proxy brushing:

Population	October 2013	November 2013	December 2013	January 2014	February 2014	March 2014
Individuals with home tooth-brushing SAP	74	75	77	76	75	76
Staff	0	0	0	0	0	0

As noted, from the above chart, the Dental Department did not provide oral hygiene instruction for staff in the home.

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		Oral hygiene instruction occurred in the residence via Skill Acquisition Plans. From October 2013 through March 2014: ▪ Thirty-eight individuals had tooth-brushing SAPs ▪ Two individuals had a flossing SAP. ▪ One individual had a water pic SAP. ▪ Three individuals had a proxy-brush SAP. According to the Dental Policy and Procedure Manual, staff responsible for high volume vacuum tooth brushing completed a specific in-service entitled: "Use and Carry Instructions for High Volume vacuum Tooth-brushing." The Dental Department indicated that the training of oral hygiene included vacuum toothbrush training (competency-based). <u>Suction Tooth-brushing</u> 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 144 individuals received suction tooth brushing, which was 144 of 363 (40%) of the population. No additional individuals were identified as qualifying for suction tooth brushing, but were not receiving that dental procedure. <u>Individuals with self brushing plans</u> From a document entitled: "OH Report Independent Brushers 4/1/13 -3/31/14 – Special Report," 53 individuals were listed as brushing one's own teeth. The oral hygiene scores of these 53 individuals were submitted for the prior two ratings completed at the time of the annual exam. ▪ Thirty-three remained in the same category of oral hygiene rating. o There were 21 that maintained a good oral hygiene rating. o For eight, the individuals maintained a fair oral hygiene rating. o For four, the individuals continued to have poor oral hygiene ratings. ▪ For nine individuals that brushed their own teeth, there was improvement in the oral hygiene ratings. o For five individuals the ratings improved from poor to fair. o For three individuals the ratings improved from fair to good. o For one individual, the rating improved from poor to good. ▪ For 11 individuals, the oral hygiene ratings worsened o For one individual, the rating changed from good to poor. o For eight individuals, the ratings changed from good to fair. o For two individuals, the ratings changed from fair to poor.	

#	Provision	Assessment of Status	Compliance
		The Dental Department provided evidence of follow-up of those with poor oral hygiene. Twenty-nine individuals were identified with poor oral hygiene. For each, a Registered Dental Hygienist completed a "dental desensitization assessment." This occurred in the residence, in the dental office setting, or in the Infirmary. A short but detailed report was documented for each of these assessments, as guidance for future steps to be taken. Each had specific recommendations. Of the 29 individuals, three recommendations included training of staff in the residence. A change in the oral toothbrush was recommended for six individuals. A change in type of toothpaste was recommended for 11. Additional sensory items for distraction, and anxiolysis were recommended for two individuals. A consult to occupational therapy for sensory defensiveness was recommended for three individuals, and two additional individuals had already had an OT consult for this. A behavioral health consultation was recommended for five individuals. Further IDT discussion was recommended for eight individuals. For each of these categories of recommendations, there were several individuals in the process of recommendations being implemented (i.e., determining whether training in the home was needed, etc.). A sample of the dental section of 20 IRRFs was provided that reflected these recommendations. The recommendations were clearly written to provide guidance to the IDTs in determining action plans to improve oral hygiene. The recommendations in the dental section included the frequency of dental visits for prophylaxis care, the frequency of tooth-brushing and need for further effectiveness in this procedure, clearly indicating when the current supports were not effective and the need for the IDT to discuss poor oral hygiene/uncooperative behavior, etc., and provided additional person-centered specific recommendations, such as the dental staff to meet with the QIDP in the residence, the QIDP formally consulting the dental hygienist to review the type of toothbrush used, determining whether pudding can be utilized as a toothpaste, need for training direct support professionals in specific techniques for oral hygiene, use of a water pic, and use of edible reinforcers, etc. Additionally 12 of these individuals with poor oral hygiene had dental skill acquisition programs in place. <u>Flossing</u> The Dental Department listed 37 individuals that received flossing in the office setting for a total of 52 visits from October 2013 through March 2014. Five individuals had more than one appointment, which included flossing. Two individuals had a residential SAP for flossing. One of these individuals had since moved from ABSSLC. Three individuals had a home SAP for interproximal cleaning (such as Proxybrush), and one had a home SAP for Waterpic use. The Dental Department also utilized glide flossers, adaptive handle flossers, and gum soft pics. However, no further information was provided to determine the setting in which they were used or the number of individuals using these inter-dental cleaning options. In a document entitled: "People who independently brush but are not flossing with reason and	

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		skill acquisition plan," 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. Fifty-four individuals were listed as being able to brush their own teeth. Of these, one was considered a self-flosser, but had moved from ABSSLC on 2/19/14. Thirty had tooth-brushing SAPs and 11 had flossing SAPs. Reasons for individuals not flossing were listed, with some individuals having more than one reason: ▪ Behaviors – 18 individuals; ▪ Individuals frustrated with time required for flossing – five individuals; ▪ Dexterity challenges of individual – 18 individuals; ▪ Individuals needed improved brushing skills before introducing flossing SAPs - 25 individuals; and ▪ The Dental Department was considering proxy or flossing SAPs for 19 individuals at the time this information was collected. Fifty-three of 54 self-brushers had been assessed for proxy brush potential. <u>Pneumonia</u> In a document entitled: "ABSSLC Pneumonia Tracking for Dental Visits Q30," the Facility submitted a list of those with a diagnosis of pneumonia from 10/1/13 through 3/30/14, along with the date of the dental appointment prior to the pneumonia, and the procedure completed during that appointment. Of a list of 26 individuals that had pneumonia, three individuals had dental appointments within eight days prior to the date of the pneumonia diagnosis. One of these had already been admitted to the Infirmary and was acutely ill. None of the three had been administered anesthesia. One was a consult for meal refusal, and one was a consult for dental clearance in starting bisphosphonate therapy. For five of the 26, the dental visit date appeared to be an error, as the date provided in four of five was in the future and had not occurred. For one, there was a typographical error with too many numerals to represent a date. Tracking data should be reviewed for accuracy. <u>Preventive, Restorative, Emergency Dental Services</u> The Dental Department did provide the breadth of services required to care for the individuals at ABSSLC. From October 1, 2013 through April 17, 2014, 589 appointments were completed for prophylactic care. From a document entitled: "Clinical Summary Preventative Procedures SAMT Q3c," these visits occurred as prophylactic care only treatment or as a combination of other dental services (i.e., annual assessments, x-rays, topical fluoride treatment, etc.). The following was the breakdown per month of the number of prophylactic care treatments completed: | Month | # Prophylactic Care Treatments | | October 2013 | 96 |	

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November 2013	77
December 2013	108
January 2014	95
February 2014	72
March 2014	95
April 2014 (partial month data)	46
Total	589

Eighteen individuals underwent restorative care during 21 appointments. Three individuals completed two appointments each during which restorative procedures occurred. Fifteen individuals completed one appointment each during which restorative procedures occurred. Two individuals were new admissions. The following was the number of restorations completed at each visit, along with the number of visits in which this occurred:

# Restorations/Visit	# Visits	# Restorations/ Visit	# Visits
1	11	4	2
2	3	5	1
3	3	6	1
Subtotal	17	Subtotal	4
Total: 21 visits			

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

Month	# Visits	# Restorations per Visit	Total # Restorations for Month
October 2013	7	1-4	14
November 2013	2	1	2
December 2013	0	0	0
January 2014	6	1-6	17
February 2014	2	2-3	5
March 2014	4	1-3	7
Total	21		45

A submitted document entitled: "Dental Emergency Log" with updates through 4/22/14, documented the following information:

Month	# Emergencies	Resolved	Month	# Emergencies	Resolved
October 2013	6	6	February 2014	2	2

#	Provision	Assessment of Status	Compliance

November 2013	6	6	March 2014	0	0
December 2013	6	6	April 2014	2	2
January 2014	2	2	Total	24	24

Information was also provided indicating timely response to dental emergencies:

Month	# of Dental Emergencies	Seen Same Day	Seen Next Work Day	Month	# of Dental Emergencies	Seen Same Day	Seen Next Work Day
October 2013	6	4*	1	February 2014	2	2	0
November 2013	6	4**	1	March 2014	0	0	0
December 2013	6	4	2	April 2014	2	2	0
January 2014	2	2	0	Total	24	18	4

*There appeared to be a data entry error as the individual date of occurrence was recorded as 10/18/14, but the date of visit was 10/1/14. The timeliness (i.e., same day/next day) could not be determined.
**There appeared to be a data entry error as the individual date of occurrence was recorded as 11/20/14 and date of visit 11/19/14. The timeliness (i.e., same day/next day) could not be determined.

It was noted that the provider column needed to be updated.

From a document entitled: "Clinical Summary Data Extractions by date" (report generated 4/22/14), 27 individuals underwent dental extractions. The number of teeth extracted per individual ranged from one to 12 per visit. Twenty-seven individuals had 63 teeth extracted. The Facility indicated that four of the individuals that underwent extractions were new admissions. There were several individuals, however, that had resided at ABSSLC for greater than this time period that had multiple extractions. The Dental Director indicated that one main reason for tooth loss was the lack of quality tooth-brushing and/or adequate frequency of tooth brushing. As these interventions occur in the home, it will be important for the Dental Department to develop a plan to provide on-site teaching and monitoring in the home setting to individuals at risk for tooth loss.

#	Provision	Assessment of Status	Compliance

# Teeth Extracted	# Individuals	# Teeth Extracted	# Individuals
1	13	4	4
2	7	5	1
3	1	12	1

The following information provided the breakdown by visit and numbers of teeth extracted per visit:

Month	# Visits with Extractions	1 Tooth Extracted	2 Teeth Extracted	3 Teeth Extracted	4 Teeth Extracted	5 or More Teeth Extracted
October 2013	4	2	1	1	0	0
November 20	4	3	0	0	1	0
December 2013	1	0	1	0	0	0
January 2014	7	5	0	0	2	0
February 2014	8	4	2	0	1	1
March 2014	5	2	3	0	0	0
April 2014	1	0	1	0	0	0
Total	30 visits	16 teeth	16 teeth	3 teeth	16 teeth	12 teeth

From a submitted document entitled: "Scheduling AE and Recall Master All by Name," dated 4/22/14, 227 individuals completed an annual dental exam from October 1, 2013 through April 22, 2014. These annual exams were done as the only procedure, or were completed in combination with prophylactic treatment, x-rays, consultations, etc. The following number of annual exams were completed per month:

Month	# of Completed Annual Exams
October 2013	29
November 2013	30
December 2013	34
January 2014	29
February 2014	27

#	Provision	Assessment of Status	Compliance

March 2014	41
April 2014	37
Total	227

The submitted document required some assumptions and interpretation, as the column headings did not contain sufficient information. The information for some individuals contained two dates for the completion of annual exams, which made interpretation difficult. The latter date was taken as the date of completion, as the key or the notes column did not indicate a reason, and the assumption was there was an appointment with attempt, but the exam was not completed until the later date. Data reports should include clear explanations.

The table below contains information from this same document. However, for annuals completed in December, not all included a prior date of completion. For October and November 2013, no annual included a prior date.

Month	# of Completed Annual Exams within 365 Days of Prior Exam	# of Completed Annual Exams Past 365 Days of Prior Exam
October 2013	Information not available	
November 2013	Information not available	
December 2013	Information not available	
January 2014	29	0
February 2014	26	1
March 2014	37	4
April 2014	36	1
Total	128	6

Compliance in this clinical area was 122 of 128 (95%).

<u>Edentulous individuals/dentures</u>
Information submitted in a document entitled: "ABSSLC Individuals without Teeth" indicated 137 individuals residing at ABSSLC were edentulous, for a rate of 137 of 363 (38%). No individual became edentulous since the Monitoring Team's last visit. Data was reviewed to determine when the edentulous state occurred, and any long-term trend for this condition. When the individual became edentulous was provided, as well as if the individual was admitted edentulous:

Year	# Edentulous	Year	# Edentulous
2013	3	2004	13
2012	1	2003	8
2011	0	2002	10
2010	1	2001	12

#	Provision	Assessment of Status	Compliance

2010-2013 total	5	2000	9
2009	5	2000-2009 total	86
2008	4	1990-1999 total	23
2007	8	1980-1989 total	4
2006	10	1970-1979 total	4
2005	7	Edentulous on admission	15

Over half the current edentulous population became edentulous from 2000-2009. The current decade includes four years, and appears to be greatly improved from the prior decade.

From data submitted by the Dental Department, 10 of 137 individuals that were edentulous had dentures. Nine of these individuals had full dentures, and one had a partial denture. One hundred twenty seven individuals that were edentulous did not have dentures. Reasons given included the following:

- One hundred four had complex oral anatomy;
- Thirty-five inadequate muscle coordination, uncontrolled muscle movements, or excessive gag reflex;
- Sixty-two refused dentures when offered;
- One had prior poor dental experience;
- One had ongoing dental procedures that might lead to dentures in the future; and
- Some individuals had more than one reason listed for not having dentures.

<u>Oral Sedation</u>

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 of five (100%) confirmed nothing by mouth (NPO) status or nothing per G-tube at the time of the dental visit. All individuals were documented to need NPO status.
- Five of five (100%) listed the medication administered, the dose, and the route.
- Five of five (100%) listed pre-procedure vital signs in the home or documented attempts at pre-procedure vital signs. Vital signs were obtained for four individuals. A fifth individual refused vital signs.
- Five of five (100%) had an examination note/operative IPN/dental progress note (DPN) on the date of the visit.
- Four of four (100%) applicable cases documented pre-procedure vital signs at the dental office. One individual refused to go to the dental office.
- Four of four applicable cases documented intra-procedure vital signs or attempts at vital signs.
- Four of four (100%) applicable cases documented post-procedure vital signs.
- Adequate documentation regarding effectiveness of sedation was found in five of five

#	Provision	Assessment of Status	Compliance

(100%) of the active records.
- Five of five (100%) included a restraint checklist.

General Anesthesia/TIVA

The Dental Department submitted the general anesthesia/TIVA appointment schedule in an untitled document for FY 2014. From this information, the time period from October 2013 through April 2014 was reviewed. The number of appointments utilizing general anesthesia/TIVA completed per month was as follows:

Month	# Completed Visits with General Anesthesia/TIVA	# Scheduled Visits with General Anesthesia/TIVA Not Completed	Completed at Second Appointment	TIVA Appointment Not Completed
October 2013	4	1	1	0
November 2013	1	2	2	0
December 2013	5	2	2	0
January 2014	7	0	0	0
February 2014	8	0	0	0
March 2014	9	0	0	0
April 2014	3	0	0	0
Total	37	5	5	0

Thirty-seven of 42 (88%) completed the initial TIVA appointment. Several of the appointments were at off campus settings. Reasons for the five initial appointments not being completed included:
- One individual had a medical illness;
- Two appointments were cancelled by the oral surgeon/off campus dentist (reason not identified in document); and
- Two appointments were rescheduled due to medical records not scheduling the individuals for a history and physical exam in preparation for off-site dental work.

The active record was submitted for five individuals who had undergone general anesthesia/TIVA in the prior six months. The procedures under general anesthesia/TIVA

#	Provision	Assessment of Status	Compliance
		included one or more aspect of dental care. The list varied in each case, and included one or more of the following: tooth extraction, dental implants, and bridge preparation. Review of these records revealed the following: ▪ Consent by the guardian/LAR for the dental procedures/anesthesia was current (i.e., defined as completed and dated within 365 days of the procedure) in five of five (100%). ▪ A copy of the HRC review and approval was submitted in zero of five (0%). ▪ A pre-operative medical clearance was completed and submitted in five of five (100%) cases. ▪ Pre-operative vital signs were recorded in four of five (80%) cases. ▪ An operative note by the dentist was recorded in five of five cases (100%). ▪ The operative anesthesia record was submitted in four of five (80%). ▪ For those with teeth, a periodontal chart/periodontal screening record was submitted for zero of five. It was noted that these five appointments requiring general anesthesia/TIVA were for specific dental procedures and not for annual dental assessments and a periodontal chart/screening would not be expected to be completed unless part of annual dental assessments. ▪ The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score, Aldrete Score, or other equivalent assessment was submitted in five of five (100%) of the active records. ▪ A Dental Department note reviewing post-operative healing was submitted for five of five (100%). ▪ A post-operative vital sign flow sheet/recovery room record was submitted in five of five (100%). ▪ Documentation of orders for post-operative pain medication was submitted in one of three cases (33%) in which extractions occurred. The Dental Department indicated there were additional standing orders for pain management in two of three cases. This information indicated pain management orders occurred in three of three cases (100%). ▪ An annual dental assessment was completed while under general anesthesia/TIVA in zero of five cases. The Facility provided information concerning injuries reported within 24 hours of general anesthesia/TIVA administration. In the prior six months, there had been four cases of TIVA administration. None had generated injury reports. <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	

#	Provision	Assessment of Status	Compliance
		anesthesia/TIVA. ▪ For four of five cases, IV sedation/general anesthesia was used. One had only a local anesthetic. ▪ From one to two teeth were extracted at a visit. This is informational only. ▪ Documentation of post-operative pain medication was submitted in two of five (40%) cases. The Dental Department indicated that five of five had 180-day medication orders for pain management and new orders for analgesics were not needed. This information indicated pain management orders occurred in five of five (100%) cases. ▪ Submitted documentation of follow-up to determine healing or complications occurred in four of five (80%) of cases. For two individuals that underwent oral surgery consultation off campus, the dental record was submitted. The following findings were noted: Reasons for consultation included: abscessed tooth and retained roots. ▪ Two of two (100%) had completed IPNs/DPNs in the record prior to referral to the oral surgeon indicating the need for the procedure. ▪ Two of two (100%) had a post-procedure note dental IPN. ▪ Two of two (100%) included an oral surgery operative report. ▪ An anesthesia report (including medication and dosage administered) was submitted for two of two (100%). ▪ A copy of the current consent by the guardian/LAR was submitted for two of two (100%) of these oral surgeries. <u>Emergency Treatment</u> Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: SIB, difficulty sleeping, painful mouth, and broken abscessed tooth. The following findings are made based on this review: ▪ Five of five (100%) records documented the presence or not of pain. ▪ Follow-up occurred for two of two (100%) applicable cases. ▪ There was documentation of closure of the dental emergency (i.e., either no further visit required by the Dental Department or scheduled for procedure) in five of five (100%) cases. ▪ The length of time from the notification of the dental emergency in the Dental Department to completing a visit varied from less than 30 minutes to 17 hours. ABSSLC was substantially compliant with many of the requirements of Section Q.1. However, areas of noncompliance remained. Areas of focus need to be minimizing the time between the annual dental exam and the annual dental summary, which is used in the ISP process. Additionally, there is an urgent need for training and monitoring of tooth brushing in the residences. This is a necessary component of improving the dental health of those with poor oral hygiene. Many of the IRRFs of these individuals included twice daily tooth brushing, but	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>compliance with this task and the quality of tooth brushing during oral hygiene will require consistent monitoring. This will require additional dental staff hours to accomplish. 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. In addition, the Dental Department should track and analyze the cause for dental extractions (e.g., new admissions, trauma, etc.) to assist in determining common causes for which preventive strategies should then be developed, as appropriate. The Facility remained in noncompliance with this provision.</td><td></td></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td>This section of the report includes a number of subsections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications.

<u>Policies and Procedures</u>
The most recent revision of the "ABSSLC Dental Policy and Procedures" Manual was approved on 3/4/14. This revised the manual which had been previously updated 9/24/13. Included were a department organizational chart, dental professionals' participation in the IDT process, ISP attendance, standards of care, quality assurance, staff training in oral hygiene, vacuum tooth brushing, the use of medical restraints by the Dental Department, general anesthesia and oral sedation policy and procedures, informed consent, oral hygiene levels, various routine dental assessments, infection control, and an appendix compiling numerous applicable forms to be used providing dental services. This Manual appeared to be thorough and reflected the scope of dental practice at ABSSLC.

<u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u>
Information was submitted concerning use of restraints for dental procedures. For the prior six months (October 2013 through March 2013), there were 1,002 completed appointments. The dental office did not use mechanical restraints. Eight of 1002 (0.8%) of completed appointments utilized oral sedation. Thirty-two of 1002 (3%) completed appointments utilized general anesthesia/TIVA.

The following table lists this information by month:

<table>
<tr><th>Month</th><th>Completed Appointments</th><th># Appointments with TIVA/GA</th><th>% Appointments with TIVA/GA</th><th># Appointments with Oral Sedation</th><th>% Appointments with Oral Sedation</th></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

October 2013	204	4	2%	3	1%
November 2013	138	1	0.7%	0	0%
December 2013	147	5	3%	2	1%
January 2014	180	7	4%	0	0%
February 2014	159	8	5%	0	0%
March 2014	174	7*	4%	3	2%
Total	1002	32	3%	8	0.8%

*A separate submitted document for general anesthesia completed appointments indicated that there were nine completed appointments under general anesthesia. The reason for the discrepancy in submitted data was not determined.

Desensitization

A document entitled: "Historical Summary of Desensitization Programs up to 4/10/14" was submitted providing current information concerning desensitization and other behavioral programs to improve individual cooperation and compliance with dental visits.

- Eighty-one individuals had been identified as potentially benefiting from a desensitization program or other plan to reduce the need for dental restraint.
- Forty-five individuals had active plans.
- Twenty of these were active desensitization plans
- Nine were active residential strategies.
- Sixteen were active office strategies.
- Twenty-one plans were not active.
- Three residential strategies were not active.
- Three office strategies were not active.
- Data analysis of current desensitization plans indicated that 16 showed improvement.
- Data analysis of current desensitization plans indicated that 11 showed slight improvement.
- Data analysis showed three made no progress or inconsistent progress.
- Data analysis showed five plans were discontinued due to success.
- Data analysis showed 14 had been assessed or continued to be assessed.
- Data analysis indicated 15 individuals had moved.
- Data analysis indicated eight plans had been discontinued due to behaviors or regression.
- Five plans had recently begun and no trend analysis was available.

#	Provision	Assessment of Status	Compliance

- Based on analysis, plans (both inactive and active) for 29 individuals were revised.

The Dental Department recorded the progress on plan steps as follows:

Step	Description of Level	% of All Individuals with Desensitization Plans
	No improvement – requires sedation and/or general anesthesia	16%
1	Arrives at dental office and sits in dental or regular chair	4%
2	Allows blood pressure/O2	4%
3	Allows full mouth brushing	8%
4	Allows use of fingers to pull lips down and cheeks out	2%
5	Allows use of mirror to view mouth	10%
6	Allows scaling with plastic implant scale, metal scaler, or Cavitron	27%
7	Able to complete full treatment and scaling at one session	29%

The Dental Department measured changes in oral hygiene index in those with desensitization plans. Thirty-five percent of individuals with the current plans and strategies showed improvement in the oral hygiene index from the initiation of the plan to the current time. Thirty-nine percent of individuals with the current plans and strategies maintained their oral hygiene level (i.e., nine had remained with good oral hygiene, six had remained with fair oral hygiene, and four had remained with poor oral hygiene). Twenty-six percent of individuals regressed in their oral hygiene level.

Changes in gingivitis were recorded from a baseline to the current status in those with desensitization plans and strategies. The following represents the change over time:

Baseline Gingivitis Level	Current Gingivitis Level	# Individuals
None	None	4
Mild	Mild	22
Moderate	Moderate	3
Severe	Severe	3
Moderate	Mild	4
Mild	None	6
Mild	Moderate	2

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Moderate	Severe	2
None	Moderate	1
None	Mild	2

Baseline Periodontitis	Current Periodontitis	# Individuals
None	None	23
Mild	Mild	7
Moderate	Moderate	4
Severe	Severe	1
Moderate	Mild	0
Mild	None	1
Mild	Moderate	2
Moderate	Severe	2
None	Moderate	0
None	Mild	7
Mild	Severe	1
Severe	Moderate	1

A document with updated desensitization/behavioral plan status/progress was provided during the Monitoring Team's visit. The following information was derived from this updated information:

- A desensitization/other behavioral plan was considered appropriate for 73 individuals. This included 19 active formal desensitization plans, 24 active residential and/or office strategies, six formal plans discontinued due to success, eight formal plans discontinued due to no improvement or regression, and four had strategies, three plans were declined for other reasons (i.e., became edentulous, etc.), one plan was declined by the LAR, one individual was subsequently deceased, and 15 moved from ABSSLC.
- A desensitization/other behavioral plan was considered inappropriate for 12 individuals. Eight formal plans were discontinued due to no improvement or regression. Three formal plans were discontinued for other reasons (i.e., became edentulous, health issues) and the LAR declined one formal plan.
- Twenty-four individuals had a desensitization/other behavioral plan in draft stage.
- Six individuals had a desensitization/other behavioral plan completed. These plans were then discontinued. For successful office strategies, these were kept in place.
- Forty-three individuals had a desensitization/other behavioral plan implemented.
    - As of 5/12/14, it was noted six plans had been implemented one to three months, three plans had been implemented four to six months, and 34 plans had been implemented longer than six months.
- Forty-five individuals had a desensitization/other behavioral plan in which data was analyzed and results were available.

#	Provision	Assessment of Status	Compliance
		▪ Seventeen individuals had a desensitization/other behavioral plan revised based on analysis of collected data due to lack of progress/regression. Eleven were formal plans and six were strategies. ▪ Twenty-eight percent of individuals with a desensitization plan/other behavioral plan made progress. ▪ Thirty-seven percent of individuals with a desensitization plan/other behavioral plan made variable progress. ▪ Thirty-five percent of individuals with a desensitization plan/other behavioral plan made no progress. ▪ Fifteen individual with an implemented desensitization/other behavioral plan had moved to the community. Ten of these had formal desensitization plans. Five had written office/residence strategies. Thirteen of these 15 moved to the community and two moved to other state SSLCs. The dental desensitization continued to have a positive impact on dental services with a number of successful outcomes. It was not clear the criteria used in determining which individuals are referred for screening for potential benefit/impact from a desensitization program. There continued to be a list of individuals not reviewed or assessed but without plans and/or strategies for desensitization. The number of individuals in this non-assessed category that might benefit from desensitization or other plans was not provided in submitted data. The current staff hours assigned to desensitization plans was insufficient to meet the needs of these individuals residing at ABSSLC. <u>Quality Assurance/Improvement Initiatives</u> The QA/QI Department used the following monitoring tools to review the quality and completeness of dental care: "ABSSLC Texas Health Monitoring Instrument," revised 11/1/12. From the 3/25/14 "Monthly Meeting Notes for the Dental Department," the QA process was described as follows: "Dental records of all individuals were eligible to be sampled. Each month the clinical dentist reviewed a random sample of 10 dental records. The Dental Director and the QA Department Monitor reviewed a smaller subset of three dental records. Inter-rater reliability computations were completed monthly by the QA Department based on the review of three charts by the QA Department and Dental Department." The impact on the QA process of losing the clinical dentist was not described, because the clinical dentist was to review the random sample of 10 dental records. Information provided at the 3/25/14 meeting indicated that the clinical indicators achieved 100 percent in all areas, and inter-rater reliability was 100 percent. Several graphs were submitted. A graph entitled: "Overall compliance by month 10/1/13 – 3/31/14" indicated 100 percent for each month through February 2014. Compliance was also graphed by individual record audited, residence, and monitoring tool question. A copy of the monitoring tool was not submitted, so the Monitoring Team was not able to interpret specific questions as only numbers were used as labels. However, compliance was 100 percent.	

#	Provision	Assessment of Status	Compliance
		A bar graph also was provided for "Inter-rater reliability per month. Q: Dental Services 10/1/13 – 3/31/14." Inter-rater reliability was 100 percent for October 2013, November 2013, and December 2013. Inter-rater reliability was 99 percent in January 2014, and 98 percent in February 2014. Inter-rater reliability was 100 percent in March 2014. The Dental Department met monthly to review findings with the Program Compliance Monitor assigned to the Dental Department. Meetings occurred on 10/29/13, 11/6/13, 1/28/14, 2/20/14, and 3/25/14. Repeatedly, the minutes indicated: "the focus of the meeting was directed towards the monitoring tool which is not useful." There was also documentation that a new monitoring tool for the Dental Department would be implemented as of June 2014. There was one corrective action plan dated 3/10/14, with the goal that the annual dental summary and the IRRF would have current information. At the Monitoring Team's last visit, it was noted that the annual dental assessments were completed up to one year prior to the annual dental summary created for the ISP process. The new CAP indicated the goal of completing annual dental assessments within nine months of the annual dental summary. However, considerable change can occur in oral health in a nine-month interval. It is recommended that a goal be established across the SSLC system, taking into consideration that it would be most helpful to the IDT and to the individual to have a current assessment completed within 30 to 60 days prior to the ISP date. For those exams, which occurred over a 60-day window, an additional annual assessment might be needed to ensure current information is available to the IDT. This is a significant challenge currently to ABSSLC with only one dentist in the Dental Department. Additionally, the content of the annual dental assessment is adapted into an annual dental summary, which is forwarded to QIDP at least 10 days prior to the ISP date. The narrow window of time adds an additional challenge in providing updated information. <u>Internal Dental Department Quality Reviews</u> The results of the Facility's implementation of the Monitoring Tool appeared to provide evidence of maintenance of quality of many areas of dental services. However, it did not appear sufficiently sensitive to challenge the Dental Department toward continuous improvement, or identify areas in which concerns continued to exist based on the Monitoring Team's review. For clinical indicators that were 100 percent compliant repeatedly, these may need to be removed or sampled at infrequent intervals and replaced with other clinical indicators. 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 (i.e., for non-traumatic reasons and excluding impacted wisdom teeth) per quarter, the rate of new caries in the quarter, the numbers of individuals per category of gingivitis/periodontitis (i.e., none, mild, moderate, severe) per quarter, and the number of permanent fillings needing restoration/replacement at 12 and 24 months.	

#	Provision	Assessment of Status	Compliance
		A considerable gap in monitoring was observing the quality of the tooth brushing in the residence, both by individuals, and when assisted by direct support professionals. The IRRFs repeatedly mentioned the need for twice daily brushing, and there was also discussion of the need for further training of the direct support professionals in assisting individuals with poor oral hygiene. A home tooth brushing monitoring tool might be needed, as quality oral hygiene is essential in preventing tooth loss and need for restorations. The dental QA process included use of the ABSSLC Dental Database (the old database) and had been updated continuously since 1/1/2009. This old database continued to allow full reporting of information entered. A new database (i.e., ABSSLC Dental Care Tracking) had data for the time period 10/1/12 through 8/31/13, but no accurate reporting had occurred from this database, and data entry has since been suspended.	

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 Facility policies, procedures and/or other documents addressing the provision of speech and/or communication services and supports; o Continuing education and/or other training completed by SLPs over the past 12 months, including agenda and certificate(s) of completion for each staff member who attended, and CEUs/contact hours completed; o List of current SLP and audiology staff, including contract staff, including titles, caseloads (including residence(s) and number of individuals) and license number, proof of ASHA certification, and curriculum vita; o Total number of SLP allocated positions, current allocated SLP positions filled, and SLP vacancies; o Communication Assessment Master Plan List with date of completed assessment, and any revisions to the priority levels; o Communication comprehensive assessments and/or screening for individuals newly admitted to the Facility since the last review, including the date of admission. o Facility Speech Language comprehensive assessment, assessment update, and any other assessment template(s) used by SLPs, including the most current date of revision; o Current communication monitoring forms(s) with any changes highlighted; date of implementation of the forms; monitoring form instructions with any changes highlighted; list of staff (with titles) responsible for monitoring; monitoring schedule; and monitoring schedule for individuals at high risk; o List of approved communication trainers for communication foundational training; and o List of approved communication trainers for communication non-foundational training. ▪ **Interviews with:** o Bobbie Holden, OTR, Director of Habilitation Therapies; o Donna Boulette, MS, CC/SLP/A, PNMT SLP; and o Leslie Riggins, SLP Assistant. ▪ **Observations of:** o No observations completed during this review due to influenza outbreak.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 4/28/14. 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 tools the Facility used to conduct its self-assessment included: the Section R: Communication Monitoring tool, revised 1/2013, and Facility-developed audit tools and HT databases.

	○ The monitoring tool and audits included adequate methodologies (e.g., observations, record review, and staff interview). ○ 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. ○ The Facility-based audit tools (i.e., SLP assessment audit tool) did not have adequate instructions. ○ The following staff/positions were responsible for the Settlement Agreement Monitoring Tool for Section R: the Director of HT, SLPs, and PCM. ○ Adequate inter-rater reliability had not been established between the Director of HT, SLPs, and the PCM. ○ The Facility used some other relevant data sources, including, for example, 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: ○ 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 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. For these areas of need, the Facility Self-Assessment provided minimal analysis of the information. However, based on the limited analysis, the Facility connected some of 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 Speech Language Pathologists (SLPs) and one full-time Speech Language Assistant (SLA). There was one SLP vacancy. Due to limited progress, the Monitoring Team conducted a streamlined review of most of Section R. Review of the Facility-selected sample of three individuals' SLP/communication assessments revealed that 16 of 23 assessment elements were present in each of the assessments reviewed. The Facility's Provision Action Information, Presentation Book, and staff interviews indicated the Facility made the following progress: developed a schedule for SLP evaluations to be completed; continued to utilize the assessment audit tool to ensure assessments contained essential elements; the Habilitation Therapy (HT) Director met with the QA Director to implement new database tracking SLP assessments and PBSPs to determine collaboration between SLPs and Behavior Health Specialists (BHSs); and SLPs presented new training for the communication portion of New Employee Orientation (NEO) to Occupational Therapists (OTs) and Physical Therapists (PTs) for feedback, and began teaching the new training of the communication portion of NEO.

#	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. 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 #388, Individual #7, and Individual #253. **Update** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section R.1: ▪ 12/15/13 – Began analysis of self-assessment; and ▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section R.1 included an action plan with the following action steps and completion status: ▪ Revise/update SLP policy (completion status - not started); This action step was applicable to achieving compliance with Section R.1. 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 four full-time SLPs and one SLA. There was one SLP vacancy. The Facility assigned caseloads based on the requirements of the job and the acuity of the individuals in relation to SLP needs [e.g., alternative and augmentative communication (AAC) systems. However, the process of assigning caseloads was not memorialized in policy and/or procedure. The SLP caseloads were: ▪ SLP #1 – 84 individuals; ▪ SLP #2/PNMT SLP – 80 individuals; ▪ SLP #3 – 115 individuals; and ▪ SLP #4 – 83 individuals. 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,	Noncompliance

#	Provision	Assessment of Status	Compliance
		including meal observations, etc. The SLPs supervised the SLA. The SLA assisted with direct therapy, was the Educational Liaison for ABSSLC for school-aged individuals, and provided assistance with the Plan of Improvement. **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** Five of the five 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: ▪ Annual Habilitation Therapies Conference: Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/31/13 to 11/1/13); ▪ Eat, Breathe and Move (11/22/13 to 11/23/13); ▪ Low Tech AAC Options and Practical Strategies for Classroom Use (1/12/14); ▪ Legal and Ethical Implications of Professional Practice: When Bad Things Happen to Good People (1/12/14); ▪ Dysphagia in Patients at the End of Life (1/12/14); ▪ Decision-Making for Alternate Nutrition and Hydration: Part 1 and Part 2 (1/12/14); and ▪ Dementia Management – Advanced Skills for the Health Care Practitioner (4/1/14). **Facility Policy** The Facility submitted the following policies: ▪ SSLC Policy: Communication Services, not dated; and ▪ Draft SSLC Policy: Indirect Supports/Programs for AAC. 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	

#	Provision	Assessment of Status	Compliance
		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 Office 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 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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample the Facility selected) for this subsection. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section R.2: ▪ 11/4/13 – Developed a schedule for SLP evaluations to be completed; ▪ 1/31/14 – Continuing to utilize assessment audit tool to ensure assessments contain all essential elements; ▪ 2/14/14 – Met with QA Director to implement new database tracking SLP assessments and PBSPs to determine collaboration between SLPs and BHSs; ▪ 3/10/14 – Began auditing SLP assessments and BSPs to determine collaboration between the SLPs and the BHSs; and ▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section R.2 included an action plan with the following action steps and completion status:	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Utilize assessment audit tool to ensure assessments contain all essential components, including collaboration between the SLP and Psychologist (in process). This action step was relevant to Section R.2, and should assist the Facility in working towards achieving substantial 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 updated and/or revised to reflect the current status of the provision of communication services and supports. **Communication Assessments Provided** During the next review, the following will be reviewed for individuals newly admitted to ABSSLC: ▪ ___ of ___ admitted individuals since the last review (%) received a communication screening or assessment within 30 days of admission or readmission. ▪ If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening, received a comprehensive communication assessment within 30 days of identification. **Communication Assessment** The Facility Self-Assessment reported 325 of 363 (90%) individuals had a comprehensive SLP assessment. This was an improvement from the last review at which time 293 of 385 (76%) individuals had a comprehensive SLP assessment. 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 three individuals' SL assessments (0%) were dated as completed at least	

#	Provision	Assessment of Status	Compliance
		10 working days prior to the annual ISP; ▪ 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; ▪ Three of three individuals' SL assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels; ▪ Two of three individuals' SL assessments (67%) (i.e., Individual #7 and Individual #253) 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); ▪ Three of three individuals' SL assessments (100%) 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, and necessary changes as required for individuals who did not communicate verbally; ▪ 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 three 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; ▪ 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 #7 and Individual	

#	Provision	Assessment of Status	Compliance
		#253) 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 #7 and Individual #253) 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 assessments (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; ▪ None of the three individuals' SL assessments (0%) supplied a monitoring schedule; ▪ Two of three individuals' SL assessments (67%) (i.e., Individual #7 and Individuals #253) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. For these individuals, the SLP assessment analysis section provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs; ▪ 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.	

#	Provision	Assessment of Status	Compliance
		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 individuals' assessments. Sixteen of the 23 assessment elements were present in each of the three assessment reviewed. **SLP and Psychology Collaboration** Based on interview with the Director of HT, SLPs were not attending the Behavior Support Committee. The SLPs had initiated audits of SLP assessments and PBSPs to assess collaboration between SLPs and Behavioral Health Specialists. The Self-Assessment reported that two of five communication assessments addressed the connection between the PBSP and the recommendations contained in the communication assessment. The Self-Assessment indicated audit data was to be presented to the QA/QI Council. An Edible Reinforcer Approval form had been developed to ensure individuals who received edible reinforcers were presented with the correct diet texture. The Behavioral Health Specialist and Registered Dietician completed this form, with the Director of HT conducting a final review. The implementation of this form should assist in ensuring individuals were not placed at risk by receiving reinforcers that were not compatible with their prescribed diet texture. 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. ▪ ____ of ____ individuals' communication assessments (%) contained evidence of review of the PBSP by the SLP. In addition to continuing to address the areas of the assessments still needing improvement, 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 parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section R.3: ▪ 2/7/14 – SLPs presented new training for communication portion of NEO to OTs and PTs for feedback;	Noncompliance

#	Provision	Assessment of Status	Compliance
	the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	▪ 3/11/14 – Began teaching the new training of the communication portion of NEO; and ▪ 4/24/14 – No other 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 (not started); ▪ Re-assess the functionality of general-use AAC devices in residences and other environments (not started); and ▪ Place pictures related to positioning of AAC system on the mobility device/bed into the PNMP (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. **<u>Integration of Communication in the ISP</u>** During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____ISPs reviewed (%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. ▪ ____ 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. **<u>Development and Implementation of Functional Individual-Specific Assistive Communication Systems</u>** During the Monitoring Team's next review, the following will be reviewed:	

#	Provision	Assessment of Status	Compliance
		▪ ____ 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** There was an action plan to re-assess the functionality of general-use AAC devices in residences and other environments. The completion status of this action step was "not started." **Direct Communication Interventions** 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. **Competency-Based Training and Performance Check-offs** Based on interview, a Facility SLP had developed a training curriculum for communication core competencies. Beginning on March 11, 2014, this training was integrated into NEO. This training included the following content areas:	

#	Provision	Assessment of Status	Compliance
		▪ Methods to enhance communication; ▪ Implementation of programs; ▪ Benefits and use of AAC systems; and ▪ Identification of non-verbal means of communication. Habilitation Technicians and PNMP Coordinators were identified as approved trainers for communication foundational training. **Individual-Specific Competency-Based Training** The Facility Self-Assessment stated: "all required staff received individual competency based training as needed for 2/2 items issued." This statement did not provide sufficient information to assess if all required staff had successfully completed individual-specific competency performance check-offs. 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 to have successfully completed individual-specific competency-based training and performance check-offs (n). During the Monitoring Team's next review, the following will be reviewed: ▪ ____ of ____individuals' staff (%) had received individual-specific training. In summary, the Facility had integrated communication core competencies training curriculum in NEO. Additional work will be needed to ensure veteran staff complete the communication core competencies curriculum and successfully pass performance check-offs. The Facility will have to provide individual-specific training documentation, and identify the total number of staff (N) required to complete the training and the total number of staff to have successfully completed individual-specific competency-based training and performance check-offs (n). The Facility remained out of compliance with this subsection.	
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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., updates only) for this subsection. The noncompliance finding from the last review stands. **Updates** The ABSSLC Provision Action Information, updated 4/28/14, reported the following for Section R.4: ▪ 11/15/13 – Revised Section R monitoring tool; ▪ 12/11/13 –Met with SLPs and PCM to approve Section R monitoring tool; ▪ 1/2/14 – SLPs and PCM began utilizing Section R monitoring tool; and ▪ 4/24/14 - No other initiatives started since last visit. The Presentation Book for Section R.4 included an action plan with the following action	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	steps and completion status: ▪ Implement schedule for monitoring persons with AAC systems to ensure their equipment is functional and adaptable to a variety of settings and that such systems are readily available to them (efficacy monitoring) (not started); and ▪ Implement monitoring schedule for those with AAC systems 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 toward achieving substantial compliance with Section R.4. **<u>Monitoring System</u>** Facility staff reported there was a monthly schedule for monitoring individuals' AAC devices. Individuals at high risk were also monitored monthly. Habilitation Technicians and PNMP Coordinators were responsible for monthly AAC monitoring. However, 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 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. Facility staff 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 at entrance meeting, on 5/12/14; o Section S Presentation Book; o Self-Assessment for Section S, dated 4/8/14; o Completed Section S Monitoring Tools for: Individual #282, Individual #347, Individual #526, Individual #21, Individual #467, Individual #523, Individual #278, Individual #71, Individual #54, Individual #519, and Individual #103; o Individual Support Plan for: Individual #280, Individual #517, Individual #334, Individual #196, Individual #276, Individual #505, Individual #545, Individual #24, Individual #256, Individual #430, Individual #397, Individual #525, Individual #447, Individual #59, Individual #327, and Individual #182; o Skill Acquisition Plans and Data Sheets for: Individual #280 (meals, ride bike), Individual #517 (reading, delivering mail), Individual #334 (calendar, write name in cursive), Individual #196 (toileting, folding clothes), Individual #276 (play DVD, use remote), Individual #505 (make drink, cross street), Individual #545 (rinse body, choose snack), Individual #24 (make bed, brush hair), Individual #256 (identify the day, trust fund withdrawal), Individual #430 (work continuously, problem solving), Individual #397 (washing clothing, conversation), Individual #525 (blood pressure check, choose CD), Individual #447 (name item, cut out shape), Individual #59 (make jewelry, count coins), Individual #327 (identify numbers, stack washcloths), and Individual #182 (paint nails, conversation); o Preferences and Skills Inventory for: Individual #280, Individual #517, Individual #334, Individual #196, Individual #276, Individual #505, Individual #545, Individual #24, Individual #256, Individual #430, Individual #397, Individual #525, Individual #447, Individual #59, Individual #327, and Individual #182; o Functional Skills Assessment Summary for: Individual #280, Individual #517, Individual #334, Individual #196, Individual #276, Individual #505, Individual #545, Individual #24, Individual #256, Individual #430, Individual #397, Individual #525, Individual #447, Individual #59, Individual #327, and Individual #182; o Vocational Assessment for: Individual #280, Individual #517, Individual #505, Individual #256, Individual #430, Individual #397, Individual #447, Individual #327, and Individual #182; o Vocational Services Department Report (10/1/13 to 3/31/14); o Monthly Reviews (1/14 to 3/14) for: Individual #59; o Monthly Reviews (2/14 to 4/14) for: Individual #280, Individual #196, Individual #276, Individual #505, Individual #430, Individual #397, and Individual #327; o Monthly Reviews (3/14 to 5/14) for: Individual #334 and Individual #447;

	○ Monthly Reviews (1/14, 3/14 to 4/14) for: Individual #517; ○ Monthly Reviews (1/14 and 4/14) for: Individual #525; ○ Monthly Reviews (3/14 and 4/14) for: Individual #182; ○ Monthly Review (5/14) for: Individual #256; ○ List of community outings per residence for November 2013 through April 2014; ○ Formal skill training provided in community settings; and ○ Community Activity Satisfaction and Skill Acquisition Program Report, dated 4/8/14. ▪ **Interviews with**: ○ Direct Support Professionals, on 5/12/14; ○ Ellen Rogers, QIDP Educator; Yvonne Chambers, Settlement Agreement Liaison QIDP; Jeff Branch, Director of Active Treatment; and Jolene Willis, Assistant Director of Programs, on 5/13/14; and ○ Candia Hallford, Vocational Services Coordinator, and Debbie Pierce, Workshop Supervisor, on 5/14/14. ▪ **Observations of**: ○ Center Incident Management Review Team, on 5/12/14; ○ Individual Support Plan Meeting for Individual #4, on 5/13/14; ○ Behavior Support Committee, on 5/14/14; ○ Restraint Reduction Committee, on 5/15/14; and ○ Internal Peer Review Committee, on 5/15/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 4/28/14. 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/auditing tools. The Facility had recently revised the Section S Monitoring Tool, dated 2/14/14. In conducting its self-assessment, this tool was used to review assessments, Individual Support Plans, and Skill Acquisition Programs for a sample of individuals. ○ The sample size was not identified in the Self-Assessment. ○ The following staff were responsible for completing the monitoring tools: the Director of Active Treatment, the QIDP Coordinator, the QIDP Educator, the Settlement Agreement Liaison QIDP, and two Active Treatment Coordinators. ○ Inter-rater reliability was determined through monitoring by a Program Compliance Monitor from the Quality Assurance Department. ▪ The Facility also utilized a Planned Activity Check tool to assess active engagement across the campus. ○ The Facility reported that 1768 audits had been completed between 10/1/13 and 2/28/14. ○ The following staff completed planned Activity Checks: Home Supervisors, QIDPs, Home Activity Specialists, and Day Program Managers. ○ Inter-rater reliability was not assessed.

	○ This tool had been revised as of 4/3/14 to more accurately measure engagement by using momentary time sampling. Therefore, the data that was presented most likely reflected inflated engagement scores, as the previous tool utilized long observation periods during which any moment of activity would indicate engagement. ▪ The Facility also presented results of monitoring conducted regarding skill acquisition implementation. ○ The following staff conducted monitoring: Home Supervisors, QIDPs, Home Activity Specialists, and Day Program Managers. ○ The total number of audits was not identified. ○ Inter-rater reliability was not assessed. ○ This tool, Skill Acquisition Training Monitoring Tool for SAP to Learn, had been revised on 4/3/14. ▪ The Facility did consistently present data in a meaningful/useful way. ▪ The Facility rated itself as being out of compliance with all of the subsections of Section S. This was consistent with the Monitoring Team's findings. However, of concern, many of the indicators included in the Self-Assessment showed high levels of compliance, which was not consistent with the Monitoring Team's findings. In reviewing the Monitoring Team's report, the Facility should attempt to determine the reason for this discrepancy.
	Summary of Monitor's Assessment: A review of documents, observation of an Individual Support Plan meeting, and discussions with staff revealed a continued limitation to habilitation planning and implementation. Too often skill acquisition programs were continued from one year to the next, opportunities for instruction were limited, problems with program implementation were not identified or addressed in a timely manner, and the individual's preferences and strengths were not adequately addressed. Assessments were not utilized to identify a range of skill needs for the individual. ISPs were limited with regard to the number and scope of training objectives designed to help the individual grow and develop his/her skills and independence. Opportunities for instruction were severely limited and reinforcement for correct responding was not individualized. In addition, training in the community was extremely limited. Many of the concerns raised in past reports remain relevant. For these reasons, the Facility remained out of compliance with all subsections of Section S.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill	The most recent Individual Support Plan was reviewed for 16 individuals. ISP meetings were held between 10/4/13 and 3/4/14. It should be noted that the date of the meeting was not identified in the ISP for Individual #59. A summary of findings is provided below. ▪ All of the ISPs (100%) included a review of the individual's preferences and strengths. ▪ In four of the 16 ISPs reviewed, the individual was identified as requiring pretreatment sedation for medical and/or dental exams. However, only the	Noncompliance

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	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.	team for Individual #196 (25%) had identified and approved this rights restriction. ▪ A total of 81 training objectives were identified in the 16 ISPs, with a range of two to seven objectives per individual. o The identified training schedule was as follows: 27 objectives (33%) to be trained daily; four objectives (5%) to be trained five days per week; one objective (1%) to be trained four days per week; 46 objectives (57%) to be trained once per week; and three objectives (4%) to be trained once per month. It is concerning that the majority of identified SAPs were going to be trained only once each week. As has been noted in the past, dense schedules of training are recommended to ensure skill acquisition. o The community was identified as a possible training environment for only 11 of the 81 objectives (14%). While most of these involved skills appropriate for the community, at least two were better addressed in one's home (e.g., hair brushing) or were specific to the Facility (e.g., trust fund withdrawal). For eight of the 16 individuals (50%), there were no community-based SAPs. o None of the 81 SAPs (0%) were described in observable and measurable terms. o Of the 81 objectives included in the 16 ISPs, 59 (73%) matched recommended skill acquisition plans identified in the individual's Functional Skills Assessment. Regrettably, 34 of these 59 SAPs (58%) had been continued from the previous year's ISP. Members of the Monitoring Team attended the ISP meeting held for Individual #4. In general, there was limited participation by those in attendance. When discussing the Individual Risk Rating Form, only the staff member from the Psychiatry Department challenged a low rating in the area of falls, despite the fact that she had experienced a significant injury during a fall. Several problems were noted when it was time to identify habilitation planning for the coming year. Data was not referenced when reviewing the individual's progress on the previous year's objectives, and there was no clear reference to assessments that had been completed to help identify skill needs or training objectives. Initially, the Active Treatment Coordinator recommended continuing all of the skill acquisition programs from the previous year. When there was further discussion, it was recommended that the individual learn to identify the times she received her medication, although she had clearly identified these times when asked. Overall, the planning for the coming year was very limited and restricted to a few areas of skill development. A total of 32 SAPs and accompanying data sheets were reviewed. This represented two	

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		plans for each of the 16 individuals in the sample. A summary of the findings is provided below. ▪ The lesson plan included the specific target behavior, general instructions, the teaching method, materials, and training steps. Information regarding the schedule of training, the prompting sequence, consequences for correct and incorrect responding, and plans for maintenance and generalization was found on the data sheets. It is recommended that all of this information be noted in the actual lesson plan. ▪ In 31 of the 32 SAPs (97%), the objective identified the conditions under which an observable and measurable behavior was to occur. The exception was the conversation SAP for Individual #182. ▪ None of the 32 SAPs (0%) included a clear mastery criterion. Thirty-one of the 32 SAPs identified an expected number of completed trials within "the reporting period," however this reporting period was not identified. ▪ A task analysis was not necessary in 16 of the 32 SAPs. Where appropriate, a task analysis was adequately identified in 14 of the remaining 16 SAPs (88%). The exceptions were the mealtime SAP for Individual #280 and the DVD SAP for Individual #276. It was unclear how Individual #280 was to learn a consistent routine of interspersing sips of liquids between bites of food when he was reliant on staff instruction. The task analysis for Individual #276 consisted of one step only, although it is clear that multiple steps are required to load and play a DVD. ▪ Twenty-six of the 32 SAPs indicated that one of two types of chaining techniques was to be employed when training the skill. Twenty of the 26 SAPs identified forward chaining, with backward chaining identified in the remaining six SAPs. It should be noted that 10 of the 20 SAPs that identified forward chaining referenced skills that were not behavioral chains. These programs represented either a discrete event, such as making a choice or naming an object, or a shaping program in which the individual was to engage in an activity for an increasingly longer period of time. As has been noted previously, when teaching a behavioral chain, it is best to guide the learner through all steps in the chain as they learn to independently complete identified training steps. This allows the individual to learn the entire chain with each link or step serving as the discriminative stimulus or cue for performing the next link or step in the sequence. Several SAPs mistakenly guided the trainer to complete all steps in the chain prior to instructing the learner to complete the training step only (e.g., Individual 196 – toileting, Individual #505 – make a drink, Individual #545 – rinse body, Individual #24 – make bed and brush hair, and Individual #397 – laundry). ▪ Six of the 32 SAPs identified either a discrete trial teaching technique or a shaping procedure. ▪ Necessary materials were adequately identified in 27 of 30 SAPs (90%). ▪ The schedule for training varied widely across SAPs. Training was scheduled to	

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		occur daily in nine SAPs (28%), six times per week in two SAPs (6%), five times per week in nine SAPs (28%), four times per week in two SAPs (6%), three times per week in four SAPs (13%), twice per week in three SAPs (9%), and once per week in three SAPs (9%). Only three of the 32 SAPs (9%) identified more than one daily trial on scheduled training days. Two of these specified twice daily training opportunities and one indicated training should occur at all meals. As noted in the past, it is important to provide sufficient opportunities for individuals to learn new skills. ▪ Only two of the 32 SAPs (6%) noted that training could occur in the community. This was not formally scheduled however. ▪ In 18 of the 32 SAPs (56%), praise alone was the identified reinforcer for correct responding. As has been noted in the past, praise does not always function as a reinforcer. It may be dependent upon the relationship the individual has with the person delivering the praise, or it may not be sufficiently motivating for the individual to learn a new and possibly difficult skill. ▪ All of the SAPs (100%) provided guidelines to follow when the individual did not respond correctly. Typically this consisted of providing a more intrusive prompt. ▪ Similarly, while all of the plans (100%) included a section that reviewed teaching techniques, some were clearer than others. o The guidelines provided to help Individual #505 learn to make a drink clearly outlined the steps in the sequence. o The SAP designed to teach Individual #256 to learn to identify the day of the week included instructions regarding any scheduled appointments and days free of restraint. This did not correspond to the objective. o The SAP for problem-solving for Individual #430 did not provide clear teaching guidelines. o It was unclear how staff were to teach Individual #182 to engage in conversation with her peers. ▪ Twenty-one of the 32 SAPs (66%) included adequate plans for maintenance and generalization. There was a lack of specificity when general case instruction was identified as the planned strategy for promoting generalization. ▪ Thirty of the 32 SAPs (94%) included the implementation date. The exceptions were the SAPs for Individual #24. As reported by the Director of Active Treatment, the Active Treatment Coordinators developed the SAPs and then trained direct support professionals through role-play. It might be helpful if the training could take place with the individual so that problems can be identified immediately. Direct support professionals with whom the Monitoring Team met reported that the person who develops the SAPs is not always familiar with the individual and when problems arise, he/she cannot always advise these staff regarding	

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		the best solution. The Facility had revised its Skill Acquisition Training Monitoring Tool for SAP to Learn, effective 4/3/14. No data was presented utilizing this revised tool. 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. <u>Engagement</u> Due to an outbreak of the flu, the Monitoring Team made the decision not to tour the homes and day program sites. As a result, engagement measures were not collected during this visit. During the Monitoring Team's last visit, a member of the Monitoring Team had conducted side-by-side assessment of engagement with Facility staff. Discussion followed regarding the expectation that Planned Activity Checks (PLACHECK) reflect a momentary time sample measurement system. As a result, on 4/3/14, the Facility had revised its PLACHECK tool. Instructions now guided staff to observe individuals "momentarily (a snapshot)" to assess engagement, although this was not specifically defined. No data was presented utilizing this revised tool. A report of activities completed by the Vocational Services Department noted that as of 3/31/14, 122 individuals were involved in employment activities. Campus-based jobs included laundry contracts, shredding contracts, employment in the diner or at food services, and participation in new employee orientation. Other individuals participated in recycling, janitorial work, mail or chart delivery, and on-campus gardening. There was one community-based job site involving janitorial work. At the time of the visit, no one was competitively employed. Job exploration continued on campus for those individuals already employed. Situational assessments were completed for 22 individuals who did not work. Since the Monitoring Team's last visit, the Facility had made limited progress in initiating changes to enhance habilitation services. For the reasons noted above, ABSSLC 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,	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	Noncompliance

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	skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	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 16 individuals in the sample were reviewed. A summary of findings is provided below. ▪ Sixteen of the PSIs (100%) were dated. Based on the information provided, 13 of 16 (81%) had been completed prior to the individual's ISP meeting. The exceptions were Individual #276 whose PSI was revised the day after his ISP meeting, Individual #24 whose PSI was completed on the same day as her ISP meeting, and Individual #59 whose ISP was not dated. It was concerning that the PSI for Individual #280 had been completed almost a full 12 months before his ISP meeting, given that preferences and strengths might have changed over the year. ▪ Questions regarding future living options, employment, relationships, leisure skills, and independence were addressed in all of the PSIs (100%). The breadth of the information provided was generally very limited. When the response to a question is left blank or is noted to be not applicable, it suggests that little effort was applied to understand the person's preferences. Questions about learning new activities or accomplishments over the previous year should be answered. ▪ When providing answers to the questions posed, staff were to indicate how this information was provided. While some reports noted responses by the individual, staff interview or observations, and/or historical information, only four of the PSIs (25%) noted the method used throughout the document. Five of the PSIs (31%) provided no information regarding the method employed to determine the answers to the questions. ▪ A brief summary of preferences and strengths was provided for all 16 individuals (100%). Again, the breadth of the information varied widely across individuals. It was concerning that an identified strength for Individual #525 was his stomping his feet and banging his head on his wheelchair to indicate that he wanted attention. This harmful behavior is not a strength. It was also concerning that a preference identified for Individual #545 was his crawling in the day room. This 43 year-old man should not be crawling in any environment. ▪ The final section, which guides teams to consider future planning for the individual, was minimally addressed in all of the PSIs. None of the PSIs reflected forward thinking or comprehensive expansion of the individual's home, work, or leisure environments and activities. Individual-specific problems are noted below. o The goals for Individual #280 included his living in his current home at the Facility, his continuing to work folding towels, and better use of his communication skills. Preferences and strengths that supported the	

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		first two of these goals were identified as not applicable. The same analysis was provided for Individual #505. o Similarly, the analysis for Individual #397 and Individual #59 was incomplete with supporting preferences and strengths not identified in three of five goals. o Individual #24 was to continue to attend the Seniors program, although it was repeatedly noted that she did not like this program. o The analysis for Individual #182 was extremely general. She was to live in the least restrictive environment, continue to work in vocational services, continue to participate in activities she enjoys, and learn skills to become more independent. There were no identified preferences and strengths to support these goals. 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. The Functional Skills Assessment Summary was reviewed for the 16 individuals in the sample. The date of completion was identified in all of the reports (100%). In every case (100%), the assessment had been completed prior to the individual's ISP meeting. A review of these 16 summaries is provided below. ▪ Fifteen of the 16 reports noted the date the assessment was completed and the date the summary was written. Only five of these 15 reports (33%) indicated that the summary had been written on the same day or within one week's time. The remaining 10 summary reports had been written between one to five months after the assessment was completed. ▪ While all of the 16 summary reports (100%) provided information regarding the individual's strengths, some of these were more comprehensive than others. Fairly good descriptions of skills were found in the summaries for Individual #280, Individual #517, Individual #334, Individual #24, Individual #256, and Individual #327. Staff should provide a thorough profile of the individual to ensure that members of the team can make thoughtful decisions regarding habilitation planning. ▪ All of the summary reports (100%) also provided information regarding needs. Again, the quality of this information varied widely. Examples of more comprehensive identification of skill needs were found in the reports for Individual #505 and Individual #525. However, several individuals had very limited recommendations for skill development. o The summary report indicated that there were no needs in 10 of 30 skill areas for Individual #280. This included leisure skills/interests and	

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		food preparation. It is suggested that this 27 year-old man could greatly expand his skills and independence across all domains, or that he should be living in a more integrated setting than an ICF/ID. o Similarly, there were no needs identified in 16 of 31 areas assessed for Individual #517. It is suggested that if he has developed his skills and independence to such a degree, he should be living independently in the community. o There were no needs identified in 10 of 31 areas assessed for Individual #276. Unless this 22 year-old individual is skilled and independent in social interaction, food preparation, money skills, computer use, and his ability to move about his community, among other areas, it is suggested that needs should have been identified. o The summary report for Individual #545 noted that he had no relevant strengths and no relevant needs in 10 areas assessed, including oral hygiene, cleaning and organization, laundry/clothing care, community leisure, and community participation. With no identified strengths, this 43 year-old clearly has a number of skills to learn. o The summary report for Individual #256 noted that she had no identified needs in 16 of 29 assessment areas. It is suggested that this 18 year-old could certainly learn to expand her skill repertoire and/or develop greater independence, or that she should be living in a more integrated setting than an ICF/ID. ▪ Between two and five skill acquisition programs were recommended in the summary reports. This computed to a total of 56 programs for an average of 3.5 programs per individual. With 13 to 32 skill areas assessed, consideration should be given to the development or expansion of skills in all domains identified in the FSA. If the summary were to identify a range of possible skill acquisition plans, the team could determine what would best meet the preferences and needs of the individual over the next year. o It was concerning that of the 56 skill acquisition plans recommended in the summaries for the 16 individuals, 37 (66%) were plans continued from the previous year. This resulted in 14 of 16 individuals with 50% or more of their recommended skill acquisition programs continued from the previous ISP. It is suggested that teaching programs need to be carefully reviewed to ensure that learning occurs, and if not, the reasons determined and quickly addressed. ▪ Individual concerns raised in the FSA summaries are reviewed below. o It was noted that the progress Individual #517 made on two objectives (i.e., making a purchase and mixing Miralax) addressed in the previous year could not be determined, because there was no data to review. This problem with documentation should have been detected and	

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		addressed much sooner than when preparing for his new ISP. o An identified need for Individual #334 was learning to write his name in cursive. It is unclear how this would be the best use of his time when it might be more functional and interesting to learn a typing program to enhance his computer skills. o Individual #24 was noted to be making progress on her lotion application program. Her progress was attributed to her "… preference for feeling as if she had been to a spa." Unless she has experienced a spa treatment or had clearly expressed this preference, it is suggested that this might not have been an accurate comment. o Individual #256 was supposed to be learning to identify one of her medications. The summary report, written in 1/14, noted that her progress on this skill had not been documented since 7/13. It is concerning that this was either not detected and/or not addressed over a six-month period. o Individual #525 had three programs introduced in 4/13. The summary report of 1/14 noted that progress could not be determined due to problems with documentation. Again, these problems should have been detected and addressed much sooner. o Individual #327 was learning to identify numbers so that she could eventually dial her family's telephone number. It is suggested that she might learn the terminal skill more quickly if she simply learned to match the numbers written on a card to the numbers located on the phone. The Functional Skills Assessment is only useful if it is used to guide comprehensive habilitation programming for the individual. The most recent Vocational Assessment was requested for the 16 individuals in the sample. The Facility provided the assessment for nine individuals (56%). A summary of the review of these documents is provided below. ▪ All of the nine assessments (100%) were completed or updated within the 12-month period before the individual's annual ISP meeting. ▪ The identified person completing the assessment had signed each of the reports (100%). ▪ A vocational vision was identified in seven of the nine reports (78%). For six of these seven individuals, the vision was to continue in their current jobs, all on campus. Individual #256 verbalized her interest in a variety of jobs, including several in the community. For Individual #505 and Individual #430, no vocational vision was indicated due to a recent introduction to work or ongoing psychiatric issues, respectively. ▪ Completed situational assessments or job exploration had occurred over the	

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		previous year for six of the nine individuals (67%). All of these involved activities that were available on campus. ▪ Recommendations for the future were provided for all nine of the individuals in the sample. For five individuals (56%), recommended vocational experiences were restricted to the campus. For the remaining four individuals, volunteer experiences or possible community-based work were recommended. 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 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. 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:		Noncompliance
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	The Monitoring Team requested Monthly Reviews for three months for each of the 16 individuals in the sample. The Facility provided reports for one to three months for 14 individuals in the sample. This resulted in a total of 38 Monthly Reviews. None of the 38 reports (0%) included a review of objective data to determine progress or the lack thereof on skill acquisition programs. Examples of individual specific concerns are reported below. ▪ Individual #280: His computer was to be equipped with wireless Internet access and his bike was to be fixed to prevent flat tires. Although the implementation date was 11/6/13, these tasks had not been completed by 4/5/14. In 2/14 and 3/14, it was noted that he had not worked on his laundry program, because he was unavailable due to his being on furlough or sleeping. In the 4/14 report, it was noted that this program had been discontinued due to a high number of refusals. The monthly reviews provided no description of a plan to gain his cooperation with learning new skills. ▪ Individual #334: For three consecutive months, it was noted that this adolescent did not choose to learn to play the keyboard. It is suggested that some other leisure skill should have been identified. ▪ Individual #196: For three consecutive months, it was noted that the QIDP	Noncompliance

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		would contact vocational services to arrange a tour and situational assessment, and the clerk would arrange for a magazine subscription. It is suggested that both of these activities should have been completed. ▪ Individual #505: For two consecutive months, staff were unsure whether this young man was learning to make a drink. In the third month, it was noted that this program had been discontinued, because he had mastered the skill. There was a lack of correspondence between these reports. Further, he was to use his communication book when at the Activity Center. There was no information for the first report, and it was noted that he was not completing this skill in the second and third reports. No explanation was provided. ▪ Individual #256: She was to visit the zoo and attend church in town. Although the implementation date was 4/1/13, neither of these activities had occurred as of 5/4/14. ▪ Individual #397: For three consecutive months, it was noted that he "… refused most of this reporting period to attend work." There was no identified action plan to address these refusals. ▪ Individual #525: Annually, he was to attend at least one country/western concert and twice visit the library. Although the identified implementation date was 2/19/13, these activities had not occurred as of 1/18/14. ▪ Individual #59: Identical comments were provided for three consecutive months for all of her skill acquisition programs, including two that had been discontinued. For three consecutive months, it was noted that a vocational assessment had been requested and was pending. This should have been completed. ▪ Individual #327: An exercise program was to be implemented on 10/29/13. However, this had not been implemented by 4/14/14. ▪ Individual #182: For two consecutive months, it was noted that the QIDP was to follow up with the Behavioral Services Specialist regarding her aggression reported by vocational services staff. This should have been addressed immediately. Monthly reviews of the individual's progress and access to scheduled activities will only be beneficial if identified problems are addressed in a timely manner. It remained that assessments were not utilized to identify a range of skill needs for the individual. ISPs were limited with regard to the number and scope of training objectives designed to help the individual grow and develop his/her skills and independence. Opportunities for instruction were severely limited and reinforcement for correct responding was not individualized. For these reasons, the Facility remained out of compliance for this provision of the Settlement Agreement.	

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	(b) Include to the degree practicable training opportunities in community settings.	The Facility provided information regarding the number of community outings per residence between 11/13 and 4/14. Across 22 residences a total of 745 outings occurred over a six-month period for an average of 34 outings per home. The range per home was between 13 and 60 outings. The number of individuals participating in an outing was not specified, nor was it clear whether there was a select group of individuals who most frequently accessed the community. The purpose of the outing and the destination also were not specified. The Facility provided a list of formal skill training that had been provided in the community. Thirty individuals and 31 programs were identified. The census at the time of the Monitoring Team's onsite review was 361 individuals. Twenty-six of 31 programs addressed money management or making a purchase. The remaining programs included running, disc golf, riding a bus, or janitorial work. The time period for this training was not identified, nor were the number of training opportunities summarized. The Facility had developed a Community Activity Satisfaction and Skill Acquisition Program Report to be used in tracking an individual's response to community activities and opportunities for training. This form had been developed on 4/8/14 and no data regarding findings were presented. At the time of the Monitoring Team's visit, training in the community was extremely limited. For this reason, the Facility remained out of compliance for 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 Presentation Book for Section T; o ABSSLC Admissions, Alternative Placement, Transfers, and Discharges Policy, revised 11/26/13; o List of all individuals referred for community transition, since the Monitoring Team's last visit with summary of status, undated; o In response to request for list of individuals who have requested community placement but have not been referred and reason, statement that there were none since 10/12/13; o List of individuals who have not been referred solely due to Legally Authorized Representative's (LAR) preference since 10/21/13, 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 List of individuals 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 11/20/12; o Community Placement Report, as of 4/25/14; o No responsive document was provided in relation to the Monitoring Team's 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"; o Individual Support Plan Addendum – Potentially Disrupted Community Transition documentation for Individual #197, Individual #227, Individual #11, Individual #483, and Individual #33, various dates; o In response to a request for a list of deaths of individuals that moved to the community

	since 7/1/09, the statement: "There have been no deaths of individuals moved to the community since the last monitoring visit in November 2013;" o In response to a request for a list individuals that have returned from a community transition since the last onsite review, the statement: "Since the last onsite review in November 2013, no individuals have returned from a community placement;" o Unduplicated counts of individuals and staff participating in Community Living Options Information Process (CLOIP) tours, since May 2013, undated; o List of training provided to individuals, families, and LARs; o Training documentation and materials for staff related to most integrated setting, various dates; o Obstacle Report, September 2013 and December 2013; o Annual Report: Obstacles to Community Referral and Transition Texas Department of Aging and Disability Services State Supported Living Center, Fiscal Year 2013, including attachment: Abilene State Supported Living Center Fiscal Year 2013 Obstacles for Referral and Transition Report; 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 #348, Individual #521, Individual #78, Individual #296, Individual #92, Individual #300, Individual #182, Individual #64, Individual #88, and Individual #307; o CLDP, any associated assessments, and most recent ISPs for the following: Individual #247, Individual #32, Individual #355, Individual #342, and Individual #379; o State Office reviews of the following CLDPs: Individual #342, and Individual #379; 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 #509, Individual #442, Individual #355, Individual #342, Individual #379, Individual #247, and Individual #32; o Monthly Meeting Notes Section T: Placement, dated 10/25/13, 12/9/13, 1/27/14 and 1/28/14, 2/27/14, and 3/24/14; 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 for Fiscal Year 2013; ▪ Obstacles Report for September to December 2013; ▪ Section T Action Plans, updated 1/14/14; and ▪ Facility Self-Assessment, dated 4/28/14; o Updated list of current referrals, as of 5/15/14; o ISPA related to death of Individual #289; o ISPA related to lack of consensus related to community transition for Individual #370; o ISPAs related to rescinded referrals for: Individual #318, Individual #137, and Individual

	#199; o For the last one-year period, ISPAs related to transition, and Transition Specialists logs for: Individual #232, Individual #136, Individual #174, and Individual #108; o Transition Specialists' possible referral list, undated; o For the last six months, meeting minutes between the Facility and the Local Authorities (LAs); o Discharge plans and related assessments for Individual #507, and Individual #81; and o In response to the request for: "If available, number of individuals for whom IDTs recommended tours of community programs, and number of these individuals that did attend community tours within the last year," the response: "There is no data available at this time…" ▪ **Interviews with**: o Kerry Loveland, Admissions/Placement Coordinator; o Heather Vivoda, Post-Move Monitor; o Diane Jackson, Transition Specialist; and o Laura Wilford, Transition Specialist. ▪ **Observations of**: o ISP meeting for Individual #411, on 5/13/14.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 4/28/14. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section T in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The Facility submitted some completed monitoring tools for CLDPs, including some that the Post-Move Monitor completed, as well as the PCM. However, the data were not being collected reliably, and it was unclear that the data were valid. o The tools being used did not define the standards used, and did not result in valid findings. o In addition, inter-rater reliability had not been established between the QA Department and the Admissions Placement Department. However, based on the list of topics discussed at meetings with the QA Department, it appeared the Admissions Placement Department was working with the QA Department on establishing inter-rater reliability, as well as developing standards/guidelines. 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 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 Although some relevant data from other sources was sometimes included (e.g., data related to number of community education tours), the data was not linked to outcome measures or goals to determine whether or not the Facility was doing well. The Self-Assessment frequently did not review the quality of supports or activities (e.g., for T.1.b.2, there was no review of the quality of individualized plans to address education on community options; or for T.1.b.3, the Facility did not assess whether team decisions were justified). ▪ The Facility rated itself as being in compliance with nine subsections, and the Monitoring Team found the Facility in substantial compliance with five, including one with which the Facility had not found 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. Although some description of actions being taken was provided, 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: Assessments prepared for annual ISP meetings generally 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 or most 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. On a more positive note, since the Monitoring Team's last review, 12 individuals had transitioned to the community, and 26 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, as noted in the last few reports, the Transition Specialists were working 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. This individualized approach to education was important and it 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. It was clear that the Transition Specialists were exerting significant effort to identify providers that could support individuals with complex medical and physical and nutritional support needs, but these providers were few, and they had limited capacity to serve more individuals than they were currently serving. Similarly, supports for individuals with complex behavioral health needs also were limited. Since the last review, some limited improvement was noted with regard to the comprehensiveness of pre-move and post-move required supports. However, the CLDPs continued to be missing a number of important protections, services, and supports needed to transition safely and successfully to the community. Although ABSSLC staff were working hard to make improvements, it did not appear State Office was providing proper guidance or training to move the CLDP process forward. On a very positive note, based on interview as well as review of CLDPs and post-move documentation, for individuals with complex behavioral needs, some teams had begun including interaction between an ABSSLC Behavioral Health Services staff person and the community provider direct support professionals to provide more hands-on training and modeling as a post-move required support in CLDPs. Similarly, some CLDPs specified that a Behavioral Health Services staff member would accompany the Post-Move Monitor on visits and/or have ongoing contact with the provider staff and community BCBA staff. These supports appeared to result in positive outcomes for a couple individuals. Facility staff indicated that similar initiatives had been started with Habilitation Therapies and nursing staff. The Facility did not provide a full list of the potentially negative outcomes that occurred after individuals transitioned to the community. However, based on the Monitoring Team's review of other documentation, a minimum of 19 had occurred, including a death, Emergency Room (ER) visits and hospitalizations, police contact, psychiatric hospitalizations, placement in nursing homes/rehabilitation facilities, and movement to other community providers. Based on a review of follow-up action, the Facility and community teams did not critically review all aspects of the CLDPs for these individuals or their implementation. As a result, the teams did not identify the missing supports, of which there were many, nor did the teams make the recommendations necessary to improve transition planning and implementation going forward. Post-move monitoring had been completed in a timely manner for individuals who had transitioned to the community. The Post-Move Monitor and Transition Specialists' comments generally 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, most often, 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. In one instance, where additional help likely should have been sought from the Local Authority and/or DADS State Office, it was not clear this had occurred. However, the Facility remained in substantial compliance with Section T.2.a.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Based on the Community Placement Report, for the time period between 10/12/13 and 4/25/14, as well as other lists the Facility provided, the transition-related numbers were as follows: ▪ Since the last review in November 2013, 12 individuals had transitioned (approximately 3% of the population); ▪ Referrals for community placement: o Twenty-six individuals were on the active referral list (7% of the current census of 361 individuals); o Nineteen individuals were referred since last visit; o Ten individuals had been on list more than 180 days; and o No individual had been on the list for more than one year; ▪ Reportedly, since the last review, no individual had requested/preferred placement, but were not referred; ▪ The Community Placement Report included data regarding the numbers of individuals that would have been referred, except for the preference of the LAR. However, this information was only included for ISPs held between 10/12/13 and 4/25/14, so it did not represent a full list of individuals for whom this was the case. According to this incomplete list, a total of 42 individuals would be referred except for LAR preference (i.e., the IDT would refer); ▪ Since the last review, three individuals' referrals were rescinded; ▪ The Facility did not provide a list of potentially negative outcomes, because the documents the Facility submitted were nonresponsive to the Monitoring Team's request. Instead of providing a list as requested, the Facility provided ISPAs for Potentially Disrupted Community Transitions. Given that the instructions State Office had issued related to these ISPAs did not include all of the events about which the Monitoring Teams requested information, without a full list of the events, the Monitoring Team could not determine if these ISPAs identified all of the potentially negative outcomes. However, based on the ISPAs the Facility provided, potentially negative outcomes included as well as review of a sample of post-move monitoring documentation for five individuals (the Facility's compliance related to review of these is addressed with regard to Section T.1.f): o No individuals had returned from community placement, although shortly prior to Individual #289's death, the team had planned a	Noncompliance

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		meeting to discuss his returning to ABSSLC; o One death had occurred following community placement (i.e., Individual #289, who had lived in the community for approximately seven months, died after a series of four ER visits over four months, and a decline in health, and subsequently being placed on hospice. As discussed with regard to Section T.1.f, his ABSSLC team concluded that the community provider should have notified ABSSLC before Individual #289 was placed on hospice, so the team "could have met and discussed a plan of action making sure all testing and services were exhausted"); and o A minimum of an additional 18 other potentially negative outcomes (e.g., Individual #442 had police contact as a result of a behavioral incident; Individual #289 had four ER visits related to an allergic reaction, complaints of pain for several days, complaints of chest pain, and a seizure lasting 22 minutes; Individual #197 had four, including three hospitalizations due to low calcium levels and a suicide threat, and transfer to a rehabilitation facility; Individual #227 had a change of home with the same provider due to closure of his original home; Individual #11 had six, including police contact after a behavior incident, which led to a psychiatric hospitalization, and the foster provider indicating he could not return, which led to a change in placement, at which a second psychiatric hospitalization occurred and a hospitalization due to lithium toxicity, and transfer to a rehabilitation facility; Individual #483 had one hospitalization due to cellulitis and a seizure after falling while exiting a bathtub when a support bar with suction cups failed; and Individual #33 had a hospitalization for constipation and wheezing in her lungs, which was diagnosed as "likely aspiration"); and ▪ Two individuals were discharged pursuant to Section T.4. As is discussed with regard to Section T.1.b.3, the determinations of professionals regarding individuals' transition to the most integrated setting appropriate to their needs continued to be an area requiring focused efforts. Individuals' ISPs generally included a recommendation from the Facility's team members' with regard to whether or not community transition was appropriate. Unfortunately, the assessments and/or ISP narratives often did not include sufficient justification for the teams' recommendations. <u>Placement and Referral Not Opposed</u> ▪ In reviewing the CLDPs and ISPs for four individuals who had been placed (i.e., Individual #355, Individual #342, Individual #379, and Individual #247), four (100%) individuals and/or LARs did not oppose transition to the community.	

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		Responding to Individual Requests and Rescinded Referrals b. According to documentation the Facility provided, since the last review, there were three rescinded referrals (i.e., for Individual #318, Individual #137, and Individual #199). Based on a review of the ISPAs for these three individuals: ▪ Of these, the reasons for the rescinding appeared to be reasonable for two (67%) (i.e., Individual #199, who made the decision herself; and Individual #137, who was currently considered psychiatrically and medically unstable). More specifically: o For Individual #318, the referral was rescinded after Individual # 318 had a number of behavioral issues at one group home at which he did an overnight visit, and had to be picked up early. Upon his return, the Behavioral Health Specialist met with him and asked if he wanted to live in the home he had gone to visit. Individual #318 said "no." The Behavioral Health Specialist then asked if he wanted to live in the residence at ABSSLC, to which Individual #318 said "yes." According to the documentation provided, no efforts were made to determine what it was that Individual #318 did not like about the community home (e.g., the other individuals living there, the staff), or to provide other options besides the one home in the community and the residence on the grounds of ABSSLC. ▪ Further, an adequate review to determine if changes in the referral and transition planning processes were needed at the Facility was conducted for none (0%) of the rescinded referrals. For example: o For Individual #318, based on the documentation, the team made no efforts to determine whether changes were needed to how they had approached the overnight visit. For example, questions should have been asked about the competency of community provider staff in dealing with behavioral issues (e.g., staff were unable to deescalate Individual #318's behavior, one staff ended falling to the ground with Individual #318 while attempting to redirect him home after he "took off"), whether the individuals living in the home selected for the overnight visit were the right match (i.e., Individual #318's behaviors at the home started after one of the other individuals "became agitated and began yelling"), whether Facility staff should have accompanied him for a longer period of time before leaving him alone with community provider staff who were new to him, whether the day program at which he spent most of the first day and had some behaviors was the correct match, etc. Moreover, the team did not review the draft CLDP that had been developed for Individual #318 to determine whether or not it included all of his support needs, and whether the team had used the draft CLDP effectively to identify a provider that could meet his needs.	

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		○ Individual #199 expressed concerns about having her medical needs met in the community, as well as the ability to live with friends. However, based on the documentation provided, it was unclear whether the team had made sufficient efforts to develop a draft CLDP that clearly identified her needs for health care supports, sought providers that could meet these needs, and showed Individual #199 how her needs could be met in a community setting. Similarly, no documentation was provided to show that efforts had been made to support Individual #199's desire to move to the community with friends. The ISPA for rescinding the referral did not include evidence that the team had reviewed the transition planning process, and critically determined if changes were needed. ○ Individual #137 had complex medical and psychiatric needs, but the team did not critically review its efforts to develop a draft CLDP that clearly outlined his support needs, and then to use such a plan to identify a community provider that could provide the supports. ▪ Of these reviews, actions were recommended in none, but should have been for all three individuals. Because no actions were recommended, the following was not applicable: Of these ___ cases, actions were implemented for ___ (%). Some examples of problems noted included: ○ As noted above, Individual #318's team had not done all it could to determine if a community program could meet his needs and preferences, and/or to revise the transition process to better meet his needs. No recommendations were included to correct these deficiencies. ○ For Individual #137, who was psychiatrically and medically unstable, the team did not set forth a plan and/or reference specific plans in his ISP to assist in stabilizing him, nor did the team set a specific date for revisiting the potential for a community referral. ○ Individual #199 made the decision herself to rescind the referral, but from the documentation provided, it was unclear whether or not it was an informed one. No action plan was set forth to educate Individual #199 about community options that could meet her needs, or to provide her with additional skills that would assist her in moving to a more integrated setting. c. Reportedly, since the last review, no individuals requested placement, but were not referred. As a result, the following metrics were not applicable: ▪ Of the ____ individuals who requested placement, but were not referred, ___ individuals had an LAR who made this decision. ▪ Of the remaining ____ individuals, for ____ (%) an appropriate review, appeal, and	

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		or lack of consensus review was conducted. <u>Systemic Issues</u> d. There were systemic issues delaying referrals (at the State and/or Facility level). There were actions to resolve some, but not all of them. For example: ▪ Based on review of a sample of 10 ISPs, the lack of or the perception of a lack of supports in the community for individuals with complex medical and/or physical and nutritional management needs, and/or complex behavioral needs were systemic issues delaying referrals. For example, Individual #521 had diabetes requiring nursing supports, but the team perceived these to be unavailable in the community. Similarly, Individual #181 had medical needs, including a need for monitoring of a specialized diet, but the team concluded such supports were not available in the community. Based on discussion with Facility staff as well as the Monitors' recent discussions with the parties, systemic actions to resolve these issues were not being implemented. ▪ For some individuals, a factor delaying referrals were the institutional practices, such as different traffic rules, on the campus that allowed individuals to become accustomed to a different set of expectations than are found in typical communities. Based on these institutional practices, teams concluded that the Facility was the "least restrictive alternative" for the individuals. For example, Individual #300's team concluded that "this is the least restrictive environment for her as she is able to walk freely on campus, she knows her environment, traffic is slower so she is at less risk… and can call home if she were having issues…" ▪ For some individuals, teams had historically failed to educate them or their guardians about options and/or teams did not know their preferences, and now concluded that because the individuals did not understand the options available to them, they should not be referred for community transition (e.g., Individual #307, Individual #300, and Individual #182). For these individuals, individualized, aggressive plans to educate them about options were not found in their ISPs. ▪ For a number of individuals, LAR Choice was cited as the only obstacle, but plans to provide guardians with viable choices for community transition were not included in ISPs, nor did they appear to exist on a systemic level (e.g., Individual #88, Individual #348, Individual #78, Individual #296, Individual #300, Individual #182, and Individual #64). e. Based on review of documentation and interviews with staff, there were potential systemic issues delaying transitions (at the State and/or Facility level). Based on information provided, it did not appear that specific actions had been identified and/or were in the process of being implemented to resolve them. For example:	

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		▪ Based on review of the Transition Specialist's documentation, one provider supporting individuals in Tarrant County had not been paid for two months for four women recently transitioned from ABSSLC due to issues with switching Medicaid from institutional to community Medicaid. This was one factor delaying the transition of Individual #232 and Individual #174, for whom the provider had agreed to purchase a new home to meet their complex needs. The purchase was delayed due to the providers' lack of funds, which resulted from not being paid timely for other individuals and having to pay for their expenses with existing capital. According to both documentation and interview with Admissions Placement staff, this was a recurrent and known problem in Tarrant County. The Transition Specialist had made efforts to offer the provider a number to call for the Consumer Services and Rights Protection hotline with which another provider had had success in addressing similar issues. However, it was unclear if this barrier was being addressed on a systemic level. ▪ Based on the ISPAs and Transition Specialists' notes, community capacity to support individuals with complex medical and physical and nutritional support needs delayed transitions (e.g., Individual 232 and Individual #174) was limited. It was clear that the Transition Specialists were exerting significant effort to identify providers that could support individuals with these needs, but these providers were few, and they had limited capacity to serve more individuals than they were currently serving. The State has not provided the Monitors with a plan for expanding this capacity. f. Funding availability was generally not cited as a barrier to individuals moving to the community. However, as discussed above, one provider supporting individuals in Tarrant County had not been paid for two months for four women due to issues with switching Medicaid from institutional to community Medicaid. This was one factor delaying the transition of Individual #232 and Individual #174, for whom the provider had agreed to purchase a new home to meet their complex needs. The purchase was delayed due to the providers' lack of funds, which resulted from not being paid timely for other individuals. g. Senior management at the Facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. The Admissions Placement Coordinator presented information regularly at the QA/QI Council meetings. <u>Pace of Transitions</u> h. At the time of the review, transitions were not occurring at a reasonable pace. ▪ Of the 12 individuals placed since the time of the last onsite review, seven (58%) was placed within 180 days of his referral.	

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		▪ At the time of the review, 26 individuals had been referred for community transition. Ten of these 26 individuals had exceeded the 180-day timeframe. ▪ Of these, none had exceeded one year. Based on the ISPAs related to transition and the Transition Specialists' notes for a sample of four individuals that had been on the referral list for over 180 days (i.e., Individual #232, Individual #136, Individual #108, and Individual #174): i. For three of the four individuals (75%) (i.e., Individual #232, Individual #174, and Individual #108) reasonable activity and actions had occurred related to the transition and placement for individuals that had exceeded the 180-day time period. ▪ For Individual #136, it was not clear why efforts were not made to identify a provider that could meet his needs when behaviors increased, and he required one-to-one level of supervision. For months, his transition process was delayed, and it appeared it was due to these needs, which were not needs that were going to go away just because he moved to the community. Therefore, he needed a provider that could support these needs. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for three of the four (75%) individuals (i.e., Individual #232, Individual #174, and Individual #108). There were for Individual #136. k. Adequate justification was provided for the lengthier transition process for three of the four (75%) individuals (i.e., Individual #232, Individual #174, and Individual #108). For Individual #232 and Individual #174, the teams were working to identify a provider that could meet their complex medical needs, and it was difficult to find one. For Individual #108, she clearly had preferences for certain homes and day programs, but not others. The team was taking the time to find one that would meet both her needs, and her preferences (e.g., she did not like one day habilitation program, and although she liked one home during the first visit, indicated she did not like "cow town" after the second visit). The team is encouraged to continue to work towards identifying a home and day program that will meet her needs and preferences. In summary, when referrals were rescinded, teams were not conducting thorough reviews of the referral process, including review of the draft CLDP to determine whether or not it included all of individual's support needs, and whether the team had used the draft CLDP effectively to identify a provider that could meet the individual's needs. Although teams, including Transition Specialists, were working to identify community supports that could meet individuals' needs, systemic obstacles related to the lack of capacity to support individuals with complex medical and behavioral support needs delayed transitions. The Facility remained out of compliance with this overarching	

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		provision of Section T of the Settlement Agreement.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	a. The State Office policy for most integrated setting practices was recently issued. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: ▪ The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy described the process of team members making recommendations in their assessments (at III.C.5.c), but did not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addressed, in very global terms, a "living options discussion," and referred the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spelled out how this would be done. ▪ There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). ▪ The policy did not thoroughly address the IDT and Facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. ▪ There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). ▪ After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. ▪ The policy did not mention the Settlement Agreement requirement that action be taken <u>prior</u> to the individual's move if pre-move supports are not in place. ▪ The policy did not address the quality of CLDPs. ▪ There was no mention of need for IDTs to use CLDP to ensure supports are in place. ▪ There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. ▪ The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports.	Noncompliance

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		b. Due to the fact that the State policy was not yet adequate, the following metric could not be assessed: There **were/were not** Facility policies that supported the state policy for most integrated setting practices. The Facility's policy, revised 11/26/13, entitled: "Admissions, Alternate Placement, Transfers, and Discharges" included a section entitled: Assisting Individuals with Moving to the Most Integrated Setting." In this section, the State policy referenced above was reiterated word for word. ABSSLC had not localized the policy. The Facility should have policies and procedures that operationalize/define implementation of the parts of the State policy that are not specific. For this policy, examples include, but are not limited to the way in which community tours are managed, how educational activities are presented to individuals, expectations regarding staff training on the most integrated setting, how the Admissions and Placement Department staff ensure that all supports and services are included in CLDPs, the expectations regarding quality assurance efforts for this section at ABSSLC, and which staff are to review the CLDP prior to its submission to the Facility Director. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. 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	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> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F.1.d, F.2.a.1, and F.2.a.3. As noted in Section F, substantial compliance was not found for F.1.d, F.2.a.1, and F.2.a.3. 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	Noncompliance

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	annually, and shall identify, and implement, strategies intended to overcome such obstacles.	protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by ABSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Referral and Transition to Community</u> Regarding referral at the individual level: b. Of the 10 ISPs reviewed, nine should have had obstacles to referral defined (the other individual, Individual #92, had been referred for transition to the community). Of the remaining nine ISPs, one (11%) included an adequate list of obstacles to referral (i.e., Individual #78). As discussed below, most often these were not well defined, and did not provide sufficient information to allow good plans to be developed to overcome them individually or on a systemic level. Adequate descriptions of missing community supports were not included for individuals whose teams identified medical supports as being the issue. c. Of the one annual ISP meeting observed (i.e., Individual #411), an adequate list of obstacles to referral was identified for one (100%). Regarding a plan to address obstacles at the individual level: d. Of the nine ISPs, one (11%) (i.e., Individual #307) included an action plan to address/overcome obstacles identified. Of these one, none (0%) was adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). Most ISPs did not include plans that addressed the specific obstacle(s) the team had identified, but rather included generic efforts to provide more information to the individual and/or guardian about community options. e. Of the one annual ISP meeting observed, a plan was included to address/overcome the identified obstacles for none (0%). As a result, the following was not assessed: Of the one plan, ___ (___%) appeared adequate. Regarding transition at the individual level:	

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		The following were not assessed during this review, but will be during the next review: f. Of the __ CLDPs and related ISPAs reviewed, at least ___ individuals should have had obstacles to transition defined. Based on review of these individuals' CLDPs and ISPA related to transition, ___ (___%) included an adequate list of obstacles to transition. g. For these ___ individuals, ____ of the ISPAs (___%) had action plans to address the obstacle to transition. Preferences of individuals: h. Of the ten ISPs, one (10%) (i.e., Individual #92) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). i. Of the one annual ISP meeting observed, the individual's preference for where to live was adequately described in one (100%), and this preference appeared to have been determined in an adequate manner for none (100%). The team for Individual #411 based their decision on his behavior in new environments and with new staff, a recent difficult transition on campus, as well as his age and declining health and the implications of both. Preferences of LARs: j. Of the seven ISPs for individuals with guardians (i.e., Individual #64, Individual #182, Individual #300, Individual #78, Individual #348, Individual #88, and Individual #296), one (14%) included an adequate description of the LAR's preference and how that preference was determined by the IDT (i.e., Individual #78, for whom the LAR's concerns related to community transition were discussed in some detail, including that the individual does not like change, services at ABSSLC could not be found in community, etc.). k. Of the one annual ISP meeting observed, the individual had an LAR (i.e., Individual #411). The LAR's preference for living setting was adequately described in one (100%), and this preference appeared to have been determined in an adequate manner for one (100%), including her knowledge of his recent difficulties, as well as tours in recent years of alternative in the area. ABSSLC had made limited progress with regard to identifying obstacles to community referral and transition, and more work was needed. Although obstacles were being identified, they were not consistently accurate, and more work was needed to determine the specific concerns of individuals and their guardians when their choice was the reason for a referral not being made. Individuals frequently did not have plans to address the specific obstacles identified, and the quality of the plans teams had developed to	

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		overcome such obstacles remained inadequate. Although plans were measurable, they continued to lack individualization. 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.	
	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.	Individualized Plans a. In reviewing 10 recently completed ISPs, one individual (i.e., Individual #92) had been referred for transition to the community, and was engaged in the CLDP process, and two individuals' guardians had refused to allow further educational opportunities (i.e., Individual #64 and Individual #88). For the remaining seven, seven (100%) had a plan that addressed education about community options. Of these seven, none (0%) were adequate. Although all were measurable, none were individualized. 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. Many examples of concerns related to the plans have been discussed in previous reports, and little change was seen in this most recent sample of ISPs. As indicated in the Monitoring Team's previous reports, the action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals or their guardians' specific questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans using the information that the team is able to gather about the reasons for the individual, family member, or LAR's reluctance and/or the team's concerns. For example, if an LAR has questions or concerns 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. When teams have questions about availability of supports in community settings, these should be researched. At the time of the review, these types of activities were not included in action plans. Creative ideas and brainstorming within ABSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. Provider Fair b. The Facility held a provider fair within the past 12 months. It was held on September 20, 2013. Previously, ABSSLC held two provider fairs each calendar year, but the decision had been made to hold one per year. The next one was scheduled for June 6, 2014. This provider fair was scheduled at the same time as the Cultural Diversity Fair in the hopes of improving individual and staff attendance. Letters were going to be sent to families.	Noncompliance

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		As noted in the last report, 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 to determine 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." <u>Local Authority</u> c. The Facility appeared to maintain good communication and a working relationship with the three LAs in the area. Facility staff participated in at least quarterly meetings with the LA (i.e., based on meeting minutes that showed quarterly meetings), and ensured relevant topics were on the agenda for the LA meetings. From the Facility, those in attendance at the quarterly meetings generally included the Admissions Placement Coordinator, the Post-Move Monitor, and Transition Specialists. These meetings rotated between the three LAs to increase participation. Based on the minutes, the group discussed individuals that had been referred to the community, provider fairs, and annual Local Authority training for staff. <u>Tours of Community Providers</u> d. The Facility did not yet have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, and identified all individuals and whether or not each went on a tour). However, in response to the Monitoring Team's request for this data, the Facility provided the following statement: "There is no data available at this time for the number of individuals whose IDTs recommended tours of community program and the number of these individuals who did attend. The APC [Admissions Placement Coordinator] will work with the QIDP Coordinator and QIDP Educator to discuss this issue and develop a means of documenting action plans that include community tours. A Corrective Action Plan may be needed to address this lack of information as it directly relates to education of individuals and families on options available in the community." Based on review of individuals' ISPs, teams frequently included community tours as an action step to provide individuals with greater exposure to options available in the community. However, as discussed above, such action plans often were not individualized, and so the appropriateness of the tours on which individuals participated could not be assessed. One of the LAs was responsible for scheduling and conducting tours two Fridays each month. When asked for "over the last one-year period, the unduplicated number of individuals that have participated in CLOIP tours," the Facility indicated that 80 individuals, and 67 staff had participated. However, because ABSSLC did not have a	

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		functioning system for tracking tours required per individuals' ISPs versus tours completed, the following indicator could not be completed: e. Based on the Facility's own report, of the ____ individuals at the Facility for whom a tour was appropriate, ___ (%) went on a tour appropriate to their needs within the past year. Based on information the Facility provided, tours were offered of homes and day/vocational programs. Providers rotated, so that different options could be seen, including ICF as well as home and community-based waiver funded homes and programs. f. For the individuals in the sample, the ISPs generally did not provide sufficient information to determine if an action plan for a community provider tour had been included in the previous ISP and if so, if such a tour(s) had occurred and was tailored to their needs. However, for two individuals (i.e., Individual #88, and Individual #77), it was clear there was no plan due to the LAR's refusal. For one individual (i.e., Individual #307), it appeared the plan had been implemented, but it was not clear the tour was tailored to the individual's needs. For five individuals, their ISPs or ISP Preparation Meeting documentation indicated the plan from last year had not been fully implemented (e.g., Individual #64, Individual #182, Individual #300, Individual #92, and Individual #296). Individual #521's previous plan was not measurable. As a result of the limited information for many individuals in the sample, the following could not be completed: ▪ Of the ___ individuals in the sample for whom their teams had determined a tour was appropriate, ___ (___%) went on a tour tailored to their needs within the past year. <u>Visits to Friends in the Community</u> g. Although the Transition Specialist was trying to make some efforts in this regard (e.g., facilitate sharing of telephone numbers and addresses), the Facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. <u>Educational Activities at/by Facility for Individuals</u> h. Since the last onsite review, based on documentation the Facility provided, other educational activities for individuals had occurred during self-advocacy meetings and did occur in ISP meetings as well as through Transition Specialists' contact with family members and guardians, but did not occur during house meetings for individuals, and did not occur during family association meetings. With regard to Self-Advocacy meetings, Transition Specialists had attended the 11/5/13, 3/11/14, and 4/8/14 meetings to answer any questions related to community living	

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		options. They also were scheduled to present at the May meeting, which was cancelled due to an influenza outbreak. As noted in the last report, Transition Specialists were attending some ISP meetings to provide information on living options to individuals and their families. In addition, 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. Facility staff were working on a way to better document these interactions. However, based on a list of "potential referrals," Transition Specialists were working with approximately 30 individuals, in addition to their caseloads of individuals that already had been referred. <u>Educational Activities for Staff</u> The Facility was able to provide some information about staff participation in education activities related to community options. For example: ▪ The Facility provided data to show that between 10/1/13 and 3/31/14, 221 staff participated in the New Employee Orientation module related to the most integrated setting. However, the overall number that should have completed this training was not provided, so a percentage of staff having completed the training could not be calculated. ▪ The Facility provided data to show that 115 core IDT members received training on the updated Facility policy on the most integrated setting. Similarly, the number required to complete this training was not provided. ▪ One Local Authority was planning to provide training to staff in September 2014. The Admissions Placement Coordinator was working with discipline heads to make this training mandatory for nurses, Behavioral Health Specialists, as well as QIDPs. ▪ Staff also were invited to attend the provider fairs. ▪ Staff also were participating in community provider tours. As noted above, during the last year, this had involved 67 staff. During upcoming reviews, the Facility will be asked to provide data for the following indicators: ▪ i. % of direct support professionals were documented to have participated in one or more activities (e.g., in-service, workshop, community tour). ▪ j. __ % of clinicians were documented to have participated in one or more activities (e.g., in-service, workshop, community tour) ▪ k. ___ % of managers and administrators were documented to have participated in one or more activities (e.g., in-service, workshop, community tour).	

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		l. Since the last onsite review: a) information had not been shared about successful community placements with individuals and guardians who were reluctant to consider community placement; but b) some other limited information had been shared with individuals and LARs who were reluctant to consider community placement (i.e., as noted above, Transition Specialists were working with a number of individuals, and their families and guardians to share specific information to answer their questions and address their concerns). Such activities with individuals, and their families and guardians were commendable, and it was good these efforts were individualized. However, more work was needed. Some additional ideas would include: as appropriate, the Facility should pair families/LARs who have experienced a successful transition with families/LARs who are reluctant; individuals who have experienced successful transitions could speak in other forums, such as at Self-Advocacy meetings; and newsletter articles could regularly highlight success stories. Although individuals often had a plan in their ISP, the plans were not individualized. The individualization of this process is key to ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. The Facility needed mechanisms to track and manage the community exposure tours to ensure that individuals participated in tours that were tailored to their needs. It was commendable that Transition Specialists were working with a number of individuals, families, and guardians to address their specific questions and identify community supports that might meet their needs. However, the Facility still needed to expand its efforts to provide individuals and families with varied opportunities to learn about community options. Staff educational opportunities related to the community needed to be tracked in a manner that would allow the Facility to determine which staff had been trained, and which still required training. Efforts to share success stories were needed, particularly for individuals and guardians who were reluctant. The Facility remained out of compliance with this provision.	
	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	The Facility was implementing the State Office's process to have each professional member of the IDT document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual ISP meetings. In addition, at the ISP meeting, the professional members of the team needed to make a recommendation to the individual/guardian. The most recent format of the ISP included a section that more specifically addressed teams' recommendations regarding transition to the community. a. Of 10 ISPs reviewed for which the Monitoring Team requested all assessments (i.e., Individual #348, Individual #521, Individual #78, Individual #296, Individual #92, Individual #300, Individual #182, Individual #64, Individual #88, and Individual #307), for none (0%), all of the assessments included the applicable statement/	Noncompliance

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	remaining individuals for placement pursuant to such policies, procedures, and practices.	recommendation. 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 habilitation therapy for individuals with ongoing PNM needs). 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. b. In one of the 10 (10%) (i.e., Individual #300) written ISPs reviewed, and during one of the one (100%) (i.e., Individual #411) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included. c. In none of the ten (0%) written ISPs reviewed, and during none of the one (0%) annual ISP meetings observed, a thorough discussion of living options occurred. d. Three of the 10 individuals' ISPs (30%) a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included (i.e., Individual #78, Individual #348, and Individual #88). Examples of the problems have been explained in detail in past reports, and Facility staff should refer to these examples as they continue to work towards making improvements. e. In ten of the ten (100%) 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 for the team's recommendation (i.e., Individual #64, Individual #300, Individual #296, Individual #78, Individual #88, and Individual #348, whose guardians chose not to pursue transition). Examples of the problems have been explained in detail in past reports, and Facility staff should refer to these examples as they continue to work towards making improvements. Teams generally were not having thorough discussions about community living options. Although Facility discipline members generally were making a specific recommendation independent of the individual and his/her guardian, problems continued with regard to teams documenting a well-supported justification for their decisions. The Facility remained out of compliance with this provision.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service	Since the Monitoring Team's last onsite review, 12 individuals had transitioned to the community. Four of these individuals' CLDPs were reviewed (i.e., Individual #355, Individual #342, Individual #379, and Individual #247). This represented 33% of the relevant CLDPs. ▪ Based on review of ISPA or other meeting documentation:	Noncompliance

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	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:	○ a. None of the four (0%) CLDPs were initiated within 14 calendar days of referral. ○ b. None of the four (0%) CLDPs included documentation (e.g., ISPAs or other documents) to show that they were updated throughout the transition planning process. ○ c. None of the four (0%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). For each of these four individuals, very little documentation was submitted to show team involvement in the process. For example, ISPAs submitted for these individuals did not show development of the CLDPs early in the process, and ongoing meetings of the teams to update the CLDPs. Documentation also was not presented to show that in selecting a provider, the teams used the draft CLDPs as guided to determine whether or not the potential provider could meet the individuals' needs. ▪ d. None of the four (0%) CLDPs or other transition documentation included documentation to show that the Facility worked collaboratively with the LA. Although the LA attended the CLDP meetings, documentation did not clearly indicate what collaboration occurred, and ISPA documentation did not show ongoing collaboration with the LA. The Facility remained in noncompliance 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 coordinating the community living discharge plan with provider staff.	a. The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. Since the last review, the Facility continued to make efforts to include some more specific supports and services. However, none of the four CLDPs reviewed (0%) (i.e., Individual #355, Individual #342, Individual #379, and Individual #247) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the following six bullets occurred adequately and thoroughly as appropriate to meet individuals' needs. The following describes examples in which some of these activities occurred for some individuals, as well as example of where they should have occurred, but did not: ▪ <u>Training of community provider staff, including staff to be trained and level of training required</u>: Generally, the plans identified the need for training for community provider staff (i.e., Individual #342, Individuals #379, and Individual #274). This was not applicable for Individual #355, who was moving to live with family. This had been improved by providing more information about what	Noncompliance

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		should be included in the training. The plans also defined which community provider staff needed to complete the training (e.g., day and residential staff, nursing staff). However, the criterion for the level of training was often described as "verbal mastery," or "verbal and performance mastery." It was unclear what this meant, or how it would be measured (e.g., every staff member had to independently repeat all of the requirements discussed in the training; selected questions would be posed to a group of staff, which clearly would not be an adequate test of staff knowledge; and when judging performance, it was not clear what criteria would be used, for example, a specific competency checklist). In addition, some skills that should have required a competency-based return demonstration were not designated as requiring such a demonstration (e.g., texture of food, transfers, specific mealtime techniques, etc.). Also, of concern, the Facility included the following in CLDPs: "All new staff hired after transition to the community to be trained by staff originally trained by AbSSLC using information provided at original training." This provided no assurance that the staff providing the training were competent as trainers, or given the lack of requirements for the initial training to be competency-based, that the community provider staff providing the ongoing training had the skills and/or knowledge to complete the training. When staff competency needs to be measured, the specific competency check-off forms or specific methodology to test competence should be identified; ▪ Collaboration with community clinicians (e.g., psychologists, PCP, SLP): On a positive note, some plans (e.g., Individual #379 required communication prior to the move between the BCBAs, as well ongoing involvement during the first 90 days of the ABSSLC BCBA, and Individual #247's included sharing of information between nurses). However, some of the plans did not do this to the extent necessary based on the individual's needs (e.g., Individual #355's guardians had specific opinions about the prescription of psychotropic medication, but no pre-move collaboration between the Facility psychiatrist and community psychiatrist were discussed as possibilities or included as supports; for Individual #342, it was unclear whether or not the team considered collaboration between the Facility BCBA and community provider's psychologist/BCBA, for this individual with a PBSP for aggression; and Individual #247 had significant behavioral issues that required enhanced and one-to-one staffing at times, but no collaboration was required between BCBAs); ▪ Assessment of settings by SSLC clinicians (e.g., OT/PT): Individual #342 had issues with gait, but it was unclear whether or not the new environments were assessed to ensure they met his needs. Individual #379 had a history of suicidal threats and also had required one-to-one staffing at times, but it was unclear if the team assessed the new environment to determine, for example, if he made threats and/or required increased monitoring, whether the environment was	

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		configured to allow for such monitoring. Similarly, Individual #247 had the need for one-to-one staffing at times, as well as a history of inappropriate sexual behavior with his peers, but no evaluation of the environment was discussed to ensure it allowed for appropriate staff supervision; ▪ Collaboration between provider day and residential staff: On a positive note, the Behavior Coach for Individual #379 was included in the CLDP to provide at least four hours of assistance and further training to staff on two shifts on the first day of the move. However, there was no requirement for community provider staff to get to know about Individual #379's preferences and needs at ABSSLC, or any indication that the team even considered this as an option. Of note, for Individual #247, one of the ISPAs related to his behavioral concerns indicated staff at ABSSLC were "afraid" of him. It was not clear if these issues had been resolved through, for example, revisions to the PBSP and/or training and mentoring for staff. If so, it would have been essential for lessons learned about how best to manage his behavior at ABSSLC to be shared with community staff, and for community staff to have the opportunity to work alongside ABSSLC staff for a period of time. There was no indication that consideration was given to this possibility; ▪ SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community): As noted above, it was good to see the Behavior Coach for Individual #379 included in the CLDP to provide at least four hours of assistance and further training to staff on two shifts on the first day of the move. In addition, it was extremely positive that a post-move required support for Individual #379 was for the ABSSLC Behavioral Health Services provider to accompany the Post-Move Monitor on some of the visits "to observe and offer assistance or further training on the BSP as needed," as well as to "be available to the provider for additional visits at other times during the 90-day monitoring period for further training or help if problematic behaviors arise. However, for none of the other individuals were such supports included, and it did not appear the teams had even discussed this as a possible need; and ▪ Collaboration between Post-Move Monitor and Local Authority staff: 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. It appeared for Individual #355, this was not applicable because he was not receiving any Medicaid-funded supports. b. Four of the four CLDPs reviewed (100%) (i.e., Individual #355, Individual #342,	

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		Individual #379, and Individual #247) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. However, documentation was not included to show that the activities did indeed occur. The Facility remained out of compliance with this provision. Continuing problems were noted with regard to teams' definition and inclusion in CLDPs of comprehensive sets of specific steps that Facility staff would take to ensure smooth and safe transitions for the individuals moving to the community.	
	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 from the last review 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 from the last review 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. Although the Facility had made progress with regard to obtaining timely assessments and some improvement was seen with some assessments, the quality (i.e., comprehensiveness) of most of the assessments was lacking. More specifically: ▪ a. For none of the four CLDPs reviewed (0%), all necessary assessments were completed. For none of the individuals had the PSI, or IRRF been updated to ensure that their preferences and needs, particularly their needs related to risk, were sufficiently addressed. ▪ b. For none of the four CLDPs reviewed (0%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. As noted above, some assessments were not submitted at all. However, for all those that were submitted, they were completed no more than 45 days prior to the date the individual transitioned to the community. ▪ c. For none of the four CLDPs reviewed (0%), all assessments were available to the Placement Coordinator/Transition Specialist and IDT prior to the final CLDP meeting. As noted above, some were not submitted at all. However, those that were available prior to the final CLDP meeting.	Noncompliance

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		▪ d. For none of the four CLDPs reviewed (0%), the assessments were of adequate quality. The following summarizes concerns and areas of some improvement: o 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 been particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. o On a positive note, some assessments had begun to include more detail regarding the protections, treatments, and supports that individuals needed (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 this remained a work in progress, it was positive that some disciplines were beginning to include more detail. As discussed in further detail with regard to Section T.1.e, of significant concern was the fact that these more detailed recommendations were not consistently being translated into necessary pre- and post-move required supports. o Although some improvement was seen, assessments did not consistently 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 should include recommendations about their continuation and/or any modifications that need to be made to accommodate community settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments should 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. o In addition to specific issues related to transition, as is discussed in other sections of this report, a number of the underlying assessments were not of adequate quality. o 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	

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		(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 following specific information is repeated here from Section M to provide additional insight in concerns related to assessments. Regarding the nursing documentation for four discharges/individuals transitioning to the community, a review of the nursing notes and nursing discharge assessment summaries for four individuals including: Individual #483, Individual #165, Individual #381, and Individual #509 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 all (100%) 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 Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessments is necessary.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such	<u>Adequacy of Pre-Move and Post-Move Required Supports</u> The CLDPs reviewed included pre-move and post-move required supports. Since the last review, some limited progress had been made. Admissions and Placement Department and Transition Specialist staff appeared to be working with individuals' teams to expand the scope and definition of pre-move and post-move required supports. Additionally, efforts were underway to improve ISPs to more effectively describe individuals' needs for supports, and define how such supports were to be provided at the Facility. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. However, to make use of these improvements, teams will need to use the ISPs more effectively when developing CLDPs. Overall, though, at the time of the current review, teams did not consistently identify all the pre-move and post-move required supports that the individual needed to transition safely and successfully to the community. This lack of comprehensive identification of supports 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	Noncompliance

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	supports shall be obtained by the Facility before the individual's departure from the Facility.	community. a. In none of the four CLDPs reviewed (0%), a comprehensive set of pre- and post-move required supports was identified in measurable/observable terms. The Monitoring Team has provided many examples of concerns in previous reports. Although some improvements were noted from previous CLDPs, the Facility's CLDPs continued to have a number of missing supports. Although it was clear that Facility staff were working hard to try to develop comprehensive CLDPs, there appeared to be a lack of guidance regarding the overall goals of transition planning, and the need for plans to provide sufficient detail to ensure successful transitions to the community to the extent possible. The following summarize a couple of examples of overall concerns: ▪ Of note, although it was extremely positive that Individual #355 was moving to an apartment, the team's reliance on natural supports without good definition of what those supports would entail was concerning. It appeared the team went forward with Individual #355's transition from a fairly restrictive setting (i.e., ABSSLC), which by its nature offers a number of staffing supports, to a setting that, while it might be the most integrated, offered little to no staffing supports. The team did so without any structured, written plan for slowly reducing the oversight (whether it be from staff or family members), and assessing Individual #355's reaction to the new setting and the minimal supports. ▪ Individual #379 had lived at ABSSLC for less than a year when he transitioned to the community. Although it was positive that transition planning had started at the time of admission and Behavioral Health Services staff were involved in the transition, it was concerning that his transition plan and process did not carefully address the structure needed to address his behavioral needs (i.e., according to the Social Summary, while in the community previously, he broke his hand four times due to self-harm, broke his jaw during a restraint, was psychiatrically hospitalized numerous times, and was supported by a couple different providers after placements failed). Specific concerns about staffing, crisis intervention, and clinical supports are discussed below. The following provides examples of CLDPs in which appropriate pre- and post-move required supports had been included for some individuals, as well as example of where they should have been, but were not: ▪ 1) <u>The list should be comprehensive and inclusive, demonstrated by</u>: o Sufficient attention should be paid to the individual's past history, and recent and current behavioral and psychiatric problems: ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with	

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		crises at the Facility should be modified in a community setting. Although Individual #379 had a crisis intervention plans at ABSSLC, it was only referenced in the training section, and not as a post-move required support. The team did not appear to discuss whether it would be used, or if it needed to be modified. For Individual #342, who had a PBSP for physical aggression, the CLDP included no requirements for provider agency staff to have training or skills in psychological or physical management techniques, and there was no plan for what should happen if a behavioral crisis were to occur. Individual #355's team discontinued his PBSP at the time of the CLDP meeting. Although Individual #355 had not displayed behavioral problems recently, his past behaviors were serious, required one-to-one staffing, and had the potential to place him and others at risk. Given that he was moving to an apartment with "natural supports" and plans to identify an "appropriate roommate," the team should have, but did not discuss the potential need for crisis planning or management; and ▪ For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle. Such supports generally were not identified as pre-move required supports, such as involvement of community provider agency behavior analysts from the time of or before the transition were not consistently included as supports, even when this appeared necessary (e.g., for Individual #355, whose PBSP was discontinued at the CLDP meeting, and who had a history of significant behaviors that had the potential to place him and others at risk, the CLDP included no involvement of a BCBA; for Individual #342, who had a PBSP for aggression, the team allowed 30 days for the community psychologist/BCBA to become involved). It was positive that Individual #379's CLDP included involvement of a BCBA from the community provider communicating with	

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		the Facility Behavioral Health Specialist prior to his move. However, other than review and updating of the functional assessment and BSP within 30 days, it was unclear what the team expected the BCBA's involvement would be. For example, based on the narrative, reinforcers in the current PBSP needed modification, but this was not identified as a pre- or post-move support. ○ All safety, medical, healthcare, therapeutic, risk, and supervision needs should be addressed: ▪ For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. All four individuals had risks that were not sufficiently addressed in the CLDPs [e.g., Individual #355, who had risks related to polypharmacy and constipation, and other than asking him "if he would be too embarrassed to inform his mother and/or father if he does not have a BM [bowel movement] for three days in a row" had no supports to manage these risks on a daily basis (e.g., his parents maintaining a BM log, or being taught to monitor for symptoms of medication side effects); Individual #379 had a history of making false allegations, which placed him at risk, but no plan was included in the post-move supports for how his allegations would be handled; according to the nursing assessment, Individual #247 was 103 pounds overweight, and was at risk due to pre-diabetes, a history of high cholesterol, and a diagnosis of hypertension. Specific plans to address these risks proactively were missing from the CLDP (e.g., exercise, ongoing monitoring of blood pressure, training on making good choices, etc.)]; ▪ For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), teams should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria are met, reporting these to health care staff. Although for some of the health care indicators of the four individuals, supports had been included to measure them (e.g., pulse, bowel	

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		movements, and weight), a number of such supports were missing. For example, Individual #342 was prescribed Lithium, but other than quarterly monitoring of side effects by the psychiatrist, the team built in no requirements for staff to regularly monitor for the potentially lethal signs of Lithium toxicity. In addition, even though day and residential staff were to monitor Individual #342's bowel movements, no parameters were established for reporting problems. Individual #379 had parameters for constipation, but not weight. Individual #247's CLDP included parameters for holding certain medications should his pulse be below a certain number, but no parameters were provided for contacting nursing or medical personnel; ▪ With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians. For some individuals there was some limited definition of the roles of clinicians, but for none of the individuals was this done comprehensively. For example, Individual #355 had involvement of Behavioral Health Services staff at ABSSLC, but, even though his behaviors had decreased, no plan was included to make behavioral supports available in the community to ensure his transition was a smooth one, and then reevaluate the need for them. Individual #342 had a PNMP, and used a gait belt due to falls and unsteadiness, but the team included no specific therapy supports to provide oversight to the implementation of these programs and supports. Rather, the team inappropriately deferred this decision to the community PCP (i.e., "need for assessment by PT within 45 days of discharge…"); ▪ In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community. For a number of the individuals, supports provided at the Facility were removed/not included in the CLDPs, and adequate justification was missing (i.e., for Individual #355, a PBSP was removed without any support to have qualified staff monitor the impact of this as he transitioned to the community to a much less restrictive setting; as noted above, Individual	

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		#379 had a crisis intervention plan at the Facility, but it was not included as a post-move support; and Individual #247 had supports related to weight management at ABSSLC, of which a number were removed without adequate justification); and ▪ Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). For none of the three applicable individuals were staffing supports defined. This was not applicable for Individual #355. For Individual #342, the only reference to staffing supports was his need for a one-person assist when transferring in and out of a van. The team did not identify staffing supports needed, for example, when ambulating in different environments (i.e., despite his medium risk for falls, and difficulty on uneven surfaces), or the qualifications of staff, such as competency of staff to use psychological and/or physical management techniques (i.e., despite his history of aggressive behavior). No staffing supports were defined for Individual #379, and although at ABSSLC he had needed increased levels of supervision (i.e., one-to-one staffing at times), there was no requirement included in his CLDP that the community provider have the capacity to provide such supervision as needed. Moreover, despite his potential need for crisis intervention, the post-move supports did not require staff to have certification for psychological and physical management techniques. Although the community provider stated that staff were trained on "restraint," no discussion was documented in the CLDP regarding whether the restraint techniques on which they were trained were appropriate, and whether all staff working with him would be trained. Without a corresponding post-move support, ABSSLC did not have	

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		adequate commitment from the community provider that Individual #379 would have adequately qualified staff. For Individual #247, no staffing supports were specifically included. However, based on review of ISPAs over the months prior to his transition, he frequently had to be elevated to enhanced or on-to-one level of supervision due to aggression, as well as inappropriate sexual behavior with peers. The CLDP did not include any supports to ensure such staffing was available, as needed, at his community home or day program. ○ What was important to the individual should be captured in the list of pre-/post-move supports. The PSI was not one of the assessments updated for the CLDPs, and preferences generally were not included. Even when some important information about individuals' preferences or communication were included in assessments (e.g., the PNMP or QIDP summary for Individual #342), they were not included in the CLDP post-move supports in any meaningful way. ○ The list of supports should address thoroughly the individual's need/desire for employment, and/or other meaningful day activities. ▪ Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component. On a positive note, some of the requirements for plans to be implemented at the day program were included in the CLDP for Individual #342 (e.g., monitoring for bowel movements, implementation of the PBSP and PNMP). However, the plan failed to define in any meaningful activities in which he would engage at the day program (i.e., "Regular attendance at a day program on weekdays. [Individual #342] will have the opportunity to explore his environment at the day	

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		program"). Individual #379 was attending school. It was not clear whether or not the team made efforts to identify a school district that could meet his needs. Individual #247's plan did not define expectations regarding what his day would entail, beyond "Participation in a structured day program on Monday through Friday (excluding holidays)." Another support was for the community provider "to contact local sheltered workshop within 45 days of transition to schedule an evaluation or put [Individual #247 on the workshop's waiting list." This was particularly concerning, because the Social/QIDP Summary for Individual #247 stated: "Work is very important to [Individual #247]. He works Monday-Friday [six hours a day]. He began working in 1988 and has worked ever since." Although vocational staff said work was not important to him, except for making money, this significant difference of opinion was not adequately reconciled, particularly because the vocational assessment did not confirm this opinion. On a positive note, some supports related to plan implementation (e.g., PBSP and portions of the PNMP) required the day programs to implement them. ○ Positive reinforcement, incentives, and/or other motivating components to an individual's success should be included in the list of pre-/post-move supports. Other than global supports related to involving individuals in community activities, supports that integrated individualized positive reinforcement of incentives generally were missing. For example, Individual #247's ISP listed swimming as a preference, which was an important exercise option given his obesity. However, his CLDP did not include a requirement for the community provider to make this activity available, but rather included the following support: "Contact the local YMCA within 90 days of transition to check into a membership for [Individual #247]. If a pool is available, check for schedule to see if there is a time available for [Individual #247] to use it." ○ There should be pre-/post-move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. These generally were nonexistent or very limited. For example, Individual #355's team included none, despite discussion of his need for increased cooking skills, money management, etc. For Individual #379, the only formal skill training was for	

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		pedestrian safety. None were included for Individual #247. o There should be pre-/post-move supports for the provider's implementation of supports, including, for example, the BSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue: ▪ As appropriate, teams should identify as post-move supports the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications should be made to the methodology for providing these supports, with the end result being the individual's need for the support being met. Based on review of the four plans, generally PBSPs were referenced as needing to be implemented, but other plans, such as nursing care/IHCPs often were not, and it was unclear if all components of PNMPs had been translated into supports, or clear justification provided for not including them. For individuals prescribed psychotropic medication, except for lab work, no plans were included for monitoring for side effects. Although Individual #355's parents were identified to provide natural supports, the continuation of plans, such as nursing and dietary, were either not included (i.e., nursing plans for constipation or polypharmacy) or no methodologies were identified (e.g., for his diet, it was unclear if he would be responsible, or what "natural supports" would be provided). Individual #342's included implementation of his PBSP, and at least portions of his PNMP, but did not require implementation of the several nursing care plans/IHCPs he had at ABSSLC. The same was true for Individual #379 and Individual #247; ▪ CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community; o All recommendations from assessments should be included, or if not, a rationale should be provided. For many recommendations for all four individuals, corresponding pre- or post-move required supports were included. However, for each of the four individuals, there were recommendations that were not included, and for which adequate justification had not been provided for not including them. For example, for Individual #355, the rationales were insufficient	

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		for the numerous recommendations that were not followed. On a positive note, the team for Individual #342 requested re-evaluation of food texture, use of an anti-tip chair, and his ability to maneuver in and out of a van. However, although the therapists changed their original recommendations for a couple of these items, the resulting recommendations and post-move required supports did not fully address the concerns identified in the original assessments and it remained unclear whether or not the CLDP supports were sufficient to ensure his safety (e.g., the anti-tip chair was replaced with one with arms, but staff needed to hold the back of the chair, which did not address the possibility he might try to get up when staff were not present, which was confounded by the fact that the CLDP did not define staffing supports). ▪ 2) <u>The wording of every pre-/post-move support should be in measurable, and observable terms</u>: Most supports were measurable. However, for each of the four individuals, supports were included that were not measurable (e.g., "Assistance with money management and budgeting," "encourage to eat slowly"). ▪ 3) <u>Every pre-/post-move support should include a description of what the PMM should look for when doing post-move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur</u>: For each support, evidence was listed. In summary, since the last review, some limited improvement was noted with regard to the comprehensiveness of pre-move and post-move required supports. However, the CLDPs continued to be missing a number of important protections, services, and supports. <u>Essential Supports in Place on the Day of the Move</u> As noted in previous reports, the Facility was having the Post-Move Monitor and/or Transition Specialists conduct a pre-move site visit designed specifically to determine if the pre-move supports were in place. Based on review of pre-move monitoring for four individuals (i.e., Individual #509, Individual #442, Individual #379, and Individual #342): ▪ b. For the four of four individuals (100%), a pre-move site review was conducted by the Facility. ▪ c. Of these four individuals' pre-move site reviews, four (100%) were done timely and completely. ▪ d. Of these four individuals' pre-move site reviews, three (75%) (i.e., Individual #342, Individual #379, and Individual #442) indicated that all of the essential supports were in place prior to the individual's move, or if they were not,	

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		identified the issue and showed that action was taken to remedy the situation. For Individual #509, the pre-move monitoring was timely, but it was unclear how the Transition Specialist confirmed that the training was provided. Although she was there to witness it, based on the report and the attached documentation, it was unclear how staff demonstrated "verbal mastery" of the information. Other reports for which similar supports were included had more evidence to show that at least some staff demonstrated verbal mastery of the information. As is discussed in further detail above with regard to the CLDPs, these types of supports were not well defined, which made them difficult to monitor. ▪ e. The following indicator was not completed, because the Monitoring Team did not observe any pre-review site visits: For___ of __ (%) pre-move site visits observed by the Monitoring Team (if any), the pre-move site visit was conducted thoroughly. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Documentation with regard to confirmation of pre-move required supports was generally sufficient to show the supports were in place. However, although some improvement had occurred with the delineation of the pre- and post-move required supports in individuals' CLDPs, a number of protections, supports, and services continued to be missing from the CLDPs.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	a. There was not a written policy or written process for quality assurance to ensure the: a) development; and b) implementation of CLDPs. As discussed with regard to Section T.1.b, at the time of the review, the Facility's policy reiterated the State Office policy, which did not provide sufficient definition of the quality assurance process for the development and implementation of CLDPs (i.e., it only addressed submission of the CLDPs to the Facility Director for approval and State Office for review, but provided for no actual quality assurance mechanisms at the Facility level). When the Facility revises its local policy, it should define the specific procedures the Facility will use to conduct quality assurance activities related to CLDPs, and the Facility's implementation of them. b. Data were collected consistently. The Facility submitted some completed monitoring tools for CLDPs, including some that the Post-Move Monitor completed, as well as the PCM. However, the data were not being collected reliably, and it was unclear that the data were valid. The tool being used did not define the standards used, and did not result in valid findings. In addition, inter-rater reliability had not been established between the QA Department and the Admissions Placement Department. However, based on the list of topics discussed at meetings with the QA Department, it appeared the Admissions Placement	Noncompliance

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		Department was working with the QA Department on establishing inter-rater reliability, as well as developing standards/guidelines. c. Based on a list of meeting dates and review of minutes, the QA Department and Admissions Placement Department had been meeting monthly to review data, and minutes were maintained. Largely, the discussions related to the monitoring process, and the establishment of inter-rater reliability. When asked for reports showing analysis of data, the Facility submitted a number of reports, including ones related to obstacles, its Self-Assessment, and Action Plans. Of relevance to this subsection of the Settlement Agreement were the Self-Assessment and Action Plans, and specifically, the sections of those documents that addressed CLDPs. The indicators in the Self-Assessment for Sections T.1.c, T.1.d, and T.1.e were not sufficient to measure compliance with the Settlement Agreement. As a result, the data collected were not valid. The major problem was that the indicators did not measure the quality of the supports provided, they largely only measured the presence or timeliness of supports. Until valid data are available, the following indicators cannot be assessed in any meaningful way: Data **were/were not** reviewed, summarized, and analyzed. Actions **were/were not** taken as a result of analysis of the data. The data **were/were not** included in the Facility's QA program. d. The following was not applicable, because no one had returned to the Facility: For __ of the ___ individual (__%) who returned to the Facility after a failed community placement, an adequate review **was/was not** conducted to determine if changes in the referral and transition planning processes at the Facility should be made. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for __ (%). Of note, however, shortly prior to Individual #289's death, the team had planned a meeting to discuss his returning to ABSSLC e. One individual (i.e., Individual #289) that transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the Facility should be made for none (0%) of the cases. Of these reviews, actions related to the transition planning or implementation process were recommended in one case, but as discussed below, these recommendations were not sufficient. Due to the recent completion of the ISPA, the following could not be assessed: Of these ___ cases, actions were implemented for ___ (%).	

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		Individual #289 died after a series of four ER visits over four months, and a decline in health, and subsequently being placed on hospice. Based on the ISPA after his death, the community provider contacted the community PCP after his fourth ER visit and asked about placing him on hospice. ABSSLC was only notified of his decline after the decision was made for hospice. According to the ISPA, his ABSSLC team concluded that the community provider should have notified ABSSLC before Individual #289 was placed on hospice, so the team "could have met and discussed a plan of action making sure all testing and services were exhausted." Based on a review of the ISPA: ▪ On a positive note, the team for Individual #289 included recommendations about the need for providers to notify ABSSLC even after the 90-day post-move monitoring period if significant events occur. ▪ On a positive note, the team also recommended that if at a CLDP meeting, a recent change in caseloads had occurred (e.g., nurse, Behavior Health Specialist, etc.), then the staff member who knows the individual best should be involved in the CLDP meeting and transition process. ▪ Of concern, the team did not critically review all aspects of the CLDP or its implementation. As a result, the team did not identify the missing supports, of which there were many, nor did the team make the recommendations necessary to improve transition planning and implementation going forward. Some of a number of examples of where the team should have identified missing pre- and/or post-move required supports, but did not included: o Verbally, staff reported to the Monitoring Team that Individual #289 would have a downward spiral medically at ABSSLC, but then would rebound. The signs and symptoms that should be monitored for and/or staff response to such symptoms were not clearly outlined in the pre- or post-move supports. Likewise, no pre-move or post-move supports were included for Individual #289's medical providers (e.g., PCP) from ABSSLC to share information with the new medical providers in the community. o The team also did not review the supports included in the CLDP regarding strategies to use when he refused to eat to determine if the community provider had implemented them, when he started to refuse to eat. Individual #289 was past his 90-day monitoring period, but the LA Service Coordinator should have been monitoring to ensure this happened. Moreover, at the ISPA meeting, the team did not discuss the fact that competency-based training had not been provided on these very specific techniques, but given Individual #289's risks and history, should have been. o According to the ISPA, while at ABSSLC, his team identified the following areas of increased risk: "choking, aspiration, constipation, underweight, osteoporosis, fracture, infection, and seizures." While at ABSSLC he had	

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		nursing supports available to him to address these areas of increased risks. No nursing care plans were mentioned in the post-move supports, nor was the level of nursing support he required (e.g., nursing available in the home or on-call, regularity of nursing assessments, qualifications of nursing staff, etc.). However, the team did not discuss these significant deficiencies in the ISPA meeting after his death. Of note, State Office's guidance to Facilities regarding ER visits and hospitalizations currently is that three instances constitute a "potentially disrupted community transition." The three Monitors and DOJ have recommended that State Office modify this guidance, because often even one ER visit or hospitalization can be a signal that the CLDP did not include the necessary supports, or the provider is not implementing the supports as written. At a minimum, review should occur to ensure the provider staff have the information they need about the history of the individual. Quite unfortunately, Individual #289 is an example of where had the team met earlier in the string of four ER visits, the outcome might have been different. f. The Facility did not provide a list of potentially negative outcomes, and the documents the Facility submitted were nonresponsive to the Monitoring Team's request. Instead of providing a list as requested, the Facility provided ISPAs for Potentially Disrupted Community Transitions. Given that the instructions State Office had issued related to these ISPAs did not include all of the events about which the Monitoring Teams requested information, without a full list of the events, the Monitoring Team could not determine if these ISPAs identified all of the potentially negative outcomes. For example, in reviewing post-move monitoring reports, the Monitoring Team identified another negative outcome that the individual's team should have reviewed, but had not. Specifically, Individual #442 had police contact as a result of a behavioral incident. As a result, the information the Facility provided was not sufficient to determine the following: Over the past year, of the ____ individuals transitioned, ____ (__%) experienced one or more potentially negative outcomes since transition. Of the ____ individuals not previously discussed (i.e., deaths or returns to the Facility), there was an adequate review conducted for ___ (__%) of the cases to determine if changes in the referral and transition planning processes at the Facility should be made. Of these reviews, actions were recommended in ___ cases. Of these ___ cases, actions were implemented for ___ (%). The Monitoring Team's reviewed the ISPAs for Potentially Disrupted Community Transitions the Facility submitted, including two for Individual #289 who died, and the six ISPAs for five other individuals involving an additional 17 potentially negative outcomes. For one (i.e., for Individual #227, who moved due to the closure of his original home for administrative reasons), no action from the team appeared warranted. However, for the remaining seven, none (0%) represented an adequate review to	

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		determine if changes were needed in the referral and transition planning processes. The following summarizes these events and provides a brief synopsis of teams' failure to look critically at the planning and implementation process and make meaningful recommendations for future efforts: ▪ Individual #289 had four ER visits related to an allergic reaction, complaints of pain for several days, complaints of chest pain, and a seizure lasting 22 minutes. As discussed above, he eventually died, but the team did not review or make recommendations related to missing pre- and post-move supports, including but not limited to nursing supports, coordination/collaboration between medical or therapy practitioners before or during the transition, identification of measurable clinical indicators to show a change in status early in the process, etc.; ▪ Individual #197 had four events, including three hospitalizations due to low calcium levels and a suicide threat, and transfer to a rehabilitation facility. Although the team reviewed some of the pre- and post-move support, it did not make recommendations related to a number of missing pre- and post-move supports, including but not limited to nursing supports, coordination/ collaboration between medical practitioners (e.g., the ABSSLC PCP with the community PCP) before or during the transition, an appointment with an endocrinologist before or shortly after transition to the community (i.e., to address what the ABSSLC PCP described at the ISPA meeting as the need for "an Endocrinologist for routine care to manage the calcium levels as this is an on-going issue that [Individual #197] has had for a long time and will need to be managed for the rest of her life"); identification of measurable clinical indicators to show a change in status early in the process, etc.; ▪ Individual #11 had six events, including police contact after a behavioral incident, which led to a psychiatric hospitalization, and the foster provider indicating he could not return, which led to a change in placement, at which a second psychiatric hospitalization occurred and a hospitalization due to lithium toxicity, and transfer to a rehabilitation facility. At the time of the Monitoring Team's onsite review, his team had met and discussed another change of community placement for him, which would increase his number to seven potentially disruptive negative outcomes. Based on the review of the ISPA as well as his CLDP, a number of important supports were missing, but the team identified none of them, and made no recommendations to ensure that such omissions were not made in future CLDPs. The following provides a review of some of the missing supports. Individual #11 had a history of aggressive behavior, but no supports were included in the CLDP in relation to a crisis intervention plan or skills that the community provider (i.e., a foster care provider) would need to have in relation to de-escalation techniques or physical management. No supports were included in relation to working with the local	

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		police in case their assistance was needed. Lithium is a drug that requires careful monitoring due to its potential to cause toxicity. All staff working with individuals on Lithium should be aware of and monitoring regularly for signs of toxicity. However, the only support included in Individual #11's CLDP related to monitoring for Lithium read: "Lithium Level to be completed in January 2014… Will not be monitored by PMM [Post-Move Monitor] as it is beyond the 90-day monitoring period but included as a reminder to the provider." The team conducting the ISPA after these events did not identify these missing supports; ▪ Individual #483 had one hospitalization due to a seizure and cellulitis due to falling while exiting a bathtub "after a support bar with suction cups failed." The team did not discuss the need to ensure his adaptive needs were met through the identification and implementation of pre-move supports, such as review of the environment by a qualified therapist. In fact, the team did not even obtain a commitment that the provider would make the needed change. According to the ISPA: "The only recommendation was from the AbSSLC PT about a screwed in support bar in the bathroom, and the Provider agreed to check if that could be done." It should have been a pre-move support, and should have been done before Individual #483 moved; and ▪ Individual #33 had a hospitalization for constipation and wheezing in her lungs, which was diagnosed as "likely aspiration." Although her team reviewed the supports included in her CLDP, they did not identify ones that were missing, and made no recommendations to improve transition planning moving forward. As just some examples, Individual #33 was at high risk for aspiration and respiratory distress, and also was at risk for constipation and gastritis. However, based on the supports the team listed, no post-move supports required the community provider to have nursing supports in place and/or to develop and implement nursing care plans that were individualized to meet Individual #33's needs. Likewise, no post-move supports were listed for direct support staff to monitor for signs and symptoms of illness, and to notify nursing staff when such symptoms occurred. Similarly, no parameters were set for when medical staff should be notified. Fortunately, the community provider had some nursing protocols in place, although it was not clear that the ABSSLC team had a full understanding of what these were. Based on the lack of post-moved required supports in the CLDP, ABSSLC certainly had no commitment from the provider that nursing supports Individual #33 required would be implemented. Since the Monitoring Team's last review, the Facility's progress in this area remained essentially unchanged. The Facility should increase and improve its monitoring activities for CLDPs, including modifying, as appropriate, the monitoring tool to improve the	

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		guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In addition, as valid monitoring results are obtained, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. It is also essential that the Facility conduct critical reviews of the CLDP development and implementation processes for individuals that experience potentially negative outcomes.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	<u>Facility Efforts</u> a. Although Facility staff verbally reported that they were maintaining a list of the obstacles to individuals' transition, when asked for: "A printout of the database/report summarizing the obstacles identified for individuals' movement to the most integrated setting appropriate," the Facility provided only a report related to obstacles to referral. The only document in which obstacles to transition were summarized was the Fiscal Year 2013 Obstacles to Referral and Transition Report. It was not clear that the system to collect information about obstacles to transition was adequate. In order for this information to be completed, teams should report information about obstacles once the individuals' referrals exceed 180 days, as well as "compromises" to meeting the individuals' needs and/or preferences as outlined by the IDT. Examples of compromises would include the individual "settles" for a day habilitation program because the vocational program that the team recommended or that the individual preferred was not available in the part of the state in which the individual/guardian wanted to live; or the individual moved to an area of the state that was not the original preference because clinical services were not available close to family or in a part of the state that the individual preferred. It will be important as a system for collection of obstacles to transition is finalized to include these types of obstacles. This is essential to ensure that State Office has information to identify areas in which community capacity should be expanded. b. The Facility did not have an annual narrative that showed it had: a) conducted a comprehensive assessment of obstacles; and b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility. Some examples of problems included: ▪ As noted above, it was not clear that teams were thoroughly and/or correctly identifying obstacles to referral or transition. As a result, the data on which the report was based was not considered valid. ▪ One of the most significant obstacles to referral was identified as Individual	Noncompliance

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		Choice – Lack of understanding of community living options. However, the report did not set forth an aggressive plan to ensure individuals were educated about their options. In fact, the report largely reiterated processes already in place at the Facility, which to date had not been effective. There was no indication of what steps Facility staff were taking to ensure that education was really individualized, or how teams were being taught to determine individuals' preferences, particularly individuals whose teams had indicated were unable to provide consent/make informed decisions. On a positive note, the Facility did indicate that: "A list of 21 individuals identified by IDTs during the living options discussions as having no other obstacle to referral other than their own reluctance will be given to the transition specialists. These individuals will be the primary focus of attempts to provide education on community options available in an effort to reduce the individuals' reluctance to consider the community as a viable living option. The transition specialists will attend as many of these individual's annual ISP meetings as possible to assist in living options discussions." This was a positive first step. ▪ Table 3, which broke down the reasons for LAR Choice, clearly did not provide information for all 196 LARs that were reluctant. This illustrated the concern that the Monitoring Team has consistently raised that teams were not identifying the specific reasons for LAR reluctance. Until this is done, it will be difficult to meaningfully address this obstacle. Similarly, though, to the concerns about the Individual Choice obstacle, an aggressive plan was not set forth to address the LAR Choice obstacle. The report correctly identified that an individualized approach was the most effective, and referenced the good work the Transition Specialists were doing. No numbers were provided of LARs with whom the Transition Specialists were working. On a positive note, the Facility indicated that: "A list of the 71 individuals identified by the IDTs during the living options discussions as having no other obstacle to referral other than LAR reluctance will also be given to the transition specialists. The transition specialists will attempt to make contact with these LARs and offer tours or other information to help educate them on the options available in the community." Again, although this was a good first step, what was unclear was how the two Transition Specialists were going to work with 21 individuals and make contact with 71 LARs, as well as effectively manage their other responsibilities. ▪ With regard to community supports needed for individuals with complex medical and/or behavioral/psychiatric needs, the Facility made no recommendations to State Office regarding specific supports that are missing from the community system that would be necessary for individuals from ABSSLC to transition to the community. ABSSLC's report provided no analysis of the capabilities or capacity of the local providers for these groups of individuals.	

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		Annual Narrative by DADS State Office c. The State did not present an annual narrative that showed it had: a) conducted an analysis of the Facilities' data; b) taken 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; and c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: ▪ The statewide report listed the six obstacles to referral categories and 12 obstacles to transition categories used in FY13. ▪ DADS included a list of 14 initiatives it was continuing to support. ▪ The report included attachments with each of the Facilities' annual reports. ▪ The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the Monitoring Teams' reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • Transition Data: In the report, the State Office provided overall data related to transition of individuals from SSLCs, and the overall census from fiscal year to fiscal year. However, the data was fairly meaningless, because the data was not broken down sufficiently or analyzed. For example, although Facility censuses had decreased over the years, data was missing and no analysis was provided regarding how many individuals had died, how many admissions occurred, the numbers of individuals that died shortly after transition to the community, the numbers of individuals transferred to other large facilities, etc. • Transition obstacles data: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles). o State Office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, State Office staff said that their data	

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		system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The Monitoring Team believes that this information should be included in the report. • DADS' strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the Facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. o During recent discussion with State Office staff, the staff agreed that better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies, and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition. • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). o The Monitoring Team was unable to determine this because there was no information in the report addressing it. The Facility remained in noncompliance with this provision.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of	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

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	this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample of five individuals) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. <u>Timeliness of the Checklists</u>	Substantial Compliance

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	three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Post-move monitoring documentation was reviewed for five of the 12 individuals (42%) that had transitioned to the community since the Monitoring Team's last review (i.e., Individual #509, Individual #442, Individual #355, Individual #342, and Individual #379). Due to the numbers of individuals that had transitioned and only one Post-Move Monitor, other staff had sometimes conducted monitoring. The sample included monitoring reports that the Post-Move Monitor as well as two Transition Specialists completed. For the five individuals during the time period reviewed, ABSSLC staff should have conducted 12 reviews. Of the 12 required visits, 12 (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. Visits to All Sites 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. Content of Checklists 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 and Transition Specialists had correctly rated the pre-move and post-move supports as being present or not. Use of Facility's Best Efforts to Ensure Supports Are Implemented 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 12 reports reviewed, eight identified issues for which follow-up was necessary to ensure supports were implemented. ▪ Of the eight reports for the five individuals for whom follow-up was indicated,	

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		documentation was present to show that for seven (88%), sufficient follow-up had occurred to address the issues identified. Some examples of good follow-up included: o For Individual #342, a number of concerns were noted at the seven-day, and at the 45-day post-move monitoring visits, and the community provider called in between with concerns about Individual #342's behaviors. Individual #342 also had experienced a number of injuries as a result of his behaviors. The Post-Move Monitor appeared to request follow-up to concerns, as appropriate. The ABSSLC team also met after each, and when the provider called, held a meeting with provider staff. At that meeting, a number of recommendations were discussed and agreed upon. Many of these supports likely should have been included in the original CLDP, but it was good that the team identified the need for them once Individual #342 began having difficulties. It was good to see the Behavioral Health Services Department provided additional support to the community provider, and members of his team went to visit him to try to identify potential causes for the issues he was having. o For Individual #379, one concern was noted at the seven-day, and a number at the 45-day post-move monitoring visits. The Post-Move Monitors followed up on all of them, and made follow-up calls or sent emails when the community provider did not respond in a timely manner. Given the nature of the issues, this was appropriate follow-up. o For Individual #509, a number of issues were identified. The Transition Specialist talked with appropriate provider staff, and then did follow-up visit within a week to ensure necessary changes had been made. The following describes the concerns noted: o For Individual #442 at two visits, issues were noted. At the time of the 90-day review, Individual #442 still did not have access to a BCBA as required at the 60-day mark. She was exhibiting significant behavioral issues, and had experienced police contact as a result of one behavioral incident. The Post-Move Monitor had contacted the community provider administration. However, there was no indication that the Facility had requested the assistance of the Local Authority and/or DADS State Office. It is important to note, though, that at the time of the Monitoring Team's visit, the IDT had not yet met to review the 90-day findings. Of additional concern, when the Behavioral Health Services staff from ABSSLC made a late visit to the home (i.e., it should have occurred at the 45-day visit, but did not occur until later), she identified that staff at the home were not correctly implementing the ABSSLC PBSP. It was concerning that: 1) the Behavioral Health Services staff's visit was not done timely to pick up on this issue earlier; and 2) the	

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		Post-Move monitoring activities of the Admissions Placement Department had not identified that implementation was not occurring as required by a post-move required support. Thorough post-move monitoring reviews were being completed. Generally, Facility staff were following up to ensure that necessary corrections were made or supports were provided so individuals received the protections, supports, and services they needed. For one individual in the sample, it was not clear the sufficient action had been taken to require the community provider to implement the agreed-up supports that were essential to the individual's success in the community. This appeared to be an isolated incident, but the Facility needs to ensure that it uses the available resources to rectify problems identified, including the Local Authority and DADS State Office, including the regulatory division. This is necessary to maintain substantial compliance. At the time of this review, 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, no post-move monitoring visits were scheduled. Therefore, this subsection was not rated.	Not Rated
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		

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	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 had agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in an individual moving from a SSLC might fall under the category of "alternate discharges." One of these reasons was an individual transferring to another SSLC. Since the last review, two individuals were considered to have an "alternate discharge" because they were discharged to other SSLCs (i.e., Individual #81, and Individual #507). Based on a review of the discharge summaries completed for Individual #81 and Individual #507, they contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. They included a summary of the individuals' developmental, behavioral, social, health, and nutritional status. The summaries appeared to "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. They also appeared to meet the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ **If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause:** Based on the information provided, in two out of two records reviewed (100%), good cause was identified in the discharge summaries (i.e., Individual #81's behavioral and security needs could not be met at ABSSLC, and Individual #507 to be closer to family). ▪ **The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies):** Based on the information provided, for two out of two individuals (100%), reasonable time was given to prepare. ▪ **At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status:** The final summary included each of these components, and the information provided summarized his current status and important milestones/events, for two of the two individuals (100%).	Substantial Compliance

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		▪ **With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies:** For two of the two individuals (100%), ABSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving Facility. ▪ **The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment:** Based on the narratives provided in the Post-Discharge Plan of Care section, the IDTs for two of the two individuals (100%) generally adequately described the key supports that the individual would need in his new setting. Of note, the recommendations from various disciplines varied in quality. Some were fairly general, and did not, for example, recommend continuation of necessary plans (e.g., nursing and speech), while others were more helpful and specific (e.g., psychiatry). Overall, the minimal requirement was met. As appeared to be the intent of this subsection of the Settlement Agreement, the same standards for an adequate plan found in other subsections of Section T were not applied here. As a result, the Facility was found in substantial compliance with this provision.	

SECTION U: Consent			
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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	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 since Last Compliance Visit;" 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, updated 3/6/14; o Individual Notebook and Guidelines for Filing and Purging, revised 2/4/14; o Minimum Documents Included in Master Record, revised January 2014; o Procedure for Section V Monitoring, revised 1/23/14; 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 Settlement Agreement Policy Crosswalk, April 2014; o ABSSLC Policies and Procedures New Approved Policies Index, revised 4/9/14; o Policies and procedures tracked and trained since the last review, including documentation of training; o Monthly Meeting Minutes Section V: Recordkeeping, dated 10/23/13, 11/19/13, 12/16/13, 1/22/14, 2/25/14, and 3/31/14; o Settlement Agreement Compliance Report: Section V – Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4, for January through March 2014; o CAP for Recordkeeping – Inter-Rater Reliability, revised 12/6/13; o CAP for Recordkeeping regarding quality of the records, revised 12/6/13; o CAP for Recordkeeping – Timely Documentation of Data, dated 12/9/13 o Compliance by Monitoring Tool: Section V – Active Records Monitoring, 2/1/14 through 4/30/14; o Compliance by Monitoring Tool: Section V – Individual Notebook, 2/1/14 through 4/30/14; o Section V Action Plans, updated 4/28/14; o Self-Assessment for Section V, dated 4/28/14; and o Presentation Book for Section V.

	▪ **Interviews with**: o Kalana Allen, Records Coordinator; o Vickie Allmand, Unified Records Coordinator; and o Gloria Sprecher, Unified Records Coordinator.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V, dated 4/28/14. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section V, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Section V – Recordkeeping and General Plan Implementation review tool, the Individual Notebook Maintenance Guidelines Review, the Master Folder Table of Contents review tool, the Document (Tracking) Monitoring Tool, the Section V.4 interview tool, and indicators within the Section F monitoring tool. ▪ Since the last review, the Records Department staff had made some important changes to the Active Records Monitoring Guidelines. For example, additional questions had been added to determine whether or not the record was complete and current. This involved review of some substantive issues related to, for example, the Medication Administration Records, ISPAs, and consultation reports. ▪ Similarly, the Records Department made changes to the Individual Notebook audit tool to include more of a focus on real-time documentation. This was a positive development. 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 two 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. This is discussed in further detail with regard to Section V.3. ▪ 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 In recent months, the Records Department had increased it efforts to determine the quality of the information included in the records (e.g., completeness and timeliness of data in the Individual Notebooks). However, the Self-Assessment did not yet include this aggregate information. ▪ The Facility rated itself as being in substantial compliance with Section V.2. This was consistent with the Monitoring Team's findings. The Facility found itself to be in noncompliance with the remaining three subsections of Section V. The Monitoring Team found the Facility was in substantial compliance with Section V.3, but not with the other two subsections. ▪ 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. 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. On a more systemic level, since the last review, the Competency Training Department (CTD) had retrained supervisory staff on recordkeeping requirements. Supervisory staff were expected to play a role in overseeing recordkeeping practices, and intervening when they noted problems. The Unified Records Coordinators sent lists of staff that had been identified through record audits as failing to comply with recordkeeping guidelines, and CTD was scheduling competency-based training for them. The Facility had a working system for policy and procedure development and the completion of related training. The Policy Review Committee provided a reasonable mechanism to ensure that an interdisciplinary group was available to critically review policies and procedures. The Facility also had a system to make decisions about training on policies and procedures. With the involvement of CTD, the Facility had a working system to track staff's completion of the related training. Although quality assurance efforts will necessarily have to continue to be modified based on the findings and the Facility's priorities, ABSSLC had implemented the basic requirements of a quality assurance system for recordkeeping. This system included auditing of a random sample of at least five records monthly,

	analysis of the resulting data, and follow-up and development of corrective action plans, as necessary to address findings on an individual record as well as systemic level. In the Monitoring Team's last report, the Monitoring Team noted that 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. Since then, Facility staff engaged in efforts to identify and correct problems with the accuracy of the documentation. Training on recordkeeping practices was re-done for all direct support professionals, the Records Department was looking more closely at the data collection issue in its audits, supervisors were responsible for developing and implementing plans of correction for issues identified, supervisors were conducting their own monitoring in a number of residences, and supervisors were providing on-the-spot training when problems were noted. Although these efforts were in the early stages, they appeared to be having a positive impact.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Progress had been made and/or sustained with regard to the establishment and maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included: ▪ According to staff, all of the individuals at ABSSLC 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. Recent data continued to show a number of deficiencies. However, the Facility continued to take steps to address the issues it identified. Its current plan was for CTD to re-train supervisory staff (i.e., Supervisors, Unit Directors, Lead staff) on recordkeeping requirements. Since the last review, this had been completed. Supervisory staff were expected to play a role in overseeing recordkeeping practices, and intervening when they noted problems. At this juncture, when record audits identified staff who failed to comply with recordkeeping guidelines, Records Department staff referred them to CTD for competency-based training. Documentation submitted showed	Noncompliance

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		the Unified Records Coordinator were sending lists of staff requiring training, and CTD was scheduling training for staff on the lists. This appeared to be a reasonable effort to make the systemic changes, but it had not been implemented for long enough to determine its effectiveness. ▪ During the exit meeting at the Monitoring Team's last review, the Monitoring Team discussed the ongoing issue with the accuracy of the data included in the records related to the implementation of plans, such as PBSPs and SAPs. 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. Since then, the Facility staff engaged in efforts to identify and correct problems with the accuracy of the documentation. These efforts are discussed in further detail with regard to Section V.3. In sum, though, training on recordkeeping practices was re-done for all staff, the Records Department was looking more closely at the data collection issue in its audits, supervisors were responsible for developing and implementing plans of corrections for issues identified, supervisors were conducting their own monitoring in a number of residences, and supervisors were providing on-the-spot training when problems were noted. In addition, the Facility had begun a workgroup that included direct support professionals to discuss ways in which documentation methodologies could be improved. Although these efforts were in the early stages, they appeared to be having a positive impact. However, further review was needed to determine the outcome of these efforts. 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	At the time of the review, based on the crosswalk the Facility provided and the Monitoring Team' s review of other Sections of the Settlement Agreement, the Facility was awaiting policies from State Office for three of the 20 Sections of the Settlement Agreement. These included a final policy for Section G on Integrated Clinical Services, a final policy for Section H on Minimum Common Elements of Clinical Care, and a second policy for Section U to address the remaining components of the Settlement Agreement	Substantial Compliance

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	appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	requirements related to consent. The Facility had developed a policy related to Section H, entitled "ABSSLC Minimum Common Elements of Clinical Care," dated 9/23/13. Although the Facility had a policy on consent, no viable process had yet been defined for determining individuals' functional capacity, and a State policy was still needed. In addition, although the Facility had adopted the State Office policies for Sections O and P, it had not yet developed corresponding local policies for these Sections. This resulted in the Facility having policies in place for 18 out of 20 Sections of the Settlement Agreement (90%). Although for most substantive provisions, Facility policies were in place, there were some areas in which further Facility policy development was still needed (e.g., Section L, Section P, Section R). The quality of these policies, any concerns regarding their content, and the status of their implementation are addressed in the various sections of this report. As noted in previous reports, the Facility had developed a process to review and revise policies, and determine which staff required training on policies, what level of training was required, and to track completion of the training. Since the last review, the Facility had made substantial progress in ensuring that local procedures had been developed to operationalize State Office policies, as well as to complete training for staff on the policies and procedures. The following summarizes the Facility's processes and progress: ▪ The Facility continued to implement the policy on Dissemination, Training, and Implementation of New/Revised Policies and Procedures, updated in October 2013. As described in previous Monitoring Team reports, 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 policy also included a mechanism to communicate the issuance of new policies and training requirements to relevant staff. Email correspondence submitted showed this correspondence was occurring. ▪ The Facility had a process for tracking the training completed and sending reminders when training was overdue. The Unified Records Coordinators as well as the Competency Training and Development Department were involved in tracking the training. Since the last review, the Facility had finalized its system for tracking training related to policies. At the time of the last review, 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. Since then, exception reports were regularly produced as evidenced in documentation the Facility provided. The system could present 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), and could produce lists of staff that still required training. Emails submitted showed that the	

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		Unified Records Coordinators were regularly using this information to notify supervisors which staff still required training. CTD confirmed when all staff were trained. ▪ Since the last review, the Facility also had developed and begun to implement a CAP related to updating policies that contained outdated language or practices. The QA Department staff had been responsible for reviewing policies and dividing them into three tiers. QA Department staff then contacted parties responsible for correcting terminology issues and other issues requiring review. A schedule according to the tier system was set forth for presentation of the revised policies to the Policy Review Committee, which met weekly, and then finalization of the policies and training of staff. At the time of the review, documentation showed that many policies had been reviewed and revised, and the CAP anticipated completion of the process by the end of June 2014. In summary, the Facility had a working system for policy and procedure development and the completion of related training. Specifically, the Facility had implemented a process to review and adopt State Office policies, and develop corresponding Facility procedures to operationalize the State Office policies as well as other procedures necessary for consistent implementation of the requirements of the Settlement Agreement. Naturally, over time, additional policies will be added, and/or revisions will be needed to current policies. The Policy Review Committee provided a reasonable mechanism to ensure that an interdisciplinary group was available to critically review policies and procedures. As noted above, the quality or completeness of the policies, as well as the full implementation of the policies/procedures are not addressed with regard to Section V.2, but rather in other sections of this report. The Facility also had a system to make decisions about training on policies and procedures. With the involvement of CTD, the Facility had a working system to track staff's completion of the related training. As a result of the existence and consistent implementation of this system, the Facility was found to be in substantial 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	At the time of the last review, the Facility had a number of the necessary processes in place related to quality assurance for recordkeeping. Since then, the Facility had worked on the remaining pieces, including the development and implementation of additional methods to assess compliance with Section V.4, and additional use of the data obtained through the auditing process to identify and implement necessary corrective actions. The following summarizes the quality assurance processes that had been in place previously and continued, as well as the new initiatives. At ABSSLC, the Unified Records Coordinators were conducting reviews of at least five full records each month, as the Settlement Agreement requires, and they were conducting additional focused audits. The ABSSLC Procedure for Section V Monitoring, revised	Substantial Compliance

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	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.	1/23/14, defined the process for the Program Compliance Monitor from the QA Department selecting a random sample of 10 records per month. The Unified Records Coordinators completed full reviews of the first five selected. This included the Active Record, the Individual Notebook, and the Master Folder, using the compliance monitoring tool, the individual notebook monitoring tool, and the master folder monitoring tool. The Unified Records Coordinators were completing a total of two interview tools for Section V.4 each month. For the last five randomly selected records, the Unified Records Coordinators completed reviews of only the Individual Notebooks. This decision was appropriately made to focus on the quality and integrity of the real time documentation, documentation requirements, and specified document accuracy. The QA Department Program Compliance Monitor and the Medical Records Coordinator also were conducting reviews of a subsample of two of records per month to assist in ensuring inter-rater reliability. Since the last review, the Records Department staff had made some important changes to the Active Records Monitoring Guidelines. For example, additional questions had been added to determine whether or not the record was complete and current. This involved review of some substantive issues related to, for example, the Medication Administration Records, ISPAs, and consultation reports. 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. The expectation was they would be filed in five days or less. Based on documentation the Facility provided, inter-rater reliability between the four staff responsible for conducting record reviews fluctuated between 73% and 88% overall in the six months prior to the Monitoring Team's onsite review. As noted in previous reports, the staff had taken steps to improve the inter-rater reliability between the various auditors. For example, they had revised monitoring instructions/guidelines. Monthly meetings were still occurring between the QA and Records Departments during which differences were discussed. 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 and 12/6/13. The goal was to reach 80% inter-rater reliability across all indicators. As discussed during this most recent onsite review, Facility staff had achieved this goal for most of the indicators included in the audit tools. However, specific indicators were problematic. As discussed, the goal should be to determine if, when looking at exactly the same portions of the record, different auditors reach the same conclusion. Given that efforts to look at the record at the same time had not been feasible, and the records were constantly changing, an alternative would be for the QA Department to select and copy portions of the record that addressed the areas where inter-rater reliability had not been established	

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		and have each auditor review the sample(s). This would ensure each auditor was looking at identical information, and might either confirm inter-rater reliability, or identify more specifically what the concerns were. Although this was a work in progress, for the majority of the indicators, inter-rater reliability had been established at 80% or better. The Facility staff clearly were committed to reaching this level of congruence for the remaining indicators. 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 within approximately 10 working days following notification about needed corrections. Notes related to follow-up were made on the original monitoring form. If corrections had not been made or corrective action (e.g., record cannot be modified, but staff need to retraining) had not occurred, the Unified Records Coordinator sent further email correspondence to the supervisor of the person responsible. This process continued until necessary corrections or corrective actions had occurred. The Monitoring Team's review of documentation continued to show effective and strong follow-up to ensure deficiencies were corrected. As indicated in the Monitoring Team's previous report, the Facility had implemented the State Office's interview tool for monitoring Section V.4 of the Settlement Agreement, and also had added a component to the Section F monitoring tool to assess teams' use of records during ISP meetings. Since the last review, the Facility had increased its monitoring of Section V.4. Based on the Monitoring Team's findings, the Facility had developed a CAP to address Real Time documentation in the Individual Notebooks: ▪ The first step in the CAP was training staff on the expectations, which occurred in January and February 2014. The Facility submitted the presentation materials. They appropriately focused on the need to document accurately and in real-time by using the Individual Notebook, and emphasized the reason documentation is so important, specifically, that major decisions are made based on the documentation. ▪ As discussed above, beginning in February 2014, the Facility added focused monitoring of the real-time data in the Individual Notebooks to its monthly record audit system, which was part of this CAP as well. Based on review of the revised Individual Notebook audit form, questions were added to assess real-time and complete entry of data across a number of different types of documentation, such as trigger sheets, SAP documentation, treatment sheets, scatter plots, and observation notes. ▪ When problems were identified, the supervisors of the staff responsible for the documentation were required to submit a plan of correction. The data the	

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		Facility provided showed that audits in February and March 2014 identified a number of concerns related to the real-time data, with some improvements noted in April 2014. At the time of the Monitoring Team's review, supervisors had submitted seven plans of correction for issues identified, and five were considered completed. This had resulted in supervisory staff conducting checks themselves of the Individual Notebooks, and providing feedback to staff responsible for the documentation. Based on documentation the Facility provided, supervisors frequently found problems with documentation, and provided immediate feedback to staff. Although it was still early to tell, it appeared at least initially that these audits and plans of correction were having a positive impact. Although as stated in previous reports, ongoing monitoring of Section V.4 will require a number of different methodologies, these recent efforts were good additions. As stated in the Monitoring Team's last report, the Facility had been implementing a CAP related to the quality of the records, because audits had revealed systemic issues related to issues such as legibility, accuracy, signatures, etc. The first phase involved the training of supervisory staff, and since the last review, this process had been completed. Records Department staff continued to refer staff for whom issues had been identified. For example, between January and February 2014, approximately 26 staff were referred. Given that over time, the Records Department had engaged in a number of creative efforts to correct deficiencies related to quality, this latest effort showed a reasonable methodology for addressing these systemic issues. 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 quality assurance efforts will necessarily have to continue to be modified based on the findings and the Facility's priorities, ABSSLC had implemented the basic requirements of a quality assurance system for recordkeeping. This system included auditing of a random sample of at least five records monthly, analysis of the resulting data, and follow-up and development of corrective action plans, as necessary to address findings on an individual record as well as systemic level. The Facility was in substantial 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,	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	Noncompliance

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	medical treatment and training decisions.	not yet self-assessing this, the Monitoring Team observed that: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. The Records Department also had developed a naming format to assist staff in finding documents. 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)**: As noted with regard to Sections V.1 and V.3, since the last review, the Records Department had added indicators to the Individual Notebook audit to review the timely and complete entering of data on a variety of topics (e.g., trigger sheets, SAPs, observation notes, etc.). This data, as well as data that supervisors were collecting as a result of required plans of correction showed an ongoing, and fairly significant problem in this area. It was positive that the Facility was taking steps to correct the issues, but it was an area in which work was still needed. In addition to ongoing monitoring and follow-up, the Facility had developed a workgroup, including direct support professionals, to make recommendations regarding documentation methodologies. Hopefully, these efforts will assist the Facility in obtaining the outcomes of more valid and timely documentation. ▪ **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	

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		V.4. 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 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
BHA	Behavioral Health Assessment
BHS	Behavioral Health Specialist
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
LPC	Licensed Professional Counselor
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
NA	Not Applicable
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