United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Review: February 22 through 26, 2010

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Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement (SA) covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement, the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the Facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the Facilities assigned to him/her every six months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of Abilene State Supported Living Center (ABSSLC).

In order to conduct reviews of each of the areas of the Settlement Agreement and Healthcare Guidelines, 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.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included

information provided by one team member in the report for a section for which another team member had primary responsibility. For this baseline review of Abilene SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Toni Richardson reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Victoria Lund reviewed nursing care, dental services, and pharmacy services and safe medication practices; Susan Thibadeau reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed integrated protections, services, treatments and supports, and serving individuals in the most integrated setting, consent and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 to the recommendations in any way they choose, and to use other methods to achieve compliance with the SA.

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 February 22 through 26, 2010, the Monitoring Team visited Abilene 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. This allowed the Monitoring Team to gain some basic knowledge about Facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans (CLDPs), and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

(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. 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, PSP team 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.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 Facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 Facilities.

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, and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the Facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each Facility, this section will highlight, as appropriate, areas in which the Facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports, and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **Summary of Monitor's Assessment:** Although not required by the SA, 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;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the Facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;

(d) **Facility Self-Assessment:** In future reports, a description will be included of the self-assessment steps the Facility undertook to assess compliance and the results thereof. The Facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the Facility self-assessments for reviews beginning in July 2010;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated in reports that are conducted after the baseline reviews, beginning in July 2010; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. It is, however, in the State's discretion to adopt a recommendation, or utilize other mechanisms to implement and achieve compliance with the terms of the SA.

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, Individual #45, Individual #101, etc.). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Abilene Supported Living Center for their welcoming and open approach to their first monitoring visit. It was clear that the State's leadership staff and attorneys as well as the management team at Abilene had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested, and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. This was much appreciated, and set the groundwork for an ongoing collaborative relationship between ABSSLC and the Monitor's Office.

As is illustrated throughout this report, ABSSLC had a number of good practices in place, and in a number of the areas in which a need for improvement were identified, the Facility had plans in place to make needed changes. In addition, ABSSLC's management team and staff generally appear to be open to making additional changes as needed.

At the time this report was issued, information was not available with regard to the Facility's status with Section J of the Settlement Agreement that addresses Psychiatric Care and Services, and limited information has been provided in this report about the Facility's status with regard to Section L of the SA that addresses the provision of Medical Care. The Monitor apologizes for any inconvenience that this may cause.

The following provides some brief highlights of some of the areas in which the Facility is doing well and others in which improvements are necessary:

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at ABSSLC:

Protection from Harm - Restraint

- ABSSLC had an active Restraint Reduction Committee. With regard to the use of restraint, trends were beginning to move downward for physical restraints, but it appeared that the use of chemical restraints was potentially increasing. The Restraint Committee notes showed a rise in the use of chemical restraint from 29 uses in May 2008 to 37 uses in May 2009, and a reduction in use of physical restraint from 69 in June 2008 to 19 in June 2009. The Trend Analysis Report for Quarter 1 of FY10 showed use of restraints to be down from 283 in Quarter 1 of FY09 to 262 in Quarter 1 of FY10, a reduction of 21 uses, or approximately seven percent. Efforts should be made to determine and address the causes for the increase in the use of chemical restraint. The Committee should continue its efforts to reduce the use of physical restraint.

Quality Assurance

- A trend analysis report for the first quarter of FY10 had been completed, and provided summary data as well as some good analysis of that data. The next step, which can be a challenging one, is responding to the trends through the development of action plans to address identified issues. Follow-up will also need to occur to ensure that actions are taken that effectively address the trends.

Psychological Care and Services

- The ABSSLC format of the Behavior Support Plan provided a great deal of relevant information. Each of the plans reviewed contained a wealth of information about the individual, and provided a good basis for developing comprehensive and effective intervention services.

Nursing Care

- ABSSLC had 82 positions allotted for Registered Nurses (RNs) with only three vacancies. Having adequate and consistent nursing staff is one of ABSSLC's Nursing Department's strengths, and facilitates the provision of clinical care and positive outcomes to the individuals being served at the Facility.

Dental Services

- From the records reviewed, it appeared that individuals generally were being seen by dental every six months, and many of the individuals reviewed had had restorative dental care completed.

Communication

- It was apparent that the communication department had made an attempt to provide information to staff regarding alternative communication systems. In most settings, Monitoring Team members observed posters identifying basic signs, or icons to communicate a variety of needs or locations.

Most Integrated Setting Appropriate to Individuals Needs

- Post-move monitoring had been completed for all of the individuals who had transitioned to the community. A few had been completed late.
- The post-move monitoring identified some issues with regard to the provision of services at the community sites. The follow-up to rectify issues identified appeared to be rigorous, and included notifying the provider agency's management team of the issues identified, attempting to reach agreement with the agency on persons responsible and timeframes for the completion of needed actions, and notifying the community Mental Retardation Authority staff of the need for follow-up.

Guardianship

- ABSSLC had developed a tool to assist teams in determining an individual's priority level with regard to guardianship. With some modifications, this tool appeared to be a positive step in providing an objective methodology for prioritizing the list of individuals who need guardians. Reportedly, the Facility was close to finalizing a prioritized list.

Recordkeeping

- At the time of the monitoring visit, the State was in the process of revising the Table of Contents for the unified record. The Records Management Department at ABSSLC anticipated the finalization of the new State requirements within a few weeks of the monitoring visit. The Records Coordinator described a detailed and thoughtful plan to convert all individuals' records to the new format within a two-week period of time.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at ABSSLC:

Protection from Harm - Restraints

- The Settlement Agreement requires that restraint must be the least restrictive intervention necessary to manage behaviors. It was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. This will continue to present serious challenges to safely reducing restraint use in the future. The Facility should develop a plan for reducing the

numbers of individuals who live and work together who have behavioral issues, as well as identifying alternatives that allow individuals personal space.

Quality Assurance

- Many of the quality enhancement activities at ABSSLC were in the initial stages of development. A Quality Enhancement Plan was in draft format, and some tools had been designed to carry out monitoring.
- There were data that had not been clearly analyzed, trends identified, and actions implemented to correct deficiencies. For example, the Monitoring Team's review of a variety of information revealed troubling trends with regard to individual-to-individual aggression that often results in injury. This is a trend that must be addressed immediately and thoroughly.

Integrated Protections, Services, Treatments, and Supports

- The biggest challenge for ABSSLC with regard to PSPs appeared to be with regard to ensuring that team meetings include interdisciplinary discussions that result in one comprehensive, integrated treatment plan for each individual. As is noted in other sections of this report, issues with regard to adequate assessments impact teams' ability to identify strengths as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions, and the resulting integrated plans.
- One area where all plans reviewed could benefit from additional attention in "community participation." While most plans included opportunities to take trips to the community, few presented opportunities for participation in a manner that would support continuous community connections such as friendships and work opportunities.

At-Risk Individuals

- The current risk assessment tools used by ABSSLC did not provide an adequate, comprehensive risk assessment for any of the areas covered, and did not result in the appropriate identification of individuals' clinical risk indicators. Standardized statewide tools should be used by all the Facilities in assessing and documenting clinical indicators of risk to ensure that individuals who have clinical risks are appropriately identified. Based on this identification, proactive interventions should be timely put in place to address the areas of risks.

Psychological Care and Services

- As noted above, BSPs provided a good foundation for the development of comprehensive interventions. Missing elements from BSPs and related assessments, however, included: a) a rationale for the current plan; b) a brief history of prior interventions and their related outcomes; c) identification of replacement behaviors that are clearly tied to the hypothesized function of the problem behavior(s); d) clearer teaching guidelines for strengthening/teaching replacement behaviors; e) enhanced antecedent strategies, including greater opportunities to make choices, to negotiate more time with a preferred item, to protest an undesired activity, to request breaks, etc.; f) richer schedules of reinforcement, that incorporate identified reinforcers; g) consequences that are developed in consideration of hypothesized function(s) of problem behavior(s); h) clear

data collection measures that reflect pertinent information about the target behavior(s); and i) identification of the person or persons responsible for oversight of the plan.

Nursing Care

- The Nursing Care Plans at ABSSLC generally did not include appropriate measurable objectives. As these are improved, it will be necessary for nursing quarterly assessments to include a discussion of the progress an individual is making or not making, interventions that are working or not working, and to recommend changes, if needed, in these interventions.

Pharmacy Services and Safe Medication Practices

- Although improvements in recent months were seen with the Drug Regimen Reviews (DRRs), this is an area that requires improvement. In addition, a system needs to be instituted to ensure that physicians and/or nurse practitioners respond to recommendations included in the quarterly Drug Regimen Reviews.
- There appears to be significant underreporting of medication errors. Nursing staff did not consistently agree on which errors needed to be reported. Since medication error reporting is not yet reliable, a spot check system should be initiated. The spot check system needs to include a review of the Medication Administration Records (MARs) and narcotics log at some time during the shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately and that both the on-coming and off-going nurse has signed the narcotics log.

Physical and Nutritional Supports

- At the time of the review, the Facility was not systematically identifying individuals with PNM concerns. There appeared to be pieces of an identification system in place, but not a comprehensive, integrated system to ensure that individuals with such needs were identified in a timely manner to allow for prompt development and implementation of plans to address their needs. The Facility also was not completing comprehensive assessments of individuals at risk with regard to physical and nutritional management concerns, or developing comprehensive plans with measurable, functional outcomes to address risk areas.
- Many of the individuals at the Facility had mealtime and/or positioning plans in place. However, many of these plans did not address all activities in which swallowing difficulties can present risk. Moreover, many of these plans did not consistently address alignment support in wheelchair and/or alternate positions, strategies for oral hygiene, medication administration, snacks, personal care and/or bathing/showering.

Dental Services

- One problematic issue was the number of individuals refusing dental care. There needs to be a system in place to identify individuals who refuse dental care so that their teams can address this issue. At the time of the review, psychology had just started collaborating with dental regarding dental refusals. The disciplines in the

Facility need to collaborate to develop desensitization programs/strategies to assist in decreasing refusals, as well as the use of pre-sedation and restraints for dental and medical procedures.

Communication

- As noted above, efforts had been made to provide information about communication alternatives such as sign language and icons. Unfortunately, individuals and staff did not access these to support functional communication. There needs to be a system of oversight and monitoring to ensure that all individuals have a means of communicating their basic wants and needs.
- It appeared that a number of individuals who did not currently have access to alternative and augmentative communication systems might benefit from such systems. However, they had not been assessed, and/or plans developed to meet their needs due to inadequate staffing levels. Given the needs of the individuals living at ABSSLC, staffing for speech and language did not appear to be sufficient.

Habilitation, Training, Education, and Skill Acquisition Program

- Currently, skill acquisition objectives are not written in a manner that provides a clear understanding of the expected outcome. The following elements are missing: a) specific conditions under which the behavior will occur; b) a definition of the behavior in observable and measurable terms; c) identification of the criteria that will be used to indicate mastery of the skill; and d) a plan for the maintenance and generalization of the skill.

Most Integrated Setting Appropriate to Individuals Needs

- The Community Living Discharge Plans (CLDPs) reviewed included essential and non-essential supports. However, it appeared that the Facility was at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to, and after the individual's transfer to the community.

Guardianship

- Concerns related to the process used by Personal Support Teams (PSTs) related to guardianship included the following: 1) the process used to determine an individual's ability to provide informed consent was vague and did not appear to be directly related to specific and adequate assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09; o DADS Policy #001: Use of Restraint, dated 8/31/09; o Health Care Guidelines, dated May 2009; o Texas Administrative Code Title 40, Part 1, Chapter 5, Subchapter H, Rule Section 5.354 General Provisions, Use of Restraint in Mental Retardation Facilities; o ABSSLC Policies: Restraint December 2009; o ABSSLC Plan of Improvement, August 2009; o ABSSLC FY10 Restraints Trend Analysis From 9/1/09 to 11/30/09; o ABSSLC Procedures and Responsibilities of the Physician Related to Restraint, dated December 2009; o ABSSLC Procedures and Responsibilities of the Restraint Monitor during a Behavioral Crisis, dated November 2009; o Restraint Documentation Guidelines for State Supported Living Centers, dated November 2008; o Restraint Checklist, revised 12/09/08; o Individuals Restrained from 7/1/09 through 12/31/09; o Individuals Injured During Restraint July-December 2009; o Restraint Used During Behavioral Crisis: July through December 2009; o Restraint Reporting Form; o Restraint Checklist (401200BR); o Restraint records of twelve incidents of restraint including: Individual #163, Individual #367, Individual #48 (three incidents), Individual #442, Individual #231, Individual #486 (three incidents), Individual #323, Individual #430; o Prevention and Management of Aggressive Behavior (PMAB), 4th edition, dated 5/25/07; o ABSSLC Restraint Reduction Committee Minutes 8/24/2009 and 12/7/2009; o New Employee Pre-Service Training schedule: (TX-AB-1002-I.7); o Behavior Support Plans (BSPs) for the following individuals: Individual #163, Individual #517, Individual #43, Individual #367, Individual #105, Individual #242, Individual #209, Individual #464, Individual #438, Individual #156, Individual #81, Individual #272, Individual #276, Individual #286, Individual #355, Individual #153, Individual #313, Individual #442, Individual #231, Individual #310, Individual #461, Individual #278, Individual #486, Individual #277, Individual #430, Individual #287, Individual #537,

	Individual #252, Individual #160, Individual #525, Individual #146, Individual #132, Individual #504, and Individual #357; o Behavior Support Plan Tracking Sheet packets for Individual #196, Individual #315, Individual #494, and Individual #365; and o Medical records for the following individuals; Individual #486, Individual #502, Individual #4, Individual #323 ▪ **Interviews with**: o Sam St. Clair, Director of Quality Enhancement; o Cathy Hennington, Chief Psychologist; o Juan Herrera, QMRP Coordinator; o Various staff during tours of Facility; o Jared Hovze, MA, Associate Psychologist III; o Amanda Liuzza, Associate Psychologist III; o Sarah Vestal, Associate Psychologist III; o Kathryn Jones, Associate Psychologist III; o Shana Carroll, Associate Psychologist V; o Adam Sticyr, M.Ed, Associate Psychologist V; o Jenni Jamison, Associate Psychologist V; o Connie Moss, Associate Psychologist V; o Stacia Ellison, Associate Psychologist III; o Barbara Strelow, Associate Psychologist III; o Victor Aguero, Associate Psychologist III; o Mary Bone, Associate Psychologist III; o Michael Smith, Associate Psychologist III; o Cathy Hennington, Director of Psychology; o Mary White, RN, Quality Enhancement Nurse; and o Frank J. Kluza, RN, Chief Nurse Executive ▪ **Observations of**: o Individual #146 on 2/24/10; o Individual #316 on 2/24/10; and o Various individuals in residences and work activity centers.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: With regard to the use of restraint, trends were beginning to move downward for physical restraints, but it appeared that the use of chemical restraints was potentially increasing. The Restraint Committee notes showed a rise in the use of chemical restraint from 29 uses in May 2008 to 37 uses in May 2009, and a reduction in use of physical restraint from 69 in June 2008 to 19 in June 2009. The Trend Analysis Report for Quarter 1 of FY10 showed use of restraints to be down from 283 in Quarter 1 of FY09 to 262 in Quarter 1 of FY10, a reduction of 21 uses, or approximately seven percent.

	With regard to the use of restraints for routine medical or dental care, work on strategies to minimize or eliminate the need for restraint was in its beginning stages.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to 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.	ABSSLC Restraint Policy, dated December 2009 prohibited prone restraint at number 23 in the definition section, and at section II. C. The policy prohibited use of restraint for the convenience of staff, or as a substitute for treatment. The policy at II.B also required use of less restrictive alternatives before resorting to restraint, and listed options for alternatives. The Trend Analysis Report for Quarter 1 of FY10 showed use of restraints to be down from 283 in Quarter 1 of FY09 to 262 in Quarter 1 of FY10, a reduction of 21 uses, or approximately seven percent. The trend analysis report showed that 33 individuals, or seven percent of the individuals at ABSLC were restrained, with most restraints occurring on the 2 p.m. to 10 p.m. shift, and six individuals for whom restraint was used with each of them more than 10 times in the quarter. The trend report did not show any use of prone restraint in Quarter 1 of FY10. Further, based on a review of 35 restraint records involving four (4) individuals, there was no indication of prone restraint, nor was there evidence from review of the documentation that restraints were being used for the convenience of staff or as punishment. The following example was noted of a situation in which the Facility was not ensuring that restraint was not used in the absence of alternative treatment: ▪ Based on observations, mittens were being used continuously on Individual #316 based on a doctor's order beginning on 12/10/09, to promote healing. According to staff and the Director of Psychology, the mittens were being used to prevent recurrence of bites to her wrists. Therefore, the restraints were a behavioral restraint (biting her wrist), but the required Behavioral Support Plan was not in place, which would include strategies to reduce the behavior as well as the need for the restraint. ABSSLC's adherence to the requirement that restraint not be used in the absence of alternative treatment will be reviewed further during upcoming monitoring visits.	
C2	Effective immediately, restraints shall be terminated as soon as the	The trend report for the first quarter of FY10 showed Individual #323 was restrained six times in the quarter using horizontal restraint, or a basketHold for over 20 minutes each	

#	Provision	Assessment of Status	Compliance
	individual is no longer a danger to him/herself or others.	time. Individual #313 was in a basket hold seven times for an average of over 10 minutes each time. Individual #260 was in a horizontal restraint 20 times for over 10 minutes each time. These represent the longest times anyone was reported to be in emergency restraint during the quarter, which indicates individuals generally were not maintained in restraint for excessive periods of time. A review was conducted of 35 restraint reports, involving four individuals. Overall, most of these holds lasted between one to five minutes with the lengthiest time being 18 uninterrupted minutes. However, it was noted that on several of the Restraint Checklists for Individual #486 that the section for documenting the time and date of release was left blank. The standard for release from restraint found at ABSSLC Restraint Policy at II.I is when the person is "no longer a danger…" A review was conducted of 43 incidents of restraint. The documentation on the Restraint Checklists indicated that for all except one episode reviewed the individuals were released as soon as they were noted to "be calm and quiet." For the one exception, the individual was released "when no longer a danger to self or others." The use of the term "calm and quiet" does not adequately define when an individual is no longer a danger to self or others. Criteria for release from restraint should make it clear to staff that release is based on safety considerations.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed	The ABSLC policy on the Use of Restraints, dated December 2009 covered approved restraints. Approved restraints also appeared on the Restraint Checklist. The policy emphasized the use of the least restrictive intervention necessary as expressed on the Restraint Checklist, which provided prompts in the form of a list of alternatives to restraint. The policy at section III. A-C, required staff to successfully complete competency-based training on the use of restraint. It required prevention and de-escalation strategies as part of that training. The policy at II.E.1 stated that only " approved mechanical restraints are permitted," but it did not list the approved restraints or reference where a list of approved restraints might be found. The schedule for new employee pre-service training included positive behavior support and PMAB training. A review of the PMAB training materials indicated the training is intended to be competency-based and to emphasize positive intervention to avoid	

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	competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	restraint. It is not clear, however, that the trainee must demonstrate competency in the use of techniques in a test environment to successfully complete the classes, or whether attendance at the classes is sufficient to complete the training. Further evaluation of staff training with regard to the use of restraint will occur during upcoming monitoring visits.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	ABSSLC policy at section II.C.3 limited restraint use to only such time as "an individual poses an immediate and serious risk of harm to him/herself or others," and only when alternative, less restrictive measures have been tried and failed. Section IIC.7 stated that restraint may only be authorized in behavioral crises that place the individual or others at serious risk of harm. Under the Restraint Policy, Safety Plans, which are components of the PSP, were defined as documents that may include the use of restraints along with the type of restraint, the designated situation for use, duration and criteria for terminating the restraint. The purpose of the Safety Plan was to provide instructions for staff on preventing harm and injury during a crisis. In a sample of 23 PSPs, all contained Restraint Risk Assessments, completed by the PST. However, five Restraint Risk Assessment forms for Individual #272, Individual #546, Individual #469, Individual #461, and Individual #293 did not correctly enter the "resolution" by marking either that there "are" or "are not" any contraindications to the use of restraint. In most cases, the form specified if the physician indicated risks, but filling out the resolution is necessary to clarify the decision of the team. Two individuals, Individual # 163 and Individual #48, whose PSPs were reviewed had been restrained, and had appropriate Risk Assessments in their PSPs. ABSSLC had a Restraint Reduction Committee with a stated goal of a "restraint free" campus by 2012. A review of the notes from the August 24, 2009, and December 7, 2009 meetings indicated the committee monitors trend reports and the restraint reduction plan, and discussed such issues as the need for strategies to support individuals to need less medication for routine medical appointments. The Restraint Committee notes showed a rise in the use of chemical restraint from 29 uses in May 2008 to 37 uses in May 2009, and a reduction in use of physical restraint from 69 in June 2008 to 19 in June 2009. As noted above, the Trend Analysis Report for Quarter 1 of FY10 showed use of restraints to be down from 283 in Quarter 1 of FY09 to 262 in Quarter 1 of FY10, a reduction of 21 uses or six percent.	

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		Of these 262 uses of restraint in the first quarter, 155 were programmatic uses (i.e., implemented pursuant to a Safety Plan), and 107 were emergency uses. With regard to the use of restraints for routine medical or dental care, an interview with the Director of Psychology indicated that work on strategies to minimize or eliminate the need for restraint for routine medical practices was in its beginning stages. This was confirmed through record review. For example: ▪ Individual #456's Rights Assessment dated 2/5/09 indicated that he required restraint for dental procedures, and sedation for certain medical appointments that require him to remain still. His PSP only referenced that sedation was used for certain medical procedures. No strategies were included in the PSP to minimize or eliminate the need for restraint. Individual #456's Rights Assessment indicated: "The sedation plan will be to send familiar staff when available and to provide informal counseling so he can know what to expect during the exam, although he may not fully understand." Although this offers a beginning to a formal plan, it needs to be expanded and formalized in the PSP. Interestingly, the Human Rights Committee (HRC), denied approval of the medical sedation due to the fact that it had not been used since 2007, and there did not appear to be any plans for the types of medical procedures for which Individual #456 requires sedation. The HRC did approve the use of dental restraints.	
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,	Facility policy required documentation of a face-to-face assessment of the individual within 15 minutes of application of the restraint. It did so by including the Restraint Documentation Guidelines for SSLCs by reference at Section V. The face-to-face assessment was completed, and on file for 10 of the 12 episodes of restraint reviewed for the month of January 2010. For those 10 episodes, the restraint monitor did not see one individual for a face-to-face assessment until an hour after the start of the restraint, specifically Individual #367, on 1/18/10, at 5 p.m. In all cases the nurse was summoned, arrived promptly, and did the required checks. From a nursing perspective, a review of 35 episodes of physical restraints consisting of application of a helmet, horizontal holds, and basket holds for four individuals (Individual #486, Individual #502, Individual #4, Individual #323) found that in 27 (77%) the vital signs were taken or attempted to be taken every 30 minutes from the start of the restraint. There were a few instances in which the initial check of the individual's vital signs was initiated well over 30 minutes after the episode began without explanation provided for the delay. In addition, in a few episodes, the mental status section and	

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	except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	respirations were marked as "refused" by the nurse. These areas do not require the individual's cooperation to be able to make observations and document these in the appropriate section. The following problematic situations were observed on site with regard to the monitoring or restraints: ▪ Individual #146 was restrained with mitts during the night to prevent serious scratching of his skin. The approved plan called for monitoring of the mitts for circulation at 30-minute intervals. This was not being done on 2/24/10, since it would risk waking him, and he was observed to be sleeping with his hand under his pillow. Access for checking the mitts was hampered by the use of a breathing device. Since staff believed he could remove them at will, they were not risking waking him. However, not checking the mitts was in contravention of the written program. Further, no nurse or other health care professional was observed to be monitoring their use. The behavior program and medical approval need be to reviewed and possibly revised to reflect the practical challenges to monitoring in this situation. One possible solution might be to have a nurse check his wrists each morning to assure the mitt was not leaving marks, and/or to modify the application, if needed. ▪ On 2/ 24/10, Individual #316 was observed to be using mitts to prevent her from biting her wrist. There was a physician's order on file ordering the mitts for 30 days at a time. In discussion with the Director of Psychology, it was clear that she concurred that this use was behavioral, not medical, and required a behavior support plan. Such possibilities as a plan to fade the mitts over time to a large bracelet or to a "sweat band" that would be less restrictive and more attractive were discussed.	
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	Facility policy requires checking for restraint-related injury at section II.C.11, and provides for release as required by this section of the settlement agreement. Most restraints were of relatively short duration (the highest for physical restraint was 35 minutes), so issues of exercise, meals, and/or toileting did not appear to be issues. Restraint-related injuries occurred in nine cases involving five people over six months (July-December 2009), and all involved bruises and abrasions. There was documentation in 33 out of 35 (94%) episodes of restraint indicating that the individual was checked for injury following the restraint episode.	

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	staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	The following situations that were observed on site showed that some staff appeared to be following the enhanced supervision requirements for individuals in restraint, while others did not: ▪ Individual #146 who was wearing mitts at night was assigned one-to-one supervision, and the assigned staff person was in the room, even though it was 5 a.m. and the individual was asleep. As described in C.5 above, staff were not following the 30-minute checks as prescribed. An alternate plan needs to be put in place and authorized by the Director and physician as may be appropriate. ▪ Individual #316 above was supposed to be in medical restraint, and therefore, receiving enhanced supervision. She was observed in a group music activity in her home, and she was in line-of-sight of the group leader during the observation.	
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:	Facility policy requires the individual's team to conduct a review of restraints used more than three times in any rolling thirty day period at section II.J.5. A review of the report entitled "Restraint Used during Behavioral Crisis July through December 2009" indicated that of the 41 people restrained, 21 were restrained more than three times in a rolling thirty day period. The PSPs were requested for three individuals restrained more than three times. The three files included Individual #486, Individual #163, and Individual #48. The following provides a summary of what was found: ▪ Individual #163's PSP was completed on 2/26/09. Over three restraints in a 30-day period were used in July, August, September and October of 2009, according to the report, "Restraints Used during Behavioral Crisis July through December 2009." There were no amendments to his PSP included in the supplied information. ▪ Individual #486's PSP was completed on 8/3/09. He had been restrained using a helmet nine times in July, before the PSP, and continued to be restrained for a total of 137 times through December 2009. The PSP noted that hand-biting had subsided, but that the program to use the helmet in response to head hitting should be continued because Individual #486 sustained serious injury and deformity to his head as a result of years of head-hitting. The Psychological Update indicated substantial reductions in frequency and length of time in restraints, but recommended continuation of the program with some modifications. There were no amendments to the PSP in the supplied information.	

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		▪ Individual #48's PSP was held on 6/3/09. He was restrained four times between August 13 and November 10, 2009. Since these restraints occurred after the PSP, there should have been meeting notes, and an amendment to show review of the restraints. There were not in the supplied PSP file.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	The functional assessment section of the Behavior Support Plans does not reflect the date of completion. Therefore, it was difficult to determine whether high rates of restraint trigger updated assessments.	
	(b) review possibly contributing environmental conditions;	See the section above addressing Section C.7.a of the SA. There were occasionally comments on contributing environmental factors, but they did not appear to be reflected upon by the team. An example would be in the psychological report in Individual #486's file where the psychologist noted that Individual #486 "had increases in his target behaviors in July 2007 and May 2007 due to changes in staffing patterns related to spurious abuse neglect allegations by a peer in the home which caused him not to be served by his regular staff." Given this environmental consideration, his BSP should include provisions for dealing with such situations, should they arise in the future. It did not. In addition, observations in residential and work activity programs revealed chaotic atmospheres in some residences, particularly those with ambulatory individuals who present behavioral challenges. Such environments often are contributing factors that increase the likelihood that individuals will engage in target behaviors, thus reducing the effectiveness of behavioral supports.	
	(c) review or perform structural assessments of the behavior provoking restraints;	See the section above addressing Section C.7.a of the SA.	
	(d) review or perform functional assessments of the behavior provoking restraints;	See the section above addressing Section C.7.a of the SA.	
	(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,	A document provided by the Psychology Department indicated that Behavior Support Plans of 33 individuals contained plans for personal, mechanical, and/or chemical restraint. Section K of this report provides feedback regarding Behavior Support Plans. Greater emphasis needs to be placed on the development of replacement behaviors, application of expanded antecedent management strategies, implementation of more enriched schedules of reinforcement, utilization of identified reinforcers, and interventions that do not potentially reinforce the unwanted behavior. Additionally, there	

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	positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	must be greater opportunity for engagement in meaningful activities. The Monitoring Team had concerns about the time lines described for the administration of chemical restraint for several individuals, including: ▪ Individual #163 was administered Thorazine Intramuscular (IM) if he did not calm after one minute in restraint; ▪ Individual #43 was administered "…emergency Haldol and Ativan cocktail…" if he did not respond to redirection for aggression after five minutes; ▪ Individual #272 was administered a "cocktail" if his aggression continued after two attempts to redirect; and ▪ Individual #132 was administered Geodon IM after five minutes in restraint. In these situations, it appeared that chemical restraint was allowed to be administered too quickly, and in situations where Behavior Support Plans were not comprehensive. In addition, combinations of medication should not be referred to as a "cocktail."	
	(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	Although there was a policy in place that outlined standards for evaluating the degree to which treatments are implemented as designed, this policy had not yet been put into practice. Its implementation will be reviewed during upcoming monitoring visits.	
	(g) as necessary, assess and revise the PBSP.	At the time of the review, practices regarding data collection and analysis were inadequate for determining the effectiveness of Behavior Support Plans. It was unclear when plans were reviewed and revised other than discussion at Behavior Support Committee meetings. When a member of the Monitoring Team observed this meeting, there was no presentation or review of data to ensure that decisions that were made were data-driven, and there were no substantive changes made to the plans reviewed.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business	Review of Incident Management Review Team (IMRT) Minutes related to the sample of 12 restraint reports from the month of January 2010 indicated that all were reviewed by the IMRT within three business days. However, the review team noted only a brief description of the event. The following is one example: ▪ On January 27, 2010, the notes under restraint for Individual #48 read: "Chemical restraint – aggression, attempting to bang head, agitated, suicide	

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	days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	threats, wants to go to BSSH." The team discussion, its results, and any exploration of underlying causes, were not included in the minutes. It is possible that the unit teams undertake a more thorough exploration of the cause of the use of restraint in their reviews, but that was not clear in the IMRT reports. The one IMRT meeting attended on 2/25/10 did not include exploration of causes.	

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

1. Criteria for release from restraint should make it clear to staff that release is based on safety considerations, not on an individual being calm and quiet.
2. If mechanical restraints are going to be permitted at ABSSLC, then the list of approved mechanical restraints should be defined clearly.
3. The Restraint Reduction Committee should continue with an emphasis on discovering the underlying causes for individuals with the most frequent use of restraint.
4. As is discussed in detail in Section K of this report, improved Functional Behavior Assessments and Behavior Support Plans need to be developed. This will help to reduce the use of all types of restraint. More specific recommendations for the Facility's consideration are contained in Section K of this report.
5. Immediate attention should be given to those individuals for whom restraint, particularly chemical restraint, is employed frequently. This should include a review of the individuals' Behavior Support Plans, with revisions made accordingly. Ongoing review of data is essential, and should occur as part of the systems developed to reduce the overall use of restraint.
6. Monitoring instruments and procedures should be developed and implemented by the Facility for review of the components of this section of the SA.

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 DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09; o ABSSLC Procedure for Timely Reporting, Reviewing, Revising, Documenting Incidents and Ensuring Levels of Supervision, dated March 23, 2005, with a header date of January 30, 2010; o ABSSLC Trend Analysis Report for QTR 1, FY10; o Adult Protective Services: Investigations of Abuse, Neglect and Exploitation in MH/MR Settings: Presentation to Monitoring Teams by Ann Cortez and Karl Urban on 11/16 /09; o Texas Department of Aging and Disability Services Operational Handbook: Revision: 09-21, Effective October 29, 2009: Part E, Section 11000: Abuse Neglect or Exploitation (A/N/E); o PSPs for twenty-three (23) individuals from fourteen (14) different residences; Individual #272, Individual #546, Individual #44, Individual #274, Individual #4, Individual #486, Individual #264, Individual #163, Individual #48, Individual #461, Individual #293, Individual #429, Individual #376, Individual #315, Individual #246, Individual #215, Individual #400, Individual #502, Individual #70, Individual #467, Individual #284, Individual #264, and Individual #146; o Twenty-five (25) incident reports, from among reports supplied by ABSSLC; o ABSSLC Incident Management Review Team Meeting records, 12/01/09 through 12/31/09; o Incident report forms and data on individuals who experienced incidents or abuse/neglect allegations during the six (6) months preceding the review; o Investigation records maintained by the Facility of 37 allegations of abuse and/or neglect; o ANE: July 1, 2009 – January 25, 2010 dated Monday, January 25, 2010, listing all investigations begun in that time period (TX-AB1002-III.12); o Abilene State School Injury Trending 9/1/09 through 11/30/09; o Information on individual to individual aggression (TX-AB-1002-iii.11, parts 1 and 2); o Training slides on Abuse, Neglect and Exploitation: Policy for DADS, DSHS and MHMR Local Authorities, Community Centers, Contractors (date unreadable); o Comprehensive Investigator Training: slides, undated; o DFPS: APS MR & MH Investigators Training Modules 1-4, 7,8,and 10; March to November 2009; and o New Employee Pre-Service Training schedule (TX-AB-1002-I.7poh)

	▪ **Interviews with**: o Linda Hinshaw Facility Director; o Luee McCreary, Incident Management Coordinator; o Sam St. Clair, Quality Enhancement Director; o Carol Pennington, Psychology Director; o David Daniel, Systems Initiative Coordinator; o Judy Leech, Job Requisition Coordinator; o Christian Ramsey, Campus Administrator (Third Shift); and o Richard Gonzalez, Campus Administrator (Third Shift) ▪ **Observations of**: o Various homes and day/vocational programs throughout the campus; and o Incident Management Meeting led by the Director on 2/25/10.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: The Settlement Agreement requires that the Facility protect individuals from harm, consistent with generally accepted professional standards of care. It was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. This will continue to present serious challenges to protecting individuals from harm, including protecting individuals from injury, as well as peer-to-peer aggression. In addition, due to the potential for individuals' behaviors being exacerbated in such situations, restraint may be used at a higher rate than it would in a setting with fewer individuals that afforded individuals additional personal space. The Facility should develop a plan for reducing the numbers of individuals who live and work together who have behavioral issues, as well as identifying alternatives that allow individuals personal space. This needs to be done carefully so as to not disrupt homes on campus that serve individuals with no or few behavioral issues. Based on reviews of 25 investigations completed by ABSSLC staff and 37 investigations completed by DFPS, investigations were not yet being consistently completed within the 10 days required by the Settlement Agreement. Generally, the investigations reviewed were thorough. Attention needed to be paid, however, to factors that potentially contribute to the incident or allegation that may be indicative of broader neglect of individuals. In some of the investigations reviewed, findings had been made that staff who were aware of potential abuse or neglect had not reported it. This is a serious issue that should be further analyzed to determine the reasons staff members are not reporting allegations, so that the causes can be addressed. These causes may be varied, and range from staff being afraid of retaliation to staff not having a clear understanding of the definitions of abuse and neglect.

	ABSSLC had begun to track and trend incidents and allegations, and had generated a number of helpful charts and graphs. The Facility was not yet tracking causes of incidents or outcomes of investigations. As this process evolves, it will be essential to ensure that there are mechanisms in place to develop, implement and monitor effective actions to correct problematic individual and/or systemic trends that are identified. One issue of concern was the use of blue vests by staff at ABSSLC (as well as other Facilities). All staff except medical personnel at ABSLC were observed to be wearing blue vests with "STAFF" written on them. Inquiry revealed that these vests were being required by the State as a means of clearly identifying staff. Based on report from various staff, the vests were introduced in response to incidents of abuse, and were viewed by some as providing a level of protection to individuals. Reportedly, the vests were worn both on campus, and when staff accompany individuals into the community. There are a number of concerns related to having staff wear the blue vests, including: ▪ Since one of the articulated interests of DADS as well as the Settlement Agreement is the integration of individuals with developmental disabilities into the community, requiring such a graphic symbol of how individuals served at the Facility differ from staff and visitors is contrary to that desired goal. When in the community, individuals accompanied by vest-wearing staff are clearly identified as "different," accentuating any perceived bias toward them that may already exist. It is reminiscent of the "medical model" that the field has spent decades trying to dismantle. ▪ The vests create a visual symbol reinforcing any beliefs that staff have that individuals living at the Facility are different from those who serve them. It sets up an "us versus them" atmosphere that is inappropriate, and may, in fact, cause more protection from harm issues than it solves. An essential component of an adequate protection from harm system is ensuring that staff have the appropriate philosophy about individuals with disabilities, including the philosophy of equality. The vests do not contribute in a positive way to such a philosophy. ▪ Other concerns about the vests include infection control issues. For example, staff were seen assisting individuals with tasks such as eating, grooming, and toileting while wearing the vests. Given that the vests, unlike typical clothing, are loose, engaging in such job responsibilities while wearing the vests has the potential to promote the spread of infection. ▪ Also, because of the loose fit of the vests, they have the potential to become stuck in wheelchairs or other adaptive equipment. This places individuals and staff at risk for falls or injuries during transfers and repositioning activities. If a way of distinguishing staff is viewed as necessary, then a more normalized and safer approach should be initiated, such as staff wearing a small unobtrusive nametag, as most staff already do. In some instances, such as in day programs, individuals living at the Facility also had nametags that were slightly different in style and orientation. If such a system were instituted, strong consideration should be given to not requiring the wearing of nametags, when individuals and staff go into the community.

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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 DADS policy on abuse, neglect and incident management was completed on November 6, 2009. The policy was reviewed, and found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are noted under the corresponding section below. The DADS abuse, neglect and exploitation rules and incident management policy stated that abuse, neglect, and exploitation are prohibited. The SSLCs are required to comply with these State policies and rules. According to the Facility Plan of Improvement, this step was completed by 6/26/09, and is ongoing. However, there does not appear to be a Facility-specific policy on Abuse, Neglect and Incident Management. Instead, the State policy number 002 .1 was presented along with formal procedures for incident reporting that were dated 3/23/03. It is not clear whether the intent was to use the State policy as it stands, or to modify it at some point to make it clearly an ABSSLC policy. It would be beneficial, for example, for ABSSLC's policy manual to include a clear statement that ABSSLC does not tolerate abuse or neglect, and that staff are required to report allegations of abuse and neglect. Moreover, it was not clear whether the Facility procedures would remain as written, or be amended to more closely reflect the Settlement Agreement requirements. For example, the procedure for unusual incidents did not refer to the standard State forms, although the forms were present at ABSSLC, and in use. The procedures did not reference the need for an abuse-reporting poster, but one was seen on walls in residences and program sites. The posted provided basic instructions on intervening to stop abuse, as well as reporting abuse, and provided the number to call.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	According to the Plan of Improvement, policies, procedures and practices were due to be completed on 2/16/2010. Training for staff was to be completed by 4/22/10. An ABSSLC policy on incident management was not available at the time of the visit. Procedures for incident management were available, and dated 3/23/05 with a header date of 1/30/10. These are discussed in further detail in the sections that follow. The Settlement Agreement requires that the Facility protect individuals from harm, consistent with generally accepted professional standards of care. It was clear from even brief visits to some residences that there were too many individuals with behavior issues grouped together. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. This will continue to present serious challenges to protecting individuals from harm, including protecting	

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		individuals from injury, as well as peer-to-peer aggression. In addition, due to the potential for individuals' behaviors being exacerbated in such situations, restraint may be used at a higher rate than it would in a setting with fewer individuals that afforded individuals additional personal space. The Facility should develop a plan for reducing the numbers of individuals who live and work together who have behavioral issues, as well as identifying alternatives that allow individuals personal space. This needs to be done carefully so as to not disrupt homes on campus that serve individuals with no or few behavioral issues.	
	(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.	ABSSLC Procedure for Timely Reporting, Reviewing, Revising, Documenting Incidents and Ensuring Levels of Supervision required reporting of serious incidents at 05-01.3 through 01-05. However, the procedures did not include provisions for use of reporting forms, or make reference to forms. There were forms, however, attached to the procedures with instructions for use. Regardless of the fact that the procedures did not specifically identify standard forms, as evidenced through review of 25 incident reports, standard forms were in use for the reporting of abuse, neglect, exploitation, as well as serious injuries and incidents. Based on a review of 25 incident reports, they appeared to have been completed in a timely fashion. It also appeared they were sent to the Director or her designee, and to the appropriate authorities including DFPS, and law enforcement, when appropriate.	
	(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	DADS policy at 002.1.IV.A.1 required immediate action to protect the individual upon notification of an allegation of abuse or neglect. This included action to stop the abuse, protect the individual, and ensure the alleged perpetrator was removed from contact with the individual. The abuse-reporting poster in use at ABSSLC called for intervening immediately to stop potential abuse/neglect, to notify the nurse, and to document the event. A review of 25 incident report records indicated this was being done. Based on interview, an incident management coordinator was responsible for reviewing	

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	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.	incidents, assuring that they were being addressed properly, and analyzing incident reports for contributing factors when there were multiple occurrences in one location. Several additional steps were outlined in the Plan of Improvement to ensure compliance in this area, including but not limited to: ▪ Use of a Critical Incident Team after hours to start investigations and assure protective measures were taken; ▪ Preliminary investigations leading to removal of alleged perpetrators; ▪ Incident Management Review Team oversight to prevent recurring issues; ▪ Provision for root cause analysis leading to action plans; and ▪ Discussion with DFPS about timeliness and false allegations at regular meetings.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The ABSSLC Procedure for Timely Reporting, Reviewing, Revising, Documenting Incidents and Ensuring Levels of Supervision provided for staff training on abuse, neglect and exploitation and on unusual incidents. However, it did not reference competency-based training, nor did it require that the training be completed yearly. More specifically, it included section #13 on staff training. This section required training on abuse/neglect/exploitation among other topics, and required that it be done at orientation and "as needed thereafter." The Plan of Improvement called for competency-based training in abuse/neglect/exploitation to be completed prior to staff beginning work with individuals, and annually thereafter. The target date for completing this action step was 2/22/10. The Director of Quality Enhancement reported that this was being done. He indicated that Director for Continuous Training and Development maintained reports on training gaps. One interesting effort to assure staff were attending required training was to link completed training to requests for time off. In other words, in order for requests for leave to be approved, staff needed to have completed required training. The February schedule for refresher courses for Abuse/Neglect and Unusual Incidents showed classes were being given on eight mornings from 8 a.m. until 9:30 a.m. There was no comparable schedule at times that would make attendance by second and third shift staff convenient. Pre-service training included four hours of training on unusual incidents/prevention of abuse/neglect/exploitation.	

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		During upcoming monitoring visits, compliance rates with regard to staff training will be reviewed as will the quality of the competency-based 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.	According to the Job Requisition Coordinator, notification to staff of their abuse/neglect reporting responsibilities took place at their pre-service and annual training. Signed statements acknowledging responsibilities to report abuse were on hand with the Job Requisition Coordinator for those people who were recently hired. The Job Requisition Coordinator reported that acknowledgement forms were being maintained by the Unit Coordinators on the residential units where staff were assigned, and that a copy was sent to DADS office in Austin. While no check of unit files for the statements of assigned staff was made, this procedure appeared awkward, in that staff files would have to be transferred every time staff make a change in assignment between units. It was not clear that all staff understood the reporting requirements and followed them. For example, in an incident report #1809, an unidentified person reported to DFPS that staff was sleeping on duty. The matter was referred to ABSSLC for investigation, which showed that other staff in that residence failed to report someone asleep on duty. The person determined to be asleep was retrained; all other staff, including nursing staff were counseled for failing to report. In another case, DFPS #34100492, an individual was reported to have developed a rash, which went unreported by three people. It was finally discovered on the next shift and reported. Neglect was confirmed. A one-page reminder to staff about the necessity of reporting abuse and neglect was available.	
	(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	There were some efforts underway to educate and support individuals, primary correspondents and legally authorized representatives (LARs) about identifying and reporting unusual incidents, including abuse, neglect and exploitation. Specifically, the Plan of Improvement called for providing a training and resource guide to recognizing signs of abuse, neglect and exploitation, and how to report it. This guide would be provided at admission and annually to all individuals, primary correspondents, and LARs. The target date for this action step was 12/26/09. At the time of the review, a draft brochure was available. This will be evaluated further during upcoming monitoring visits.	

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	exploitation.		
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	At the State-level, the DADS policy on abuse, neglect and exploitation did not appear to require a rights posting. Posting of a statement of individual's rights, how to exercise them and report violations appeared in the eight sites visited. Some residences had a rights poster called "You Have the Right," which contains the required information, and some had a poster featuring a picture and phone number of the Human Rights Advocate to contact for support. Some residences had both. While the advocacy poster was helpful, the rights poster is the one that should appear in every home as it contains the required information.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The training slides on Abuse, Neglect and Exploitation clearly stated on slide 31 that the APS (DFPS) investigator may notify law enforcement, or Office of Inspector General (OIG). That slide also indicated that the head of the Facility has the ability to notify OIG. A review of 37 abuse files indicated procedures were followed. Abilene Police or OIG were notified in the ten 10 cases that appeared to require such a referral. The Assistant Commissioner for State Supported Living Centers had indicated that a Memorandum of Agreement/Understanding was being developed to clearly identify responsibilities in this regard.	
	(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, 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.	Specific references to protection from retaliation were not found in Facility policy. However, training for staff included a section dealing with retaliation, warning against it, and setting out penalties, including loss of job, if retaliation was found. Staff were instructed to report retaliation to their supervisor, or if that was not appropriate, to the Director. According to the Director of Quality Enhancement, residents, families and other non-employees could go directly to the Director to report any threats or retaliation, or to the Human Rights Office. If the threat was against the resident, they also could contact DFPS via the 1-800 number. It was not clear whether or not staff felt free from fear of retaliation when reporting incidents and abuse. This is based on the fact that at least two incidents in the sample of 25 found that staff failed to report, and two abuse reports involved failure to report. Although it is unclear what staff's reasons were for not reporting, one possibility is that they feared retaliation by their co-workers. There are other possibilities as well,	

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		including, for example, staff not having clear understanding of what constitutes abuse and neglect, or personal relationships between staff. It is important that the Facility evaluate the reasons for staff failing to report, and address any underlying issues. The following provides examples of staff's failure to report allegations: • Incident tracking #1971 involved Individual #422 and a nurse who used an improper technique to clear a feeding tube. Two staff were found to have witnessed the actions, knew they were incorrect, but did not report them. • Incident tracking #1809 involved a staff member asleep on duty. Investigation revealed other staff were on duty who failed to report the incident. • DFPS case #34442290 involved seven residents. A staff member had been throwing away evening snacks instead of giving them to the individuals as ordered by the physician. Investigation revealed that multiple staff knew the snacks were being thrown away over a two-week period, but they did not report the situation. • DFPS case #34272109 involved an individual who fell to the floor when a staff member failed to fasten a strap on the tub. The individual was moved before the staff member called for help, which violated procedure. Multiple staff knew that the incorrect procedure had been used resulting in harm to the individual, but failed to report it. Concerns about retaliation will be explored in more detail during the next monitoring.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Plan of Improvement indicated that semi-annual audits of progress notes, shift logs and injury reports were underway. Issues uncovered were to be reported to the Incident Management Team, and documented in their notes. The Director of Quality Enhancement was responsible to do this, and had five program compliance officers on staff to assist with this as well as other monitoring efforts. It is too early in the development of this process to fairly assess progress.	
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		

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	policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	State Policy required both DFPS and Facility investigators to have training in investigations. However, the policy did not make it clear that both DFPS and Facility investigators must have training in working with people with developmental disabilities. It also was not clear that the investigations must be carried out by persons who are outside the direct line of supervision of the alleged perpetrator. To qualify as an investigator a person must pass the competency-based training provided by the State. At the time of the review, four staff were available on campus as investigators, including a full-time investigator, a campus administrator, the QE Director and the Director of Risk Management. Five additional staff were in training to become investigators, including three full-time investigators. All of these staff appeared to have experience working with individuals with developmental disabilities. DFPS investigators receive the same training, but it was not clear whether or not they had training in working with individuals with developmental disabilities. This will be reviewed during the next monitoring visit.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	DADS Policy Number 002.1, entitled Protection from Harm – Abuse, Neglect, and Incident Management, referred at I.D to cooperation with DFPS, and Section V.A.2.d referred to cooperation with DFPS in the conduct of investigations. Policy 002.1 at D provided for reporting to law enforcement and required staff to abide by all instructions of the law enforcement agency. ABSSLC procedures did not specify how cooperation with outside entities was to occur. The Plan of Improvement offered assurances that ABSSLC would cooperate, and the Incident Management Coordinator was clear that her office stands aside for investigations by DFPS, as well as for law enforcement, when necessary. The Incident Management Coordinator indicated that she had frequent contact with the DFPS office about on-going cases.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	DADS policy at Section V.D referred to reporting to and coordination with law enforcement. Facility policy did not address this, but the Incident Management Coordinator's understanding of the need to cooperate and coordinate was clear. Based on sample of thirty-seven (37) abuse investigations, ten (10) referrals were made	

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		to local law enforcement or to OIG. In interview with the ABSSLC Incident Management Coordinator, it was clear that she understood the need to defer to law enforcement authorities when there was joint involvement in an investigation.	
	(d) Provide for the safeguarding of evidence.	The Investigator's Training Manual did not provide requirements for safeguarding of physical evidence. Based on interview with the Incident Management Coordinator, evidence was bagged, labeled, and stored in the treatment room in the infirmary. When an entire space, such as a room, constituted evidence, the room would be locked, or an employee posted to safeguard it.	
	(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.	DADS Policy #0002 dated 11/06/09 set forth requirements for SSLC investigations at VIII that are consistent with the Settlement Agreement. ABSSLC Procedure for Timely Reporting, Reviewing, Revising, Documenting Incidents and Ensuring Levels of Supervision, dated 3/23/05, set out requirements for reporting of incidents, but not for investigation of incidents. Review of the investigation process and discussion with the Incident Management Coordinator indicated the Facility was following the DADS policy on investigation. Review of 25 unusual incident investigations revealed that ABSSLC investigators were following the state policy requirement that investigations begin within 24 hours, unless superseded by DFPS or law enforcement investigation. Completion within the 10-calendar day timeframe was not as clear. Seven of 25 (28%) were clearly within the timeframe. Some death investigations were not within the time frame, but this was likely due to issues such as autopsy reports that were not within the investigator's control. Other incidents did not have sign-off dates on the forms provided, and, therefore, the conclusion date could not be established. There were two reports (#1817, and #1783) that were completed outside the specified time frames. DFPS had required investigations to be done within 14 days of notification. This was being changed to within 10 days according to the presentation to monitoring teams on	

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		11/16/09. Of 37 DFPS investigation reviewed, 29 (78%) were completed within 15 days. There was a mechanism in place to allow for extensions to be granted for the completion of investigations. Future reviews will include review of the documentation justifying any extensions.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The Comprehensive Investigator Training Slides provided direction on preparing an investigation so that it forms a clear basis for its conclusion. Thirty-seven (37) investigations of abuse and neglect allegations, written by the DFPS investigators were reviewed for this report, and were generally found to have provided clear bases for their conclusions. A standard format was used. Some observations include: ▪ One report, Case #10-01-030, contained confusing information about locations of those involved in the alleged incident. A drawing, locating people in the area would have aided understanding. ▪ Case #34035652 involved use of the Abdominal Thrust to stop choking on a liquid. The resident was reported to be red in the face (not blue as when an airway is blocked.) The report did not address whether the use of the Abdominal Thrust was appropriate. ▪ Case # 34078451 described considerable disruption and confusion in the home at the time of the alleged abuse. In the investigation report, nothing was recorded about the possible issues that disruption was causing other residents, and whether the entire situation might have been neglectful of a larger group of residents. Of the twenty-five (25) Unusual Incident Reports examined in this review, all were in a standard format, and most contained sufficient information to draw conclusions. Some observations include: ▪ Report #1842 involved an alleged incident of sexual contact between two residents. However, there was no report of an examination of the individuals by a nurse, no collection of evidence such as clothing or sheets, and few interviews of staff. Yet, the conclusion was that nothing had happened. ▪ The Unusual Incident Tracking Form was not organized to collect information in as comprehensive a way as the DFPS report format. For example, the form did not include provision for restatement of the allegation, points of agreement and disagreement, a summary of witnesses' credibility, and/or a probable version of events. Most reports examined for this review did not include these elements. However, some did add these sections as separate pages within the report. Whether these pages were extracted from DFPS work or added to illuminate the investigation by ABSSLC is not known, but they did improve the reports. • Sometimes there were omissions on the forms such as dates and times of	

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		reporting to other staff; occasionally blanks in notifying DPFS of an incident (e.g., Report #1680 involving an allegation of sexual contact); and often missing dates for sign-offs indicating the case was closed, which may have been the result of the way copies were made for this review.	
	(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.	DFPS investigation reports were signed by the investigator. It was unclear if supervisory staff at DFPS reviewed the investigations to ensure they were thorough, complete, accurate and coherent. This will be reviewed further during upcoming monitoring visits. According to an interview with the Incident Management Coordinator at ABSSLC, she reviewed the reports, and can and has on occasion asked for additional information or further investigation	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Unusual Incident Reports have space for supervisors to sign off as having reviewed and approved the reports. While signatures were not on the forms examined, this appeared to have been the result of drawing copies from the electronic files for purposes of this review. This requirement will be reviewed further during upcoming monitoring visits.	
	(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.	There were entries on many Unusual Incident forms for immediate actions to be taken, and for future actions with timeframes for completion and persons responsible. Since these forms went to the Incident Management Review Team, they had the ability to monitor these actions for completion. A review of IMRT notes indicated this was being done, but it was difficult to track a case through the daily notes to conclusion. During upcoming monitoring visits, reviews will be conducted to determine if actions documented as needing to be or having been taken have been completed on an individual as well as systemic-level.	
	(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	The policy on retention of records was not reviewed as part of this review. However, the results of investigations were in the electronic system, and files were maintained in the office of the Incident Management Coordinator. She was able to rapidly retrieve any requested file. Further review will need to be conducted to determine if DFPS has a system that permits investigators to access every investigation involving a particular staff member or	

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	particular staff member or individual.	individual.	
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.	ABSSLC had a system in place to track and trend data on unusual incidents, and abuse and neglect allegations. The report for the first quarter of FY10 was available for this review. It provided a wealth of valuable information about types of incidents, staff involved, location, and time of incidents. Causes of incidents, and outcomes of investigations were not yet tracked. According to the quarterly trend analysis report, deaths, serious injuries, choking and sexual incidents were being reported and analyzed by unit, by home, by shift, and by day of the week. One result of this reporting was the ability to determine where most incidents occur (Units I and IV), on what shift they occur most frequently, etc. In addition, abuse/neglect allegations were tracked by disposition. As a result, it was possible to see that for the first quarter of FY10, there were 60 pending cases out of 160 reported or slightly more than one third. Given that the timeframes for closing cases is tight (10 days), it would appear that some cases were lagging behind. However, in discussion with the IMC, it was clear that cases were closed in the electronic files when the required corrective actions were complete, not when the investigation was complete. Some cases were slowed by the need to await DFPS or law enforcement involvement. Abuse/neglect allegations were being tracked and analyzed according to the following criteria: individuals with more than two, by units and homes, and by shift and day. Causes were not being tracked, but dispositions of investigations were being tracked.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for	The State policy on Abuse, Neglect and Exploitation did not contain information on prerequisites to allowing staff or volunteers to work directly with individuals. However, Section 3000 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers at section 3200.3. The DADS Operational Handbook, Revision 09-21 Effective 10/29/09, at Part E, Section 19000 requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff of volunteers to work directly with individuals. According to the Job Requisition Coordinator, these were accomplished by entering information on new hires/volunteers directly into the electronic system. The results were reported to DADS central office, and a "clear" or "not clear" report was sent to the Facility. It was not clear from discussions with staff that volunteers were always cleared before they are allowed with individuals. The SA does allow volunteers for whom an investigation has not yet been completed to work with individuals, if staff directly	

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	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.	supervises them. This will be reviewed in further detail during upcoming reviews.	

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

1. The Facility should develop a plan for reducing the numbers of individuals who live and work together who have behavioral issues, as well as identifying alternatives that allow individuals personal space. This needs to be done carefully so as to not disrupt homes on campus that serve individuals with no or few behavioral issues.
2. If a way of distinguishing staff is viewed as necessary, then a more normalized approach than the use of the blue vests should be initiated, such as staff wearing a small unobtrusive nametag, as most staff already do. In some instances, such as in day programs, individuals living at some Facilities also had nametags that were slightly different in color and orientation. If such a system were instituted, strong consideration should be given to not requiring the wearing of nametags, when individuals and staff go into the community.
3. Requirements about training of investigators should be included in the DADS policy on Abuse/Neglect/Exploitation (A/N/E), or if these requirements are elsewhere in state policy, reference to their location should be provided in the A/N/E policy. The DADS policy also should include requirements that the Facility Investigator be outside the direct line of supervision of the alleged perpetrator.
4. The Facility Policy Manual should specifically state that staff must complete annual competency-based training on abuse and neglect.
5. The Facility Policy Manual should state specifically that retaliation will not be tolerated against anyone who in good faith reports allegations of abuse or neglect, and/or participates in a related investigation.
6. When it is identified that staff have failed to report a serious incident or allegation, the Facility should evaluate reasons for staff failing to report, and address the underlying issues.
7. Specific language should be included in the Facility Policy Manual requiring annual notification to staff of their obligation to report abuse, neglect or exploitation, and the requirement that each staff member provide a written statement of acknowledgement of their responsibilities to report.
8. The detailed action steps in the Plan of Improvement for Section D.2.b of the SA regarding follow-up to allegations of abuse and neglect should continue to be implemented.
9. The training and resource guide to recognizing signs of abuse, neglect and exploitation, and how to report it that the Facility was developing for individuals, their families and LARs should be finalized and distributed.
10. The expectations with regard to the safeguarding of evidence should be added to the Investigator's Manual.
11. The IMRT should discuss, record the results of deliberation and take action on investigations they review that raise serious systemic issues such as failing to report, possible fear of retaliation, the chaotic conditions in some homes, etc.
12. The IMRT should take steps to address not only the investigated issues, but also the underlying issues that may be contributing indirectly to the incident such as aggression by individuals toward their peers.
13. The IMRT's tracking system and meeting notes should be modified to ensure they provide an easy way to track an incident and its follow-up

through to conclusion.

14. The tracking and trending system for unusual incidents and investigations should be modified to include causes of incidents and outcomes of incident investigations.
15. The Facility should develop and implement an investigation format that meets the requirements of Section D.3.f of the SA. This format should be included in the Facility's Policy Manual, along with an explanation of how the investigation report should be completed.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #003: Quality Enhancement, dated 11/13/09; o ABSSLC Plan of Improvement, dated 8/09; o CMS Statements of Deficiencies, dated 2/20/09, 2/27/09, 4/03/09, 4/27/09, 8/11/09, and 11/05/09; o ABSSLC Trend Analysis Report for Quarter 1, FY10; o ABSSLC Trend Analysis Report FY10: December 2010; o Leadership Council notes for 2/1/10; o Incident Management Review Committee notes; o Performance Improvement Council Meeting notes for 1/25/10, and 12/21/09; o ABSSLC – Review Processes: Quality Enhancement Plan, dated 9/08/09; and o Monitoring tools associated with the Quality Enhancement Plan (TX-AB-IV.2a-b and 2d-m); ▪ **Interviews with**: o Sam St. Clair, Director of Quality Enhancement; and o David Daniel, Settlement Agreement Coordinator ▪ **Observations of**: o Incident Management Review Team Meeting on 2/25/10 at 11 a.m.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Many of the quality enhancement activities at ABSSLC were in the initial stages of development. A Quality Enhancement Plan was in draft format, and some tools had been designed to carry out monitoring. A trend analysis report for the first quarter of FY10 had been completed, and provided summary data as well as some good analysis of that data. The next step, which can be a challenging one, will be responding to the trends through the development of action plans to address identified issues. Follow-up will also need to occur to ensure that actions are taken that effectively address the trends. There were other data that had not been clearly analyzed, trends identified, and actions implemented to correct deficiencies. For example, the Monitoring Team's review of a variety of information revealed troubling trends with regard to individual-to-individual aggression that often results in injury. This is a trend that must be addressed immediately and thoroughly.

	A Leadership Council had been developed, and met on 2/1/10 to review the Trend Reports; however no actions were taken on the issues identified in the trend analysis report. The Leadership Council appeared to be a venue for exchanging of information (who was hired, who will be visiting campus, what personnel issues need attention), rather than a forum for discussing solutions to emerging issues, identified in the trend reports. A Performance Improvement Council was in place, with many of the same members as the Leadership Council. The roles of these two groups should be better defined. A Quality Enhancement Plan was available, and contained some ideas about which quality enhancement processes needed to be developed, how to monitor plans of care, and what to analyze. However, it was incomplete as it stood. It needed further work to specify how and when the quality enhancement processes will be developed and implemented, and who will be involved. Monitoring forms needed to be finalized, and staff will need to be trained in their use. Most importantly, the work of the quality monitors must lead to enforceable corrective action plans. Action had been taken to address major concerns raised by ICF-MR surveyors in response to reports of multiple deaths, and serious health concerns for a person with pica behavior. However, some of the issues identified in these reports were indicators of deeper underlying problems that should be further assessed and addressed.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The Monitoring Team's review of the State Policy with regard to quality assurance/enhancement showed that it was consistent with the requirements of the Settlement Agreement. The Facility had not yet developed quality assurance policies. The Facility's Quality Enhancement Director was interviewed, and provided helpful information about the activities of the ABSSLC quality enhancement program. Data on allegations of abuse/neglect and exploitation, unusual incidents, restraints and injuries were available by number per month, by living unit, work shift, and individual. A/N/E data contained details of type of allegation, disposition, and staff involved.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the	The data was summarized in a quarterly trend report, and analyzed to identify indicators of issues within the system. For example, the FY10 first quarter report identified that 10 deaths had occurred in the quarter. Two nurses were assigned to review the deaths, and report on status by an assigned date. While this was an important issue to address, there were several other tends that also would have benefited from review and	

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	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.	recommendations. For example, the analysis of data on restraints revealed that five individuals were restrained over 20 times each during the quarter. A root cause analysis of the need for restraint for these five individuals would have been a useful recommendation to include in the trend report. The analysis of injuries was more thorough. The data indicated that there were 1636 injuries during the quarter. Within the report, the injury data was analyzed by types of injury, seriousness, locations, cause, time of day, and individual injured. Then the data for the four top causes for injuries (scratch, unknown, other, and slip/trip/fall) were isolated, and it was determined that 80% of those injuries were non-serious. The analysis went on to identify the four people with the most injuries, and to drill down to causes, locations, etc. This detailed analysis needed to then be used to inform the development and implementation of action plans. However, Section V of the trend report from Quarter 1, FY10 that provided the overview of trends with recommendations and follow-up only included the recommendation concerning the 10 deaths. A Trend Analysis Report was available for December 2009. It displayed data in the same manner as the quarterly report, but did not include analysis. It included a follow-up to the recommendation in the Quarter 1 report regarding deaths, and included a summary report by the assigned nurses. This was reviewed by the Leadership Council, and reported in their notes of 2/1/10. No further attention to the data analyses in the Trend Report was evident. The process for addressing trends, uncovered through data analysis, was not yet fully developed. A start had been made by including in the trend report an overview of trends, and in some instances requiring review, the development of action steps, and corresponding due dates. However, two necessary elements were missing: a clear expectation that trends will be addressed, and an expectation that the Leadership Council will discuss, prioritize and record their work. ICF-MR surveys and investigations sometimes raise issues that can aid in identifying trends and permit intervention at a systemic level. For example: ▪ The ICF-MR report of 2/20/09 found the Facility deficient in preventing individuals from engaging in pica (ingestion of foreign objects). This led the Facility to put a number of corrective actions in place, including sweeps of homes and day programs to collect potentially inedible items, enhanced staffing, and programs using edible reinforcers to discourage ingestion of inedible objects. The Monitoring Team's checks of residences that serve individuals with	

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		pica behaviors found most were taking care to keep floors and counters free of potentially dangerous objects. Areas outside of homes were often littered with nuts with hard shells. As was discussed with Facility management, it needed to be determined how great a risk these nuts were, and whether they should be routinely removed from the ground. ▪ The ICF-MR report of 2/27/09 identified issues related to staff calling individuals inappropriate names. The report of 4/3/09 dealt with providing privacy for individuals when bathing. The identified issues were dealt with in the response to the report. However, these kinds of issues can be more widespread than the scope of the ICF/MR report, and steps to guard against them becoming part of the local culture needed to be made. ▪ The ICF-MR reports of 4/27/09, 8/11/09, and 11/05/09, involved provision of Cardio Pulmonary Respiration (CPR), following bed-check routines, and the need for nurses to inform physicians of deteriorating health of an individual. The immediate deficiencies were handled in response to the reports. However, these types of issues suggest an inattention to the health of individuals that may require a long-term correction and prevention strategy. Trends also can be identified by reviewing data from many sources together. For example, there were multiple indications that individual-to-individual aggression was a serious problem. Evidence appeared in: ▪ The section in IMRT reports on individual-to-individual aggression included 314 reports of aggression between 12/11/09 and 1/28/10. That was an average of over six (6) per day. ▪ Injuries that resulted from individual-to-individual aggression between 7/1/09 and 1/12/10, numbered 245 over 195 days or an average of 1.25 injuries per day. These numbers suggest that individuals may be experiencing an unacceptable level of violence in their daily lives, and that a plan needs to be in place to discover and address the underlying causes. No such plan was identified.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The Settlement Agreement Coordinator reported that the process was just beginning with the follow-up on the 10 deaths that occurred over a one-month period. A nurse followed up on the investigations, summarized the results, and made recommendations to the IMRT. According to an interview with the Facility Director, because two reports involved delayed reaction times on the part of staff, mock code drills were stepped up to include every home and shift, and nurse managers were added to provide a health care presence in the homes. As is noted in the section below that addresses the provision of	

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		nursing supports (Section M.1 of the SA), code blue drills were not adequate at the time of the review.	
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.	According to the Plan of Improvement, the Quality Enhancement Division will monitor corrective action plans. This was not yet underway. An example of a corrective action plan that was being monitored in a creative way was the plan developed to address the requirements of the Settlement Agreement. The Settlement Agreement Coordinator with the assistance of the staff he supervised developed a visual tracking system to assist the many staff involved in the process to concretely see what progress was being made. By using a sports theme/framework, it provided staff with a familiar rubric as well as incentives for implementing their portions of the action plan. As other action plans are developed and implemented, equally creative ways should be considered to ensure that staff understand their roles and responsibilities, and commit to implementing the action plans.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	This is not yet underway.	

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

1. Based on the State policy, the Facility should develop a Facility-specific policy to address quality enhancement activities.
2. The data currently being collected and analyzed should be used better to identify areas in which improvements are needed. More specifically, these data should be used to identify problematic trends and/or individual issues, and the Facility should develop, implement and monitor corrective action plans to address them.
3. Individual-to-individual aggression that often results in injury is an extremely concerning trend that should be addressed immediately. An action plan should be developed, implemented, and monitored to ensure that it results in a change in outcome for the individuals served by the Facility. In developing such an action plan, a variety of staff should be involved, including but not limited to quality enhancement staff, psychology staff, direct support professionals, and unit management.
4. Information gained through the ICF/MR regulatory process should be used not only to correct the immediate deficiency, but also to analyze potential underlying issues/causes, and to address those as well.
5. As action plans are developed and implemented, creative ways such as those developed with regard to the Plan of Improvement should be considered to ensure that staff understand their roles and responsibilities, and commit to implementing the action plans.
6. While there were quality monitoring tools in draft form, the Quality Enhancement Director indicated an interest in synchronizing them with the tools used by the Settlement Agreement Monitoring Team. This would be useful, particularly with regard to health and behavioral health.
7. The Quality Enhancement Plan should be further developed. It needs to include specific steps, people responsible, and time frames to develop and implement the processes listed in the plan. The expectations of the Performance Improvement Council (PIC) need to be clearly articulated, and there needs to be an understanding of how its work differs from that of the Leadership Council.

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 The following blank assessment forms: Draft Living Options Considerations Checklist, updated 7/7/09; Audiological Evaluation; Audiological Screening; Reiss Screen for Maladaptive Behavior Scale; Dental Exam Shell; Annual Medical Summary and Physical Examination Evaluation; Speech-Language Evaluation; Nursing Assessment; Adaptive Equipment Assessment; Adaptive Equipment Services Objectives; Lifting/Transfers Assessment; PT Services Plan; Request for Consent for Restraint; Risk Screening Tool; Performance Oriented Assessment of Balance and Gait; Occupational/Speech Therapy Eating Evaluation/Nutritional Management Plan; Cratty Perceptual-Motor Test; Physical Therapy Bicycle Assessment; Home Exercise Instructions; Positioning Instructions; o Facilitator's Notes for training entitled "Personal Support Teams: PDP Process," Copyright 9/29/09; o QSO Scoring Guide Person Directed Planning Process 12/09; and o PSPs and related assessments for Individual #27, Individual #69, Individual #83, Individual #117, Individual #189, Individual #199, Individual #268, Individual #277, Individual #341, Individual #357, Individual #358, Individual #380, Individual #381, Individual #389, Individual #404, Individual #408; Individual #421, Individual #429; Individual #452; Individual #456, Individual #475; Individual #496, Individual # 504, Individual #514; Individual #272, Individual #546, Individual #44, Individual #274, Individual #4, Individual #486, Individual #264, Individual #163, Individual #48, Individual #461, Individual #293, Individual #429, Individual #376, Individual #315, Individual #246, Individual #215, Individual #400, Individual #502, Individual #70, Individual #467, Individual #284, Individual #264, and Individual # 146 ▪ **Interviews with**: o Juan Herrera, Qualified Mental Retardation Professional (QMRP) Coordinator; o Various staff in residences and attending PST meetings; o Sam St. Clair, Director of Quality Enhancement; and o Laura Wilford, Post-Move Monitor ▪ **Observations of**: o Individual #227's Annual PSP meeting; o Individual #376's Annual PSP meeting; o Individual #461 Annual PSP meeting; and o Activities in eight homes and day programs
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future

	reports.
	Summary of Monitor's Assessment: ABSSLC was at the beginning stages of implementing a new Personal Support Plan format that was introduced in February 2010. It appeared that the new format was designed to address some of the components of the Settlement Agreement that the previous format did not address. Because very few teams had utilized the new format at the time of the review, the sample of PSPs reviewed generally used the old format. One area where all plans reviewed could benefit from additional attention in "community participation." While most plans included opportunities to take trips to the community, few presented opportunities for participation in a manner that would support continuous community connections such as friendships and work opportunities. The biggest challenge for ABSSLC with regard to PSPs appeared to be with regard to ensuring that team meetings include interdisciplinary discussions that result in one comprehensive, integrated treatment plan for each individual. As is noted in other sections of this report, issues with regard to adequate assessments impact teams' ability to identify strengths as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions, and the resulting integrated plans. Quality Enhancement activities with regard to PSPs are in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.

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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:	The DADS policy for this section had not been developed at the time of this review, and so it was not reviewed. ABSSLC also did not have a policy to address interdisciplinary teams or the planning process.	
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.	According to the ABSSLC Plan of Improvement, a QMRP was assigned for each individual to fulfill this requirement. In the three PST annual planning meetings attended, all were facilitated by a QMRP. In one case, the QMRP was the regularly assigned person. Updated assessments were not complete and available at the meeting, including the ones for which the QMRP was responsible. In another case, the QMRP was a substitute who had not worked on the individual's assessments and planning. He substituted for the assigned QMRP who was present, but new on the job. Updated assessments were not complete and available at this meeting either. For the third meeting attended, the QMRP	

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		was new, so the Post-Move Monitor, who was the individual's previous QMRP, assisted the new QMRP. QMRPs ability to effectively facilitate the meetings, and ensure full team participation varied. As is discussed below, resulting plans did not show an integrated approach to the development of PSPs.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	According to the QMRP Coordinator and the Plan of Improvement, there was to be an automated system in place as of 12/31/09, to track participation in annual planning meetings. This system was not evaluated, but will be reviewed during upcoming monitoring visits. Based on reviews of PSPs, QMRPs were present at the annual meetings. Others participating varied and included nurses, direct care professionals, Legally Authorized Representatives, psychologists, Occupational Therapists (OTs), Physical Therapists (PTs), and other disciplines. Issues were noted with regard to team members' attendance that was necessary to provide input into the planning process. For example: ▪ Vocational staff or day program staff were not always in attendance, as noted for Individual #467, Individual #284, or Individual #70. ▪ Individual #456 had a physical and nutritional management plan (PNMP) for mealtimes and ambulation as well as recommendations for communication. In addition, a physical therapy update, dated 1/5/10, recommended modifications to Individual #456's wheelchair. However, no physical therapist (PT), occupational therapist (OT), speech and language pathologist (SPL), or dietician was present at his 1/28/10 PSP meeting. ▪ Individual #452's assessments described her as having complex physical and nutritional support needs. For example, Individual #452 was described as having a gastrostomy tube (g-tube), and a tracheostomy tube, as well as using a wheelchair for mobility, requiring repositioning, and using a number of pieces of adaptive equipment. Documentation showed that changes had been made to her formula due to weight issues. At her 1/20/10 PSP meeting, however, no therapy staff (i.e., OT, PT, or SPL) were present, nor was a dietician or physician present. This provision will continue to be reviewed during upcoming monitoring visits.	
F1c	Conduct comprehensive assessments, routinely and in	Most of the PSPs reviewed contained assessments of health, residential living [often Positive Adaptive Living Skills (PALS)], behavior including psychological evaluations,	

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	response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	speech, OT/PT, nutrition, self-administration of medication, audiological screening, dental, community living options, and other assessments based on specific needs. Vocational evaluations were in most, but not all, files. Sometimes vocational information was included in the PALS, but not always. Some plans included a "Personal Focus Worksheet" (PFW) that gathered information on the individual's preferences. Some plans included the DADS-authorized assessment forms for various potential risks such as aspiration, weight, nursing risks, and polypharmacy. 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. In order for adequate protections, supports and services to be included in individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. As noted above with regard to Section F.1.a of the Settlement Agreement, in two of the three PSP meetings attended on site, a full array of updated assessments was not available. Likewise, record review showed problems with updated assessments being available for team review. For example: ▪ A number of the assessments used to develop Individual #456's PSP were old and did not appear to reflect Individual #456's current status. For example, the most recent psychological assessment was dated April 5, 2001. Other assessments such as the Activity Center Program evaluation, dated 1/28/10, identified behaviors that appeared to have a negative impact on his treatment. This evaluation stated: "When he is working with items he is usually trying to put it in his mouth to lick on it. When we assist him to the table he will get up. He wants to sit in a chair to the side. We have tried several things to keep him at the table. It is not working." His Inventory for Client and Agency Planning (ICAP), dated 2/1/10, identified his "mouthing objects" as a "slightly serious" problem, and his "refusals" as not serious. The 1/25/10 nursing and 4/2/09 communication assessments also identified head-banging or self-injurious behavior as ways that Individual #456 communicates that he is not feeling well or other "negative feelings." It is not clear why a more recent psychological assessment has not been conducted to assist the team in developing strategies to address these identified concerns. Other assessments that had not been updated prior to the 1/28/10 PSP meeting included the Annual Habilitation Services Review Evaluation dated 1/31/08, the Speech-Language Evaluation dated 4/29/09, and the dental evaluation completed on 5/11/09.	

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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.	There was not always a clear connection between the assessments and the PSP. For example: ▪ As addressed in the section of this report that addresses SA requirement F.1.a, if the assessments were not complete and available to team members at the PSP meeting, it prevented productive cross-disciplinary discussion. ▪ The personal focus worksheet was not available in all plans reviewed, but where it was, it showed promise for shaping plans that attend to the interests of the individual across disciplines. ▪ The following are examples of how assessments were not used effectively by Individual #456's team to develop an adequate PSP: o His Physical therapy update, dated 1/5/10, recommended "altering his current wheelchair by lowering the armrests, elevating his footrests, replacing the old sling back with a new one and padding the portion of the wheelchair that comes in contact with his shoulder and upper arms." His 1/28/10 PSP did not include this recommendation, nor was discussion documented regarding any reasons why his team did not agree that the recommendation should be implemented. o The 1/25/10 nursing and 4/2/09 communication assessments identified head-banging or self-injurious behavior as ways that Individual #456 communicates that he is not feeling well or other "negative feelings." The team did not address this either through communication or behavioral treatment. Vocational/Day Activity assessments were not comprehensive, and offered little in the way of ideas to build effective supports and programs. For example: ▪ Individual #215 who is described in his PSP as capable and independent in many areas did not attend work 182 times in six months, and he did not attend the Activity Center program 77 out of 135 times. No ideas were offered as to how to change this pattern, or to discover why he dislikes these programs. His team recommended that he continue in them anyway. ▪ Individual #452's 1/20/10 PSP did not specifically identify the day program supports that her team agreed she should be provided. The Activity Center Program Annual Evaluation, dated 12/16/09, indicated that Individual #452 was attending the Activity Center Mondays, Wednesdays and Fridays from 1:30 p.m. until 4:30 p.m. Her team provided no rationale for the abbreviated day program schedule. ▪ Individual #504's 12/1/09 PSP included three training objectives for her to go to her work station upon arrival, request a job assignment, and begin work. The	

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		vocational assessment reviewed by her team was a one page document that identified where she worked on campus; her work schedule; a list of three abilities/achievements, including expressing her needs, enjoying making money, and completing neat work; and recommendations that were reflected in the objectives described above. The vocational assessment did not offer a vocational profile of Individual #504 based on, for example, objective data, situational assessments, and/or a thorough work history or interest inventory. It provided little to no meaningful information for her team to design an appropriate plan for her vocational path. Although vocational staff indicated that a more extensive vocational assessment was being instituted, it was not seen in the PSPs reviewed.	
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.	
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:	As noted previously, there were no policies and/or procedures provided at either the State or the Facility-level. The Plan of Improvement called for two steps to accomplish this element. One included providing policies and procedures, and the second provided for review of plans and recommendations from QMRP Coordinators. The target date for both was 12/31/09, but no policies were provided for review.	
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	The Plan of Improvement included seven action steps to address this requirement. Based on a review of these steps, it may need to be made clearer that "barriers" to addressing needs are not necessarily related to rights restrictions. Barriers, for example, may be not having enough vehicles to get a person to church off-campus every Sunday, or not being	

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	needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	able to locate a community-based job for someone who wants one. Lists of prioritized needs were not found in the plans reviewed. This did not seem to be part of the discussions at the team meetings attended. Another area where all plans reviewed could benefit from additional attention in "community participation." While most plans included opportunities to take trips to the community, few presented opportunities for participation in a manner that would support continuous community connections such as friendships and work opportunities. If barriers for supporting individuals to participate in the community exist, then these need to be identified in individuals' plans. Identification of strengths and preferences would benefit from additional work in most plans. Often the identification was limited to "what is most important to the person." In some plans, there was a degree of specificity in the list of important considerations. For example: ▪ In the PSP for Individual #215, the list included his preferences for dipping snuff, collecting cans, playing a soda lid game on line, and playing video games at the diner. This specificity presents ideas to build on in his plan: Could a job be developed around collecting cans in the community? Could video games at the diner be developed into a connection with someone else in the community who likes to play video games? In many plans the list was not as specific. Such lists included only generic items such as visiting family, having good health, and having time to one's self. Better entries might, for example, say "time to herself to…" and specify what it is she likes about time to herself.	
	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	PSPs generally had some individualized and measurable goals/objectives, treatment strategies and supports. However, none of the plans reviewed included a comprehensive set of measurable goals, objectives, treatments and strategies to be employed to fully support the individual. As is discussed in other sections of this report, nursing plans, Behavior Support Plans, and physical and nutritional support plans were not fully integrated into the PSP. They were generally stand-alone documents that may have been referenced in the PSP. Specific individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of these essential plans. For example, in order to provide health care supports to individuals served, direct support professionals (DSPs) as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is	

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	appropriate to his/her needs;	repositioned every two hours should be specified in measurable ways in individuals' PSPs. Some examples of the ways in which PSPs failed to define measurable objectives include: ▪ The following were examples of areas in which measurable objectives should have been identified for Individual #456, but were not: o Individual #456's PSP dated 1/28/10 indicated that he is prescribed medication that causes constipation, and is prescribed daily medication to manage constipation. Neither his nursing care plan nor his PSP identified the measurable steps that staff should take to monitor for or help prevent constipation. The risk tracking record in his PSP stated: "Encourage fluids and assist as needed." His team did not translate this into an action plan item, and/or develop a measurable objective to ensure that staff were offering him fluids regularly and/or tracking his intake of fluids. o Individual #456's 4/29/09 speech-language evaluation recommended three communication strategies for staff to utilize, including parallel talk, showing him objects that will be used during activities, and providing him choices. Individual #456's PSP did not include measurable goals or objectives to ensure that these strategies were employed. The PSP merely stated: "Follow communication instructions." ▪ Individual #504's Behavior Support plan was included in Action Plan #1 of her 12/1/09 PSP. The "Steps that will be taken to reach the Desired Outcome" simply stated "Behavior Support Plan." The only person listed as responsible was the psychologist. There was no reference to direct support professionals or their role in the implementation of the BSP. The timeframe was listed as ongoing with documentation being recorded in the progress notes. This does not describe a measurable goal/objective related to the provision of behavioral supports by either the psychologist or direct support professionals. In addition, it was not always clear that the goals and objectives were the ones that were most important to the person in light of his preferences. Instead, preferences tended to be addressed separately, mostly as "special considerations," or reminders to staff of interests. With regard to the requirement that PSPs identify plans to overcome barriers to living in the most integrated setting, this is discussed in further detail with regard to the Facility's compliance with Section T.1.b.1 of the Settlement Agreement.	

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	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted above, none of the plans reviewed included a comprehensive set of measurable goals, objectives, treatments and strategies to be employed to fully support the individual. For example: ▪ Individual #452's 1/20/10 PSP did not integrate all of the protections, services and supports, treatment plans, and clinical care plans into one comprehensive plan. A couple of examples illustrate this: o Her OT/PT assessments recommended daily implementation of hand hygiene, use of a splint, an exercise program, and positioning schedule. In the Assessment Section of Individual #452's PSP, these recommendations were summarized and the reader was referred to Action Plan #2. Action Plan #2 did not detail any of these as service objectives, nor were these supports identified elsewhere in the PSP as needing to be provided routinely to Individual #452. o Likewise, the 12/29/09 Nursing Assessment indicated that nursing care plans were in place for hypothermia, skin integrity, g-tube, seizures, and bowel management. The PSP incorporated none of these.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, PSPs generally described the timeframes for completion, and the staff responsible. Methods for implementation were not always adequate as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	
	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	Not all strategies and supports were practical and functional at the Facility and in the community. Strategies, particularly behavior plans employed restraint and close supervision, which should be viewed as short-term protections while more practical and functional options are developed and instituted. For example: ▪ Individual # 272 has serious pica behaviors that place his health in danger. A promising plan was devised to substitute vegetables for the non-edible objects he craves, by having him constantly followed by a staff member with a container of vegetables that are offered whenever he wants them. The process includes tracking the process, and the staff member must carry a booklet to capture the information. The individual moves very quickly and constantly, so the assigned staff had a rigorous assignment. One of the possibilities discussed with behavioral staff was eventually fading the staff's need to provide a continuous flow of edible objects, by teaching the individual to wear a fanny pack, and retrieve the edible objects himself. If this strategy works well and the close staff contact can be weaned successfully, then this has potential to be a useful program in a variety of settings.	

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		This is a requirement that requires further review during upcoming monitoring visits.	
	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.	For the goals and objectives included in PSPs, generally, the PSPs specify data to be collected and/or documentation to be maintained and specify a frequency for collection. Although often the frequency was vague, for example, it was listed many times as "ongoing." In addition, it was not always clear who is responsible for reviewing the data, and what that review means in terms of making changes to the process when there is little or no progress. For example: ▪ In the PSP for Individual #215 discussed above in section F.2.a.1, he clearly did not have an effective vocational plan yet it was included in the PSP. If it is the QMRP who has the authority to challenge input from team members, then the QMRP should challenge the responsible professional to produce a better plan or involve the whole team in creating a more workable one. The overarching concern was that many goals and objectives were not specified in individuals' PSPs. As a result, appropriate data was not being collected to assist teams in decision-making. For example: ▪ As discussed in further detail above in the section addressing Section F.2.a.3 of the SA, Individual #452's PSP did not identify many of the supports and services that need to be provided to her on a daily basis by DSPs, nurses, and other staff. As a result, the PSP did not include an adequate description of the data to be collected. This will make it impossible for her team to objectively analyze her progress. This was illustrated in her 1/20/10 PSP that summarized her progress on training objectives in a purely subjective manner, for example, with regard to play and leisure she was noted to be "progressing slowly," or for her attention span objective, it was noted she was "progressing well."	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The Plan of Improvement called for a system to track Person Directed Planning, and monitoring and reviews to assure the PSP contains coordinated services, supports and treatments. The system was scheduled to commence by December 26, 2009, and be fully implemented by April 26, 2011. The Monitoring Team will continue to monitor the progress as the new PSP policy and format is implemented. Based on the review of PSPs, this was an area that requires substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between psychiatric and behavioral support; dental/medical and behavioral/psychology; nursing and dental; and between the disciplines responsible for the provision of physical and nutritional supports to	

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		individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	
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.	At the time of the review, PSPs were located on the residential units in locked cabinets for security reasons. Given privacy and security considerations, this was appropriate. A key appeared to be available to staff when there was a need to see a plan. Staff had access to "Risk Cards" which contained critical information about each individual in the residence. At the beginning of a shift, staff were assigned responsibility for specific individuals, and were supposed to be carrying their cards for ready reference. To the degree that the risk cards help translate key information from the PSP to staff, they may prove to be important links. This will be reviewed further during future monitoring visits.	
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.	This requirement will be reviewed during upcoming monitoring visits.	
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	In response to a document request for training materials on the PSP process, including competency-based evaluation tools, the Facility provided a copy of the training slides and facilitator notes for a training entitled: Personal Support Teams: PDP Process, dated 9/29/09. According to the QMRP Coordinator, this training was provided to QMRPs at ABSSLC. The training curricula included a number of positive components, but also was	

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	related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	lacking in a number of areas relevant to compliance with the SA. Positive aspects of the training included: ▪ The training curricula showed an emphasis on values related to supporting individuals with disabilities. The training described the focus of planning as shifting to a person-directed format. ▪ The use of a Personal Focus Worksheet was a good tool to assist teams in identifying what is most important to the individual, and incorporating this information into the PSP. According to the QMRP Coordinator 20 out of 22 (91%) QMRPs have completed training on the completion and use of PFWs. However, as is discussed below, this training did not appear to be competency-based. ▪ The training appeared to use a number of adult-learning methodologies to enhance participants' understanding of and retention of information being taught. ▪ The training included a component on including community involvement in each individual's plan. Although clearly, this is an area in which teams will continue to need support and assistance, it is positive that the training set this expectation. The following describes some of the concerns with the training: ▪ Although many of the concepts related to individualized planning and the interdisciplinary process were mentioned in the training, the skills to make this happen were not overtly included in the training. For example, the need for assessments to incorporate the individual's preferences was discussed, as was the need to collect assessments from various team members prior to the meeting. The processes and skills for integrating and incorporating such information into one comprehensive plan were not taught, though. ▪ Prioritizing an individual's needs was not covered. For example, there was discussion regarding the completion of the Positive Assessment of Living Skills (PALS), but not how the results of that assessment in concert with other assessment information need to be used to identify prioritized training needs for the individual. ▪ Action plans were discussed, including the need to include measurable goals and objectives, as well as descriptions of responsibilities for implementation, and data collection. However, this component of the training was not sufficiently detailed. For example, it did not appear that there was training related to what is and is not measurable.	

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		▪ As the facilitators of the team meetings, QMRPs need to be able to demonstrate skills related to group facilitation as well as conflict resolution. According to the QMRP Coordinator, the training offered to QMRPs on the new PSP process provided some, but limited, training in these areas. Review of the training materials confirmed that very limited information was provided in these areas. Additional competency-based training should be provided to QMRPs to ensure that they have adequate skills in these areas. With regard to the competency-based component of the training, the Facility provided a document entitled QSO Scoring Guide Person Directed Planning Process that was dated 12/11/09. This document provided a description of a monitoring process to determine the quality of the planning process, including the assessment process, the composition of the team, the PSP, as well as the ongoing review and PSP modification process. This monitoring tool included a number of components that related directly to Settlement Agreement requirement. It is unclear, however, if or how this tool will be used to measure the competence of specific QMRPs or team members. This will be further discussed with staff during upcoming monitoring visits.	
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.	This requirement will be reviewed during upcoming monitoring visits.	
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	According to the Director of Quality Enhancement, this process was under development. Staff in his office will be responsible for implementing the monitoring once the process has been put in place. As noted above with regard to section F.2.e of the Settlement Agreement, the Facility submitted a monitoring tool related to PSPs, but it was unclear how or when this would be implemented.	

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	the ISPs are developed and implemented consistent with the provisions of this section.		

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

1. The following recommendations are offered with regard to training staff on the interdisciplinary approach and individualized planning process:
   - Methodologies for determining QMRPs' as well as other team members' competence with regard to the development and implementation of PSPs should be developed and/or implemented. In order to measure a QMRP's competency in the development of PSPs, a two-step process should be considered. Specifically, tools should be developed to evaluate a QMRP's ability to facilitate the team meeting, and another to evaluate the QMRP's ability to develop a PSP that meets all of the related requirements.
   - QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, including conflict resolution, particularly as is relates to the interdisciplinary team process.
   - As teams are trained on the new PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
   - The training curricula currently used at ABSSLC should be reviewed and enhanced to address additional areas, including but not limited to identifying priority needs of individuals served; identifying all of the protections, services and supports an individual requires; developing measurable goals and objectives; and clearly defining expectations with regard to the implementation of and data collection related to action plans, Specific Program Objectives (SPOs), and Staff Service Objectives (SSOs).
2. As indicated in other sections of this report, focused efforts should be made to improve the quality of assessments that are used in the development of individuals' PSPs.
3. The Facility's QE processes with regard to PSPs should include reviews to ensure that all of the components of the Settlement Agreement with regard to PSPs are addressed, including but not limited to assessment to ensure that:
   - Team composition includes the individual, the LAR, the QMRP, staff who regularly provide direct supports to the individual, and others that reflect the individual's preferences, needs and strengths;
   - Comprehensive assessments are completed, and the results integrated into the PSP;
   - Assessments are completed to identify the preferences of the individual and his/her LAR, and that this information is used meaningfully by the team in developing supports and services for the individual. Teams should constantly challenge themselves to discover creative ways to deliver what is needed in ways that are positive for the individual, and help move her/him farther toward her/his goals.
   - Team meetings include interdisciplinary discussion that utilizes the team's knowledge of the individual and his/her strengths, preferences, desired outcomes and needs to develop one comprehensive, integrated plan for each individual.
   - Interventions, strategies and supports are functional at the Facility and in the community.
   - Community integration is encouraged.
4. Personal Focus Worksheets should be completed on everyone before their annual PST meeting. Staff should be trained on how to discover important information about a person's interests and wishes from observation rather than only from conversation, particularly when the individual does not communicate verbally.

5. Alternatives to the vocational evaluations/assessments should be identified and implemented. Vocational evaluations should focus on potential work that is interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories.
6. Vocational/Activity staff should examine the underlying causes for individuals' failures to attend programs, and make modifications, as appropriate.
7. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavioral support plans a part of the PSP, rather than stand-alone documents.
8. QMRPs need to provide a leadership role with regard to PSPs, and require team members to perform their responsibilities with regard to providing assessments on time, and deliberating with the team on how to integrate assessment results into the PSP in an integrated fashion.
9. The new process of having a Post-Move Monitor participate in PSTs should be continued. In the three PSTs attended for this review, the Post-Move Monitor brought both fresh ideas about community services, and the concept of integration of supports to the team.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. It appears that the Facility is working on methodologies to ensure that recommendations from non-Facility clinicians are reviewed, considered, and documentation maintained justifying decisions.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. Some of the most striking include the need for greater integration between psychiatric and behavioral support; dental/medical and behavioral/psychology; nursing and dental; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. These are all discussed in further detail in the sections of this report that address these various disciplines.	
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	It appears that the Facility is working on methodologies to ensure that recommendations from non-Facility clinicians are reviewed, considered, and documentation maintained justifying decisions. According to the Facility's Plan of Improvement, processes were being put in place for this beginning on 12/26/09, shortly before this review, with a target date for completion of 6/26/11. During upcoming monitoring visits, this will be reviewed.	

#	Provision	Assessment of Status	Compliance
	refer the recommendations to the IDT for integration with existing supports and services.		

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

1. Recommendations regarding integration of clinical services may be found in each of the respective sections of this report.
2. The Facility should continue to move forward with plans to ensure that appropriate clinicians review recommendations from non-Facility clinicians, and document whether or not such recommendations are accepted, and, if not, why not. As appropriate, recommendations should be forwarded to individuals' PSTs.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: According to the Facility's Plan of Improvement, the Facility is in the process of developing policies and procedures to implement these provisions of the Settlement Agreement. The target date for most of these activities is 6/26/11. As is illustrated throughout this report, different clinical disciplines were at different stages of ensuring that assessments and evaluations were completed as required or needed, treatment plans were developed and implemented, monitoring systems were in place to measure compliance with and the efficacy of treatment plans, and treatments and interventions were modified as needed.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness; individuals who may benefit from communication systems; individuals being considered for enteral nutrition; and individuals requiring restorative dental care.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the	As is illustrated, particularly with regard to psychiatric services, the assessment processes used to determine diagnoses was not always consistent with DSM criteria, or generally accepted standards of practice.	

#	Provision	Assessment of Status	Compliance
	International Statistical Classification of Diseases and Related Health Problems.		
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.	As is referenced in the section above with regard to Section H.1 of the Settlement Agreement, without timely and thorough evaluations and assessment, the planning of treatments and interventions is hindered. For example, for individuals for whom communication needs had not been properly assessed, adequate treatments and interventions were not being developed, and implemented. Likewise, because psychiatric diagnoses were not accurate, and/or psychiatric services were not integrated with behavior supports, then proper treatment was not being provided.	
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.	As is illustrated in various sections of this report, clinical indicators often were not identified. For example, when psychiatric medications were prescribed, the target symptoms were generally not clearly identified, and tracked to assist in determining the efficacy of the treatment. Likewise nursing plans did not identify what clinical indicators were to be tracked, by whom, or when. Physical and nutritional management plans also did not identify the functional outcomes to be measured.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	Again, as is illustrated, for example, in the nursing and physical and nutritional support sections of this report, there were not systems in place to effectively monitor the health status of individuals.	
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.	Until accurate clinical indicators are developed and monitored/measured, this will continue to be an indicator on which the Facility needs to work.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the	According to the Facility's Plan of Improvement, such policies were anticipated to be completed beginning at the end of December 2009, with a target date of 6/26/12. This will be further assessed during upcoming visits.	

#	Provision	Assessment of Status	Compliance
	provisions of Section H.		

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

1. Recommendations regarding the common elements of clinical care are included in other sections of this report.
2. The Facility should continue to develop and implement policies related to the common elements of clinical care.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #006: At Risk Individuals, dated 10-15-09; o DADS Risk Assessment Tools, dated 8-31-09; o Health Risk Assessment Tool-Nursing; o Braden Scale; o ABSSLC lists of individuals with risks indicators; o List of High Risk Individuals undated, marked VI.3.a-t; o Individuals Injured During Restraint July-December 2009 (II.9); o ABSSLC Injury Trending: 9/1/09 through 11-30-09; o Health Risk Assessment Rating Tools and Health Status Team Recommendations/Signature Sheet and Healthcare Provider Statement forms for the following individuals: Individual #119, Individual #162, Individual #7, Individual #208, Individual #361, Individual #489, Individual #452, Individual #91, Individual #212, Individual #53, Individual #21, Individual #340, Individual #492, Individual #253, Individual #359, Individual #270, Individual #497, Individual #114, Individual #385, Individual #186, Individual #468, Individual #409, Individual #517, Individual #319, Individual #188, Individual #481, Individual #434, Individual #247, Individual #310, Individual #405, Individual #302, Individual #139, Individual #397, Individual #225, Individual #136, Individual #146, Individual #387, Individual #163, Individual #438, Individual #227, Individual #81, Individual #355, Individual #274, Individual #160, Individual #260, and Individual #132; and o PSPs, Evaluations and Assessments for the following individuals: Individual #272, Individual #546, Individual #44, Individual #274, Individual #4, Individual #486, Individual #469, Individual #163, Individual #48, Individual #461, Individual #293, Individual #429, Individual #376, Individual #315, Individual #246, Individual #215, Individual #400, Individual #502, Individual #70, Individual #467, Individual #284, and Individual #264 ▪ **Interviews with**: o Cathy Hennington, Chief Psychologist; o Juan Herrera, QMRP Coordinator; o Sam St. Clair, Director of Quality Enhancement; o Frank J. Kluza, Chief Nurse Executive; o Marilyn Branson, RN, Infection Control; o Krista Hamilton, RN, Infection Control; o Carole Ivy, Nursing Operations Officer; o Mary White, RN, Quality Enhancement Nurse;

	○ Debralea Sessions, MS, CCC/SLP, Chairperson of Nutritional Management Team (NMT); and ○ NMT Members ▪ **Observations of**: ○ Health Status Team meeting for buildings 6750 and 6760; and ○ Nutritional Management Team on 02/24/10
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: The current risk assessment tools used by ABSSLC did not provide an adequate, comprehensive risk assessment for any of the areas covered, and did not result in the appropriate identification of individuals' clinical risk indicators. Standardized statewide tools should be used by all the Facilities in assessing and documenting clinical indicators of risk to ensure that individuals who have clinical risks are appropriately identified. Based on this identification, proactive interventions should be timely put in place to address the areas of risks. Once an appropriate risk identification system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform interdisciplinary assessments of services and supports for at-risk individuals. Such assessments also should be used for reassessment in response to changes as measured by established at-risk criteria. Such initial assessments and reassessments will need to occur according to the required timeframes set forth in the Settlement Agreement. The Health Status Team (HST) meeting has potential, however, in its current form it lacks appropriate criteria and structure to assist the teams in accurately determining risk levels. The team discussion at these meetings should result in identification of an associated level of intensity of clinical supports to address the risks, as well as the implementation of proactive measures aimed at preventing risks.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	DADS completed the "At Risk Individuals" policy on 1/5/09. DADS also provided the Facilities with a set of risk screening tools that cover health risks, challenging behaviors, injuries and polypharmacy. An ABSSLC policy was not available, nor was there a reference in ABSSLC's policy index, as updated in 1/10, indicating that a policy had been developed for risk screening, assessment and management. The ABSSLC Plan of Improvement indicated that this step would be completed by August of 2010.	

#	Provision	Assessment of Status	Compliance
		There were a variety of assessment tools in use. Of 23 PSPs reviewed, all had some risk tracking information on file, including: ▪ Risk Tracking Record: 13 individuals; ▪ Health Risk Assessment Rating Tool: nine individuals; and ▪ Health Risk Assessment: three individuals. A list of individuals considered to be at high risk was generated in response to the request for documentation, with 83 people identified as at high risk across a variety of categories. The most frequently marked were polypharmacy (34), and challenging behavior (29). It was not clear how the determination was made to include some on that list and not others. At the time of this review, ABSSLC was not able to accurately identify individuals with clinical health risks. The Facility was using the Health Risk Assessment Tool-Nursing as directed by the State as the tool to identify the clinical risk indicators for individuals. However, this tool was a questionnaire that simply scored either "yes" or "no" for questions in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. These questions had no weighted values and consequently, the tool did not provide an accurate indication of risk. The tool was not an adequate comprehensive risk assessment for any of the areas mentioned, and did not result in the appropriate identification of clinical risk indicators. Standardized statewide tools should be used in assessing and documenting clinical indicators of risk to ensure that individuals who have clinical risks are appropriately identified so that proactive interventions can be timely put in place to address these risks. For example, the Facility was using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. Moreover, the strategies utilized by the Nutritional Management Team did not ensure that individuals at highest risk were identified and reviewed. The primary focus of NMT was a paper review for people with nutritional support concerns. For example, people at risk for fractures, mobility-related falls, decubitus ulcers, and fecal impactions were not reviewed by the NMT. The identified risk levels on the Nutritional Management Screening Tool did not provide a comprehensive list of health risk indicators. The Facility identified individuals at high risk within the categories of aspiration, choking, constipation, gastrointestinal (GI) concerns, osteoporosis, respiratory, skin integrity, and weight which reflect physical and nutritional support needs, but many of these individuals were not reviewed by the NMT. The NMT must establish guidelines to	

#	Provision	Assessment of Status	Compliance
		further define categories of high, moderate, and low risk levels for physical and nutritional health risk indicators, and ensure there are collaboration and agreement with the medical and nursing departments. Such guidelines should include thresholds to trigger initial and further evaluation, and establish intervals of review based on the degree of an individual's identified level of risk. These guidelines need to define the entrance criteria for review by the NMT to ensure the individualized physical and nutritional support needs of a person are addressed. Furthermore, exit criteria should be defined as meeting the measurable, functional outcomes established by the NMT. Based on observations of the Facility's Health Status Team Meeting for homes 6750 and 6760 during which representatives from all disciplines discussed and determined the risk rating (one to three; with one being the highest level of risk) for individuals, the lack of criteria used to assign a risk level rendered the determinations arbitrary at best. For a number of individuals reviewed, the team struggled to assign risk levels without guidelines to assist in the process. In addition, aside from the Health Status Team meeting more frequently for individuals determined to be at the highest risk level, there appeared to be no other clinical benefit or intervention associated with being deemed at the highest risk level. Also, there was no discussion or review of individuals assigned lower risk levels to ensure proactive measures and interventions were in place to possibly prevent them from moving to a higher risk status. The Health Status Team meeting has potential, however, in its current form it lacks appropriate criteria and structure to assist the teams in accurately determining risk levels. The assignment of such risk levels should result in an associated level of intensity of clinical supports to address the risks, as well as the implementation of proactive measures aimed at preventing risks.	
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	As noted above, the risk tool that the Facility was using was inadequate in identifying individuals' clinical risks indicators. Without an adequate system to identify individuals' risk indicators, the appropriate assessments had not been completed. As noted above, even for individuals who had been identified as at risk, the NMT was not completing comprehensive assessments. All of the files examined for this review included some assessment of risk as part of the PSP. There did not appear to be a system for assessing risk that provided direction on when to use which assessment forms, and/or how to determine level of risk in an objective manner. An example was with regard to Individual #469. In his PSP and related assessments	

#	Provision	Assessment of Status	Compliance
	possible but within five working days of the individual being identified as at risk.	there was: ▪ A health risk assessment tool-injury, identifying risks for slips and falls, and noting that he had had serious injuries in the past year; ▪ A Braden Scale was included in the nursing assessment that noted no problems; ▪ A Restraint Risk Assessment, showing no contraindications to the use of restraint; ▪ The Risk Tracking Record that was part of the PSP indicated he had risks associated with: o Constipation; o Skin integrity; o GERD; o Aggression; o Verbal hostility; and o Depressive-like behavior. The Risk Tracking Record indicated that these issues were addressed in the Health Care Plan and the BSP. The BSP provided instructions to staff on preventing his target behaviors, which were the ones identified in the Risk Tracking Record. The Health Care Plan was supposed to include protocol/guidelines for constipation, GERD and skin integrity, but these risks were not reflected in the PSP Action Steps, or in the Assessment/Services column in the plan. It was unclear how his Braden Scale indicated no problems, when he was listed as at risk for skin integrity issues. Moreover, it was unclear how his repeated injuries related to slips and falls were being addressed. No comprehensive, interdisciplinary assessment and planning process had occurred for Individual #469 to address his areas of risk. Once an appropriate system is developed and implemented, the Facility must develop and implement appropriate assessment tools to perform interdisciplinary assessments of services and supports for individuals, and in response to changes as measured by established at-risk criteria according to the required timeframes set in the SA.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to	A system for establishing and implementing an individualized plan within 14 days that included preventive interventions to reduce risk did not appear to be in place. Review of PSP files revealed that there was information about potential risks in each individual's file, though not in a consistent or standard format. It appeared to be part of the PSP process to review/assess risks at the time of the annual PSP. It was not clear what the process was when a new risk was identified apart from	

#	Provision	Assessment of Status	Compliance
	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.	the annual PSP. There did not appear to be a clear method for reviewing all potential risks, including data from trend analysis reports that identify unknown injuries, restraint use, and other factors that could signal a risk to an individual either because of the high numbers of injuries he/she is experiencing, or because the individual's home is one in which high numbers of injuries occur. As stated previously, the Facility did not have the underlying screening and assessment processes in place that are necessary for implementation of this provision. As the result of the NMT not completing comprehensive assessments for identified individuals at high risk (for example, a diagnosis of aspiration pneumonia), PNMPs had not been developed. From review of the Health Risk Assessment Rating Tools and Health Status Team Recommendations/Signature Sheet and Healthcare Provider Statement forms for 46 individuals from 9/09 to 1/10, the section "Team Discussion/Recommendations" was blank for all of the 46 individuals reviewed, including those who had health risk indicators assigned at the highest risk level. In addition, the section addressing "Healthcare Provider's Statement" was blank on all 46 forms. Consequently, there was no documentation indicating that any recommendations made by the Health Status Team were being documented, communicated to the appropriate Personal Support Team (PST), or tracked to ensure that they were actually implemented. From observation of the Health Status Team meeting and review of the documentation generated from the meeting, there was no indication that the Health Status Team had any effect on clinical outcomes for individuals.	

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

1. The State should consider identifying and implementing standardized tools to be used by all the Facilities in assessing and documenting clinical indicators of risk. Standardized tools should be selected based on their ability to provide a weighted score, as well as meaningful clinical information to allow teams to identify objectively individuals' levels of risk in a number of areas.
2. In addition, there is a variety of information available from which to identify individuals who are potentially at risk. The policies and procedures for a risk management system should draw together the various risk assessment instruments and procedures into one process that can reliably identify individuals whose health or well-being are at risk, and to address their needs.
3. The Facility should develop and implement interdisciplinary assessments of services and supports for the individuals identified as at risk, and in response to changes as measured by established at-risk criteria, according to the required timeframes set forth in the Settlement Agreement.
4. As required by the SA, for each individual assessed, the Facility should establish and implement a plan within fourteen days of the plan's

finalization, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk. More immediate action should be taken when the risk to the individual warrants. Such plans should be integrated into the PSP, and should include the clinical indicators to be monitored, the person(s) responsible for the monitoring, and the frequency of monitoring.

5. The NMT should establish guidelines to further define categories of high, moderate, and low risk levels for physical and nutritional health risk indicators, and ensure there are collaboration and agreement with the medical and nursing departments. Such guidelines should include thresholds to trigger initial and further evaluation, and establish intervals of review based on the degree of an individual's identified level of risk. These guidelines need to define the entrance criteria for review by the NMT to ensure the individualized physical and nutritional support needs of an individual are addressed. Furthermore, exit criteria should be defined as meeting the measurable, functional outcomes established by the NMT.
6. The Health Status Team meeting format should be redesigned to ensure that appropriate criteria and structure are in place to assist the teams in accurately determining risk levels. The assignment of such risk levels should result in the teams identifying an associated level of intensity of clinical supports to address the risks as well as proactive measures aimed at preventing risks.
7. As individuals with pica are assessed, if this has not already been done, a complete assessment of the individual's health status, including, where appropriate, a review of iron levels, should take place to rule out potential medical causes for the pica.

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:	At the time this report was issued, information on the Facility's provision of psychiatric treatment was not available.

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 Behavior Support Plans for the following individuals: Individual #163, Individual #517, Individual #43, Individual #367, Individual #105, Individual #242, Individual #209, Individual #464, Individual #438, Individual #156, Individual #81, Individual #272, Individual #276, Individual #286, Individual #355, Individual #153, Individual #313, Individual #442, Individual #231, Individual #310, Individual #461, Individual #278, Individual #486, Individual #277, Individual #430, Individual #287, Individual #537, Individual #252, Individual #160, Individual #525, Individual #146, Individual #132, Individual #504, and Individual #357; o Behavior Support Plan Tracking Sheet packets for the following individuals: Individual #196, Individual #315, Individual #494, and Individual #365; o Personal Support Plans and accompanying Training Documentation Reports for the following individuals: Individual #163, Individual #517, Individual #43, Individual #105, Individual #242, Individual #209, Individual #464, Individual #438, Individual #93, Individual #81, Individual #272, Individual #276, Individual #286, Individual #355, Individual #153, Individual #313, Individual #442, Individual #231, Individual #461, Individual #278, Individual #486, Individual #277, Individual #287, Individual #537, Individual #252, Individual #160, Individual #525, Individual #146, Individual #132, and Individual #504; o Personal Support Plans were also reviewed for the following individuals: Individual #367, Individual #323, and Individual #94; o Psychological and Behavior Services Policy, dated 11/13/09; o Challenging Behavior – Positive Behavioral Support and the Achievement of Fundamental Outcomes for Persons Served, dated 4/11/08; o Positive Behavior Support (PBS) Monitoring Tool & Reliability Probe; o Structural and Functional Assessment Report, dated 12/15/09; o Intervention Strategies for Behavior Change; o Regular Meetings/In-services/Responsibilities from Psychology Procedures Manual, Revised 10/09; o Personal Focus Worksheet/Guide; o List of Tools Used for Psychology/Behavior-Related Assessments; and o Vitae – C. Hennington, and R. Manns; ▪ **Interviews with**: o Catherine Hennington, Chief Psychologist, and Ron Manns, Behavior Analyst on 2/23/10;

	○ Cheryl Balanay, Director of Speech and Language Services on 2/25/10; ○ Juan Herrera, QMRP Coordinator on 2/25/10; ○ Individual interview with senior psychology staff including Joseph Abeyda, Shanna Carroll, Jason Fry, Jenni Jamison, Kathryn Jones, Connie Moss, Michael Smith, and Adam St. Cyr on 2/24/10; ○ Group interview with psychology department staff on 2/25/10; and ○ Interview with 12 direct service personnel representing six residences and three different shifts; included seven Mental Retardation Assistant (MRA) I staff, two MRA II staff, two MRA III staff, and one staff member who did not indicate her position, on2/26/10 ▪ **Observations of**: ○ Vocational activities in the workshop, diner, and laundry areas; ○ Staff training in Positive Behavior Support Plans on 2/24/10; ○ Behavior Support Committee Meeting on 2/23/10; ○ Personal Support Plan Meeting for Individual #461 on 2/25/10; ○ Unit Meeting on 2/24/10; ○ Residences/Homes: 5961, 5962, 6330, 6350, 6380, 6390, 6400, 6700, 6710, 6730, 6740, 6750, and 6760; ○ Sensory Gym at the Beehive; and ○ Activity Centers
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: At the time of the review, the Facility had one BCBA certified staff person, the Behavior Analyst. The Director of Psychology was in the process of completing coursework toward certification. Given that 254 individuals had behavior support plans, there was not a sufficient complement of psychology staff with demonstrated competence in Applied Behavior Analysis. The ABSSLC format of the Behavior Support Plan provided a great deal of relevant information. Each of the plans reviewed contained a wealth of information about the individual, and provided a good basis for developing comprehensive and effective intervention services. Missing elements from BSPs and related assessments, however, included: a) a rationale for the current plan; b) a brief history of prior interventions and their related outcomes; c) identification of replacement behaviors that are clearly tied to the hypothesized function of the problem behavior(s); d) clearer teaching guidelines for strengthening/teaching replacement behaviors; e) enhanced antecedent strategies, including greater opportunities to make choices, to negotiate more time with a preferred item, to protest an undesired activity, to request breaks, etc.; f) richer schedules of reinforcement, that incorporate identified reinforcers; g) consequences that are developed in consideration of hypothesized function(s) of problem behavior(s); h) clear data collection measures that reflect pertinent information about the target behavior(s); and i) identification of the person or persons responsible for oversight of the plan.

	It is essential that the Facility improve its data collection system to ensure that collected measures are reliable and valid. Measures should reflect the rate, duration, and/or intensity of problem behavior and its corresponding replacement behavior. Staff must understand the operational definitions of all targeted behaviors, must be able to identify the presence and absence of the same, and must collect measures that provide an accurate reflection of the rate and severity of the problem. Training of staff responsible for the implementation of BSPs needs improvement. Both orientation training as well as training on individual BSPs is insufficient to ensure that plans are implemented with integrity. At the time of the review, it did not appear that direct support professionals were provided adequate time to attend training on BSPs.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the review, the psychology department employed a total of 22 Master's level staff, including the Chief Psychologist and Behavior Analyst. It appears, however, that most of these psychology staff have degrees in counseling psychology, with the Behavior Analyst being the only Board Certified Behavior Analyst (BCBA). With 254 individuals, as of 1/29/10, identified with Behavior Support Plans, the task of overseeing the development, implementation, and continued monitoring of these plans is overwhelming for one person trained in Applied Behavior Analysis. While Abilene State Supported Living Center is to be commended for recruiting and hiring a Behavior Analyst who is BCBA qualified, without additional staff with expertise in Applied Behavior Analysis (ABA), Behavior Support Plans will be developed by staff who are not sufficiently qualified.	
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	Abilene State Supported Living Center is to be commended for having a Chief Psychologist with many years of experience in providing services to individuals with disabilities. Further, the Chief Psychologist is to be commended for beginning coursework in Applied Behavior Analysis through the University of North Texas. During the monitoring visit, several staff were absent at the end of the week because they were scheduled to attend a professional conference. This should be recognized as a	

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	care throughout the Facility.	positive way to enhance staff training. In addition, the Chief Psychologist reported that she had an "open door" policy, and met monthly with her staff. When the psychology staff were asked for feedback regarding the supervision they received from the Chief Psychologist, they reported that she provides her staff with a good degree of independence. Staff reported several areas of concern related to the provision of supports to individuals at ABSSLC including: the staff felt that the mandatory vests were inappropriate due to their negative impact on efforts to adhere to the principles of normalization; others noted that there are houses with 22 to 24 individuals in residence making for very uncomfortable living environments that contribute to behavior problems; several noted that direct service staff are not paid sufficiently, and that mandatory holdovers of staff result in high turnover; one person made a request that each residence be provided its own van so that individuals can have greater access to the community; and one indicated that there is a lack of meaningful and varied jobs for many of the individuals who live at ABSSL. Further discussion revealed that increased feedback regarding work performance would enhance the work environment. When staff were asked about annual evaluations, they reported that these were not standard practice at Abilene State Supported Living Center.	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	At the time of the review, Abilene State Supported Living Center utilized the Behavior Support Committee to provide internal peer review. The Chief Psychologist chaired this weekly meeting during which time a review was conducted of identified Behavior Support Plans. While several members of the psychology department were in attendance, along with the Director of Speech and Language Services, the author of the Behavior Support Plan under review was not present. Further, it appeared that the primary function of this meeting was to ensure that plans are clearly written, without typographical errors, and with current information regarding the individual's communication dictionary. Substantive changes to the strategies employed (including preventative measures, teaching of replacement behaviors, reinforcement systems, consequent contingencies, etc.) to bring about positive behavior change were not discussed. Without the benefit of data review and input from colleagues regarding the specifics of the plan, this committee does not fulfill the expected functions of an internal peer review system. And while it was encouraging to see the Director of Speech and Language Services present, the participation of direct service personnel who implement the plan would have greatly enhanced the functional outcome of the meeting. Although there is a policy in place for external peer review, this has yet to be implemented at Abilene State Supported Living Center. The implementation of this	

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		policy will be reviewed during upcoming monitoring visits.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	In the Psychological and Behavioral Services Policy, there was one section regarding psychological reports. The following statement was included: "If the individual exhibits challenging behavior, available data regarding the topography, rate, intensity, and duration of the behavior will be provided (p. 8)." While this is a noteworthy directive, there was no adherence to this policy. Specifically, BSPs did not identify adequate data collection methodologies to allow review and analysis of any of the characteristics of behaviors identified in the policy, including the topography, rate, intensity, or duration of behavior. For example, all Behavior Support Plans reviewed indicated that scatter plots, and occasional Antecedent-Behavior-Consequence (ABC) reporting forms were used to measure identified problem behaviors. For many of the plans (for example, the BSPs for Individual #242, Individual #438, Individual #486, Individual #537, Individual #160, and Individual #132), directions for data collection indicated that staff should "Record a maximum of 1 incident per 30 minute period." When speaking with staff in the residences, many seemed to understand this to be true for all plans. This clearly does not allow one to determine the rate of the target behavior. Further, although the policies stated that inter-observer agreement was to be assessed, this policy has yet to be put into practice. Data collected via scatter plot can provide valuable information regarding the times of day the behavior is most likely/least likely to occur. This can then be used as the basis for determining the best times of day to engage in the following activities: a) collect more specific measures of the rate or intensity of the target behavior; b) conduct a more thorough examination of environmental factors that contribute to the presence/absence of the target behavior; c) observe to provide support and make recommendations regarding antecedent, and/or preventative strategies; d) collect measures of inter-observer agreement; and/or e) conduct competency-based training. However, unless the scatter plot is used to collect specific measures on every occurrence of the target behavior, its usefulness as a tool to assess individual progress is compromised.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological	In each of the Behavior Support Plans reviewed, there was a section that provided a summary of information gathered through functional assessment. Hypotheses regarding the function of identified behavior problems were suggested, and possible setting events and relevant antecedents were often noted. Potential reinforcers were also listed for each individual.	

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	assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	Less specific information was provided regarding replacement behavior. General statements regarding improved communication skills or improved tolerance for specific situations did not identify what behavior the individual could exhibit that would allow him/her to obtain something desired or escape/avoid something unwanted. It was also unclear who had participated in the functional assessment, what tools had been used, and when the assessment had been completed.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Psychological assessments will be reviewed during upcoming monitoring visits.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	The Psychological and Behavioral Services policies indicated that every individual residing at Abilene State Supported Living Center would have a current psychological evaluation. The policy was clearly written and comprehensive in its scope. It specified that individuals who are school-aged should receive assessments every three years. For all individuals, the policy required that assessment be completed if there were changes in intellectual or adaptive functioning. As illustrated below, the policy was not being consistently implemented. It will now be necessary to put the policy into practice. The date of the most recent psychological evaluation could not be determined for all of the individuals whose records were reviewed. Where noted, these were not always current. For 19 individuals reviewed for whom a date could be determined, 18 (95%) had psychological assessments over three years old. The following indicates the date of the most recent psychological evaluation as noted in the individual's Personal Support Plan or Psychological Update: Individual #163 on 1/24/07, Individual #464 on 6/5/90, Individual #438 on 8/14/01, Individual #93 on 2/27/80 (cognitive) and 5/24/93 (adaptive behavior), Individual #81 on 12/13/06, Individual #272 on 11/9/98, Individual #196 on 2/20/89, Individual #286 on 8/3/07, Individual #315 on 2/15/90, Individual #355 on 11/8/02, Individual #153 on 8/12/95, Individual #494 on 10/8/96 (cognitive) and 9/17/97 (adaptive), Individual #486 on 11/16/87, Individual #365 on 4/22/92, Individual #323 on 2/6/02, Individual #94 in 1991, Individual #160 on 1/17/03, Individual #132 on 8/25/05, and Individual #357 on 4/28/09.	

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		In addition to the lack of current assessment information, 12 of these plans included the following statement: "Based upon behavioral observations and records, it does not appear that there have been any clinically significant changes in these functioning levels since his/her last full evaluation." It is concerning that the assumption was that there had been no changes in the individual's life for the past three to 30 years that would affect the individual's functioning level or abilities. Further, seven of the above mentioned individuals are school-aged. As stated in the Psychology and Behavioral Services policy, and as mandated by the Individuals with Disabilities Education Act (IDEA), a full evaluation should be completed at a minimum of once every three years for school-age individuals unless determined to be unnecessary by the team.	
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.	In addition to Behavior Support Plans, several individuals' records indicated that they received other interventions. For 19 individuals, counseling was provided. One of these individuals received play therapy. Several others (including Individual #242, Individual #530, Individual #464, and Individual #132) had notes in their Personal Support Plans indicating they were provided access to sensory integration therapies offered through the Occupational Therapy Department. Some of these therapies included weighted vests, access to a "sensory activity box," or time in the sensory gym located in the Beehive. A tour of a newly renovated activity center also revealed a meditation room and a "Snoozelen" room. Specific goals were not found for these various therapies, nor did it appear that objective measures were employed to determine progress.	
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.	Abilene State Supported Living Center is to be commended for developing Behavior Support Plans for the individuals who have identified problem behaviors. Each of the plans contained a wealth of information about the individual, and provided a good basis for developing comprehensive and effective intervention services. Below is a review of different components of the existing plans. The plans all contained a section in which the results of the functional assessment were summarized. Missing was a list of the tools used to complete the assessment, a description of the information each provided, the staff who participated, and the date(s) the assessment was completed. This information could be provided in the assessment itself. Next the plans provided a list of identified preferences/reinforcers. It is unclear how these were identified. Moreover, what is most concerning is that further review of the plan suggested that these reinforcers were not made readily available to the individual for the absence of the target behavior(s), or for the presence of the replacement	

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	Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	behavior(s). Many plans call for token reinforcement (e.g., stars, smiley faces, points, etc.) to be delivered once per shift, with exchange occurring once per week. This is a very thin schedule of reinforcement that is not sufficient to result in positive behavior change. All the plans included a section in which replacement behaviors were identified, and strategies for strengthening/teaching these replacement behaviors were described. In many cases, however, it was unclear how the identified behaviors provided the individual with functionally equivalent alternatives. Greater emphasis should be placed on functional communication training. Preventative strategies or antecedent management should also be expanded. Information regarding setting events and immediate antecedents should help guide this section so that plans become more proactive in reducing the likelihood of occurrence of problem behavior. Lastly, in many of the plans, the contingencies described may actually serve to reinforce the very behaviors they are designed to reduce or eliminate. Examples from specific plans of the issues described are provided below: ▪ Individual #163 - The function of four targeted behaviors was thought to be access to attention or some tangible item. The plan did not include a description of appropriate means to access either. Also, when three of these four behaviors occurred, the first step in the intervention was to talk with the individual, thus providing attention. Two behaviors were thought to function as a means of escaping unwanted tasks or demands. Yet in the prevention section, staff were instructed to give him an opportunity to engage in a preferred activity if he refused to engage in the requested activity. Staff were further instructed to withhold attention for 10 minutes following any refusal. Both of these strategies effectively reinforce this escape-motivated behavior. ▪ Individual #367 – The plan called for staff to conduct anger management training once per shift. It is not clear that staff are qualified or properly trained to conduct such training. ▪ Individual #242 – His plan noted that he is does not communicate verbally, yet the replacement behaviors describe staff behavior; there appeared to be no plan for developing/enhancing his functional communication skills. Staff were directed to provide praise once per hour for the absence of identified problem behaviors. The reinforcer assessment noted that staff attention is only preferred at times. Praise once per hour may not be reinforcing and if it is, this is too thin a schedule of reinforcement. ▪ Individual #209 – The function of this individual's aggression was thought to be	

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		to gain attention, yet the first step staff were instructed to take when the behavior was displayed was to talk with him. Preventative strategies included in the BSP were for the staff to talk with him for five minutes every hour. And, although the identified replacement behavior was to gain attention appropriately, there was no description of the steps to take to teach this skill. ▪ Individual #464 – Leaving without proper escort was noted to occur when he was not engaged, or when he was seeking attention. However, if he displayed this behavior, staff were to engage him in a preferred activity. This may reinforce the behavior. It would be more appropriate to teach the individual an appropriate way to request an activity or attention from staff, neither of which was identified as a replacement behavior. ▪ Individual #438 – The plan called for 30 minutes of fine motor activity per shift, although rectal digging is more likely to occur when he is sitting for long periods of time without interaction. One suggestion for staff included describing the color of the materials used, but this individual is visually impaired. Contingent upon aggression, the BSP indicated that the individual should be offered a change in environments including the opportunity to listen to music (an identified reinforcer). It would be more appropriate to teach him a means of requesting music so that he can access this prior to displaying problem behavior. Also of concern, the plan directed staff to give him his radio pillow after he had displayed rectal digging. A preventative strategy would be to give him access to this prior to engaging in the problem behavior. Continued access to the radio pillow would be provided only as long as he refrained from rectal digging. ▪ Individual #272 – The function of aggression was suggested to be escape from a crowded or noisy environment, or escape from demands. However, his replacement behaviors did not include functional communication training that would allow him to request a break, to appropriately protest an activity, or to make a choice between two or more available activities. On a positive note, there was the recommendation that staff prevent problem behavior by offering an alternative when the environment becomes crowded or noisy. ▪ Individual #313 – Under replacement behaviors, staff were encouraged to participate in an activity with this individual at least one time per shift. Active engagement once per shift is not sufficient. Individual #313 was also to be encouraged to practice calming techniques. There was no clear plan for teaching her strategies to help her calm or to deal with her reported anxiety. ▪ Individual #486 – A note was included in the BSP that data was not to be collected on eye poking as it occurs so frequently. As noted later in the plan, this behavior, along with head hitting, necessitated one-to-one supervision due to	

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		the risk of harm that it poses. This is all the more reason to ensure that the behavior is measured. Behavioral criteria addressed the use of restraint and the length of time in a helmet versus the actual rates of the targeted behaviors. Further concerns were raised when reviewing the intervention for head hitting. One of the hypothesized functions of this behavior was for the individual to gain sensory stimulation, yet staff were advised to give him a vibrator or neck massage when he hits his head. Once again, this may reinforce the behavior targeted for reduction. ▪ Individual #287 – The functional assessment indicated that target behaviors are less likely to occur if the individual is engaged in interesting activities throughout the day, yet the BSP instructed staff to engage her in an activity only once per shift. ▪ Individual #537 – A note was provided in the functional assessment section that this individual was least likely to display problem behaviors when he was sitting alone in a quiet environment. Yet, the teaching of replacement behavior was to occur twice each shift for a total of five minutes per occurrence. The individual was to learn to tolerate a staff person sitting next to him. If either aggression or SIB occurred, he could be offered a change of environment by going to his room or to another quiet area. As these are preferred settings for him, there was a significant risk of reinforcing the two behaviors the plan was designed to eliminate. ▪ Individual #252 – Once per shift, staff were to sit with the individual for five minutes to discuss better ways to control his anger. This is not sufficient time to teach replacement behavior, nor does it specifically provide him a functionally equivalent means of escaping unpleasant events, or obtaining things he wants. Further, the intervention included separating him from others; the presence of others is noted as often the reason he becomes agitated or aggressive. Therefore, by allowing him to escape an unpleasant situation only after he has displayed the target behavior, there is the risk that the behavior will be reinforced. It would be more appropriate to teach him a means of requesting a break in his room, or offering a break in his room when his environment becomes crowded with others and before he exhibits the target behavior. ▪ Individual #160 – Replacement behavior included his using the Picture Exchange Communication System to express himself, yet when he was observed, he did not have a communication book. Further, the Director of Speech and Language Services indicated that PECS was no longer in use as it had proven difficult to keep icons in the individuals' books. Reinforcement was to be provided once per each of the two day shifts by the psychologist. Individual	

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		#160 was also to earn one point per shift to be exchanged once per week for an outing. Neither of these reinforcement plans appeared to be adequate for bringing about positive behavior change. ▪ Individual #146 – In reviewing the BSP, concerns were raised regarding the individual's right to undisturbed sleep. Each night, he went to bed with restraint mittens on his hands. Staff were instructed to check him every 30 minutes throughout the night. The check involved placing two fingers inside the mitten and checking for good color and abrasions, requiring light to be used. This intervention can potentially result in a night of continuously interrupted sleep, which is a potential violation of the individual's rights. Individual #146's team should meet to discuss this issue in an integrated fashion. Such discussion should include from a medical perspective whether such frequent checks are needed, and from a behavioral perspective whether the data show the ongoing necessity of the mitts. The team also should discuss alternatives to the mitts, and/or a plan for reducing the use of the mitts. A document entitled "Intervention Strategies for Behavior Change" included a list of strategies, some of which were of concern. First, it was unclear why functional communication training was listed as a Level II intervention. Before Level II procedures may be used, per Facility policy, less restrictive approaches would need to have been shown to be ineffective. Functional communication should be a component of most, if not all, Behavior Support Plans because it addresses the need for functionally equivalent replacement behaviors. The Monitoring Team has significant concerns about the use of many of the procedures listed under Level III Intervention Strategies, including aversive stimuli, visual/facial screening, required exercise, several forms of overcorrection, and exclusionary time out. The first two of these strategies should not be employed. If the last three were to be employed, they would require extensive oversight to ensure that the procedures were carried out for a prescribed duration, without physical discomfort to the individual, and with careful documentation of each occurrence. According to an interview with the Chief Psychologist and Behavior Analyst, it appeared that consents for Behavior Support Plans were not consistently obtained in a timely manner. This had the effect of delaying the implementation of BSPs.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding	At the time of the review, there were no systems in place for determining inter-observer agreement on data collected for target behaviors or replacement behaviors. Abilene State Supported Living Center had developed policies for measuring inter-observer agreement, which was a good first step in meeting this requirement.	

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	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.	At the time of the review, data was presented graphically using monthly averages. This did not allow individuals' teams to determine trends in behavior, or subtle changes and improvements in responding to treatment. Although these same graphs noted medication dosages, it was difficult to determine changes in behavior following introduction of medication, change in dosage, or discontinuation of medication due to the limited amount of behavioral data on the graphs. Changes in targeted behaviors can occur even when over-the-counter medication is introduced. Monthly reporting of the average occurrence of targeted behaviors does not allow for a clear understanding of the effects of Behavior Support Plans or medications. Additionally, the graphs in use at Abilene State Supported Living Center included all behaviors targeted for reduction. This made for a very cluttered or busy graph, increasing the difficulty in completing an analysis of behavior change. Without ongoing review of daily changes in the target behavior, timely revisions to Behavior Support Plans will not occur.	
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.	During the next monitoring visit, additional time will be spent with the direct service personnel on-the-job to determine whether plans are clearly written and readily understood. During discussion with representatives of the staff, the reviewer did find a range of opinion regarding the support provided by the psychologist assigned to the residences. Some reported frequent contact with the psychologist who provided consistent support, others reported much more limited involvement. All did note that the training provided on Behavior Support Plans was less than optimal. As noted below in Section K.12, training often consisted of discussion of the plan as staff were working with individuals. Most of the plans were several pages long, reducing the degree to which they can serve as quick reference guides. One of the psychologists reported that she thought the plans were not "user friendly."	
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 Psychology and Behavioral Services Policy described a system for competency-based training to be provided to staff who are responsible for implementing Behavior Support Plans. As described, the training system included standards for observing staff on-the-job as they implement the plans. Further, there was a description of a method for providing feedback including checks for treatment integrity. The Positive Behavior Support Monitoring Tool and Reliability Probe was a good first step in assessing and monitoring the degree to which plans are implemented as written. Lastly, the policy also noted that a staff person "… proficient in completing competency-based training…" would be documented as competent in his/her performance evaluation. The policy as stated is certainly appropriate. The issue remains one of implementing this	

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		policy. During interviews with both psychology staff and direct service personnel, the Monitoring Team was informed that there was not sufficient time allocated for training on Behavior Support Plans. Staff indicated that discussion often took place as direct service personnel attended to other responsibilities, including the care of the individuals. There was no indication that direct service personnel were provided time to commit exclusively to training. This is in clear violation of the policy in the Psychology Procedures Manual – Regular Meeting/In-services/Responsibilities (revised 10/09). The policy stated: "Effective training should be provided in which the direct contact staff are relieved of their normal work responsibilities and trained in a setting in which their attention can be focused on learning about the Behavior Support Plan/Addenda (p. 2)." Further, there was no evidence of competency-based training as described in the policy. When direct service staff were asked for feedback regarding Behavior Support Plans, they provided a variety of responses. Some thought the psychologist for the home provided adequate support and effective training on what were perceived to be appropriate plans. Others reported that half of the plans were a "joke," and that individuals receive reinforcement regardless of their behavior. One staff member commented that the "b-mod" trips (trips off campus if an individual has earned a requisite number of points) were arranged because the individuals were "bad." The reviewer had the opportunity to attend the two-hour training provided to staff on Positive Behavior Support. While the beginning of the training was a good introduction to understanding the day-to-day events that can influence behavior, the overall explanation of possible functions of problem behavior was inadequate. As the training progressed through identifying behavior, the teaching of replacement behavior, and the principle of reinforcement, the time spent on these topics was much too limited. When discussing the "Five Fundamental Outcomes in Life," many of the examples described activities to which individuals at Abilene State Supported Living Center have limited access at best. These included choosing where to work, interacting with people who do not have disabilities, getting married, and traveling. The training concluded with a discussion regarding documentation. The trainer did a nice job encouraging staff to speak up when they observe individual preferences and dislikes, to follow the plans as written, and to provide feedback if there are problems implementing the plan or with the individual's response to the plan. His guidelines for completing the scatter plot were not as clear. He stated that a mark should be made as close to the half hour as possible, and that documentation should be made on the day the problem behavior occurred, and as close to the actual time as possible. This leaves an opening for inaccurate recording or lapses in recording.	

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K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the review, Abilene State Supported Living Center employed one Board Certified Behavior Analyst for a total of 467 individuals, 254 of whom had Behavior Support Plans. As noted in Section K.1 above, the Facility employs 22 Master's level psychology staff, resulting in an average ratio of 1:22. There was at least one psychology assistant for every two Master's level psychologists. While the total number of master's level psychology staff and psychology assistants is appropriate for the population at the Facility, improvements must be made in the number of professionals who have proven competence in Applied Behavior Analysis.	

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

1. The Chief Psychologist is encouraged to continue to pursue coursework and supervision that will enable her to take the exam to become board certified in ABA. It might be helpful to develop a timeline for completion of coursework and training. It is recommended that a professional other than the Behavior Analyst provide the supervision necessary for the Chief Psychologist to obtain her BCBA to ensure that lines of supervision within the ABSSLC Psychology Department remain clear.
2. It is also recommended that the Facility consider developing a training track for current Master's level psychology staff. This could take one of two forms. Financial support could be provided to staff to complete on-line coursework with at least some of the supervision provided by the Behavior Analyst, or the Facility could develop an affiliation with a university so that courses could be offered on site. Consideration should be given to developing a similar system to provide training to staff with undergraduate degrees who could work towards certification as assistant behavior analysts. It will then be necessary to create a system for ensuring that all ABA trained staff maintain their certification. Further assistance could be provided to certified individuals by scheduling on-site opportunities for continuing education, and/or by supporting attendance at regional and national conferences or workshops.
3. Monthly meetings with department staff should be organized to provide all staff with an opportunity to voice concerns and needs.
4. Annual work performance evaluations should become standard practice across all departments of Abilene State Supported Living Center.
5. Changes should be made to the Behavior Support Committee meeting to ensure that it results in functional outcomes that will benefit the individuals served. The author of the Behavior Support Plan should be present along with the Chief Psychologist, the Behavior Analyst, the psychology assistant and/or behavior services team member assigned to the individual's home, and a minimum of two master's level psychologists. The author should be prepared to present data, discuss the success or failure of the plan, and suggest/request changes to the plan, if necessary. Input from QMRP, and other PST members may be provided to the committee in alternative fashion through review of PST minutes, signature attached to the BSP, etc. The Committee should obtain input from direct support professionals responsible for the implementation of the plan. This also may occur in a format other than their attendance at the meeting. Minutes should be recorded with tasks assigned with expected due dates.
6. To facilitate the development of external peer review, consideration should be given to partnering with the nearest State Facility in San Angelo. Psychology staff from the Abilene and San Angelo facilities could travel to each location once per month to provide external peer review. If travel proved difficult, review meetings could be held at each Facility on alternating months. Each group could spend time presenting individual cases while getting feedback from their colleagues at the other Facility. This might be a good first step in fulfilling this requirement of the settlement agreement. As the Facility develops peer review policies, regular visits should be scheduled from professionals in the field of

Applied Behavior Analysis and developmental disabilities to provide additional objective feedback and advice.

7. Functional behavior assessment should be completed annually for every individual who has not made progress under the current Behavior Support Plan. The guidelines outlined in the Structural and Functional Assessment Report are an excellent resource. The Facility should ensure, however, that there is a section that provides a review of previous interventions and their related effectiveness. It will be essential when completing this assessment to ensure the participation of direct service personnel who are most familiar with the individual.
8. The Facility should identify a battery of assessments that will be completed annually, or more frequently, as needed. At a minimum, this battery should include an assessment of adaptive behavior across a range of domains, including, but not limited to: functional communication, self-care, domestic, leisure, vocational, and community skills. Assessment of biologically-based or mental health disorders should also be completed at least annually.
9. Clear behavioral objectives should be identified whenever a person receives therapy or support services in addition to their Behavior Support Plan. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness or lack thereof of the recommended practice.
10. A system should be established, if it has not been already, to ensure that timely consents are obtained from guardians and the Human Rights Committee to ensure that appropriate intervention is not withheld for extended periods of time due to lack of consent.
11. As previously noted, the current format of the Behavior Support Plan provides a great deal of relevant information. The following changes should be made: a) a rationale for the current plan; b) a brief history of prior interventions and their related outcomes should be added to the BSP or Functional Assessment; c) identification of replacement behaviors that are clearly tied to the hypothesized function of the problem behavior(s); d) clearer teaching guidelines for strengthening/teaching replacement behaviors; e) enhanced antecedent strategies, including greater opportunities to make choices, to negotiate more time with a preferred item, to protest an undesired activity, to request breaks, etc.; f) richer schedules of reinforcement, that incorporate identified reinforcers; g) consequences that are developed in consideration of hypothesized function(s) of problem behavior(s); h) clear data collection measures that reflect pertinent information about the target behavior(s); and i) identification of the person or persons responsible for oversight of the plan.
12. As BSPs are developed, and as part of the peer review process, careful consideration should be given to ensuring that responses to behaviors do not result in strengthening the behavior, by for example, reinforcing the individual by providing them with what has been identified to be the function of the behavior. This will require strong emphasis on replacement behaviors and antecedent strategies. For example, instead of waiting to remove a person engaging in SIB from a loud environment, when the function of the behavior has been identified as escaping from such environments, the BSP should focus on removing the individual before the problem behavior occurs, and helping him/her develop a communicative response that signals a desire to change environments.
13. Consideration should be given to developing an abbreviated version of the Behavior Support Plan that can serve as a quick reference for all staff.
14. The administrators of the Facility should develop a plan to reduce the numbers of individuals residing together in living units. The congregation of 15 to 22 individuals in one residence likely contributes to the problem behavior that is exhibited by individuals served.
15. It is essential that the Facility improve its data collection system to ensure that collected measures are reliable and valid. Measures should reflect the rate, duration, and/or intensity of problem behavior and its corresponding replacement behavior. Staff must understand the operational definitions of all targeted behaviors, must be able to identify the presence and absence of the same, and must collect measures that provide an accurate reflection of the rate and severity of the problem.
16. Inter-observer agreement should be assessed regularly, but no less than once each month.
17. Each identified problem behavior should be graphed separately, with graphs depicting daily occurrence of the same. Phase changes lines should be included to note changes in intervention, medication (including dosage), health status, or environmental change. There should be a system in place to ensure regular review of all graphs, resulting in revisions to the Behavior Support Plans, as necessary. All staff working with

the individual should have the opportunity to participate in this regularly scheduled review.

18. The initial training in Positive Behavior Support that is provided to staff should be greatly expanded. A more in-depth review of all of the following areas should be provided: possible functions of problem behavior, identification and teaching of replacement behavior, identification and application of reinforcement, antecedent strategies, and interventions that can be applied contingent upon the target behavior. Additionally, efforts should be made to ensure that all examples depict actual situations that may be encountered at the Facility. This same criterion should be extended to the discussion relating to the Five Fundamental Outcomes in Life.
19. Training on individual Behavior Support Plans should occur across all shifts as these plans are developed and revised. The policy that describes competency-based training for all staff implementing Behavior Support Plans should be put into practice as soon as possible. Time should be arranged for uninterrupted initial training for staff on all plans, with follow up conducted on-the-job.

SECTION L: Medical Care	
	At the time this report was issued, only limited information on the Facility's provision of medical treatment was available. **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o "DNR" List, updated 2/22/10
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: A list provided by the Facility showed that a total of 61 individuals had DNR orders. This represented approximately 13 percent of the total population of 465 individuals served at the Facility. Review of a small portion of these records revealed that individuals without terminal illnesses had DNRs in place, as well as individuals who did not have guardians and who did not appear to be able to make informed decisions about medical care. If Facility physicians initiated such individuals' DNR Orders, this should be reviewed from a conflict of interest perspective. In addition, DADS should review its policy regarding the use of DNR orders within its service delivery system, with careful consideration given to the ethical implications of allowing the use of DNR orders for individuals with developmental disabilities who do not have terminal conditions.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	At the time this report was issued, only limited information on this requirement of the SA was available. <u>Use of Do Not Resuscitate (DNR) Orders</u> A list provided by the Facility showed that a total of 61 individuals had DNR orders. This represented approximately 13 percent of the total population of 465 individuals served at the Facility. Review of a small portion of these records revealed that individuals without terminal illnesses had DNRs in place, as well as individuals who did not have guardians and who did not appear to be able to make informed decisions about medical care. It appears that the State has regulations that allow guardians to put DNRs in place for individuals with developmental disabilities without petitioning the court. The regulations also appear to allow a physician(s) to put a DNR order in place. It was unclear if this was the method used to institute DNRs for a portion of the individuals with DNRs at ABSSLC, and, if so, if it was the Facility's physicians who approved the DNRs. Further inquiry is needed, but if Facility physicians are approving DNRs, this raises a conflict of interest issue, not to mention complex ethical issues. The following provide a	

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		couple of examples of individuals with DNRs: ▪ Individual #456's Annual Medical Summary and Physical Examination, dated 12/16/09, indicated that he has a DNR order dated 4/13/07. Qualifying conditions were listed as: "1) Recurrent pneumonias with associated high fevers. 2) Abnormal modified barium swallow with efflux of liquids into the nasal cavity with each swallow. This predisposes him to further pneumonia. 3) Gross kyphoscoliosis and chest deformity which could make chest compressions virtually impossible. He is not an adequate surgical risk for an anti-reflux procedure." Individual #456 did not appear to have any terminal illness. His 1/25/10 annual nursing assessment noted only one hospitalization during the year for a colonoscopy. His annual physical listed his medical conditions as "stable." It is unclear why a DNR is in place. ▪ Individual #452's Annual Medical Summary and Physical Examination, dated 11/16/09, indicated that she had a DNR order dated 2/13/03. Qualifying conditions were noted as: "1) spastic quadriplegia with lexion contractures of all extremities and kyphoscoliosis. 2) Bulbar paresis, inadequate oral intake required G-tube feeding to sustain life. 3) Sleep apnea with severe oxygen desaturation, required tracheostomy for breathing. 4) She does not communicate verbally and is unable to walk independently. She possesses no self-help skills and depends totally on staff for her care." Individual #452 did not appear to have any terminal illness. Again, it is unclear why a DNR is in place. In addition, although Individual #452 does not appear to be able to provide/express informed consent, she does not have a guardian. It was unclear who approved the DNR order. The Stated indicated that there are circumstances where an Out-of-Hospital DNR order had been issued on behalf of an individual who had severe recurring complications of a chronic disabling illness where resuscitation would be contraindicated, yet did not have a terminal or irreversible conditions. The State indicated that these cases were referred to an ethics committee for deliberation as to whether to give effect to the DNR order. This issue will be reviewed further during upcoming monitoring visits.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility	At the time this report was issued, information on this requirement of the SA was not available.	

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	physician case review and assistance to facilitate the quality of medical care and performance improvement.		
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	At the time this report was issued, information on this requirement of the SA was not available.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	At the time this report was issued, information on this requirement of the SA was not available.	

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

1. The Facility should review individuals with current DNR orders. If Facility physicians initiated such individuals' DNR Orders, this should be reviewed from a conflict of interest perspective.
2. In addition, the State, specifically DADS, should review its policy regarding the use of DNR orders within its service delivery system, with careful consideration given to the ethical implications of allowing the use of DNR orders for individuals with developmental disabilities who do not have terminal conditions.

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 Nursing QE Quarterly Reports for past four quarters; o Nurse Manager Monitoring Tool and data; o Psychiatric Services Monitoring tool; o Dental Services Monitoring tool; o Pharmacy Services Monitoring tool; o Medical Services Monitoring tool; o Nursing Services Quality Enhancement Monitoring tool; o The medical records for the following individuals: Individual #212, Individual #114, Individual #117, Individual #535, Individual #546, Individual #289, Individual #529, Individual #126, Individual #240, Individual #216, Individual #134, Individual #346, Individual #139, Individual #407, Individual #338, Individual #544, Individual #545, Individual #502, Individual #127, Individual #411, Individual #322, Individual #434, Individual #316, and Individual #283, Individual #515, Individual #314, Individual #386, Individual #39, Individual #262, Individual #371, Individual #267, Individual #149, Individual #422, Individual #41, Individual #448, Individual #165, Individual #284, Individual #69, Individual #51, Individual #313, Individual #243, Individual #198, Individual #76, Individual #478, Individual #272, and Individual #507; o ABSSLC policy regarding Role of Hospital Liaison/Discharge Planner; o ABSSLC's Infection Control Manual; o Pharmacy and Therapeutic Committee minutes dated 1/28/10; o Infection Control Committee minutes dated 9/17/09, and 12/17/09; o Infectious Disease Status Reports/Graphs; o Communicable Disease Reports; o Infection Control Monitoring Tool and data from 9/09 through 12/09; o Human Immunodeficiency Virus (HIV) Prevention, Testing, and Treatment policy; o Infection Control course description for new employee orientation; o H1N1 Outbreak State Supported Living Center Response timeline reports; o Medication Administration Observations data; and o The following Nursing Policies/Procedures: Communication with Hospitals and other Acute Care Facilities; Medication Errors/Incidents; Neurological Assessment; Nurse Competency-Based Training Curriculum; Self-Administration of Medications (SAMS); Weight Management; Weight Management Guidelines—Team Roles; Guidelines for Comprehensive Nursing Assessment; Nursing Services: Care Plans' Nursing Services: Management of Acute Illness/Serious Injury; Planning End Of Life Care; DNR Policy;

	Injury/Incident Management; 24-Hour Nursing Care; Nursing Services: Administration of Sedating Intravenous (IV) or Intramuscular (IM) Medications; and Nursing Services; and o Mock Medical Emergency Drills from 7/09 through 1/2010 ▪ **Interviews with**: o Jim Kluza, RN, BA, Chief Nurse Executive; o Mary White, RN, BSN, Quality Enhancement Nurse; o Krista Hamilton, RN, BSN, Infection Control Nurse; and o Marilyn Branson, RN, Infection Control Manager ▪ **Observations of**: o Medication Administration in homes 6480 and 6510; and o Demonstration of the emergency equipment in homes 6521, 6510 and Treatment Room (TR)
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: ABSSLC had 82 positions allotted for Registered Nurses (RNs) with only three vacancies. One of the RN positions was being filled with a Licensed Vocational Nurse (LVN) stipend (a staff person who is pursuing an RN degree with tuition reimbursement from the State). The Facility had 105 positions for LVNs, with only two vacancies. Having adequate and consistent nursing staff is one of ABSSLC's Nursing Department's strengths, and facilitates the provision of clinical care and positive outcomes to the individuals being served at the Facility. ABSSLC needs to develop and implement a number of Nursing and Infection Control monitoring instruments that will accurately reflect the quality of nursing care and practices being provided, and to ensure timely identification of problematic trends and implementation of timely plans of correction. In addition, these data generated by the Nursing monitoring tools need to be integrated into the Facility's Quality Management and Risk Management systems. There were a number of significant problematic issues found regarding complete and adequate nursing assessments related to symptoms for acute changes in status. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer to the Infirmary and off-site medical center, as well as upon return to the Facility. Although there was regular documentation provided by the hospital liaison nurse who visited the individuals while hospitalized, it was kept in the Hospital Liaison Log rather than in the individuals' medical records. The Nursing Care Plans at ABSSLC generally did not include appropriate measurable objectives. As these are improved, it will be necessary for nursing quarterly assessments to include a discussion of the progress an individual is making or not making, interventions that are working or not working, and to recommend changes, if needed, in these interventions.

	The monitoring instrument used for Medication Administration Observations needs to be expanded to include the appropriate procedures for medication administration. Observations of medication administration should be conducted quarterly rather than annually.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Given that this paragraph of the Settlement Agreement, includes a number of requirements, this section of the report includes a number of different section 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 Code Blue drills. 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 SA. <u>Staffing</u> Regarding nursing staffing, ABSSLC's RN and LVN staffing data at the time of the review showed that they had adequate staffing of nurses at the Facility. The department had 82 positions allotted for RNs, with only three (3) vacancies. One of the RN positions was being filled by a LVN stipend (a person who was pursuing an RN degree with tuition reimbursement from the State). In addition, the Facility had 105 positions for LVNs with only two (2) vacancies. The Chief Nurse Executive reported that they have two Nursing Schools in the area, Texas State Technical College and Cisco Junior College which sends student nurses to the Facility for some clinical training, and these relationships had resulted in some success in recruiting new nursing graduates. He also indicated that maintaining adequate nursing staffing levels had not been a significant issue for the Facility. Since there had been stability in the Nursing staff, the Facility had not needed to utilize the services of staffing agencies to augment nursing staffing coverage. Having adequate and consistent nursing staff was one the ABSSLC's Nursing Department's strengths, and facilitated the provision of clinical care and positive outcomes to the individuals being served at the Facility. The Facility should continue its efforts in recruiting and maintaining a stable nursing staff. ABSSLC had five buildings that had 24-hour nursing care, including buildings 6521, 6510, 6480, 6500 and the infirmary. The Facility had a Campus Nurse that made regular rounds, and covered the portions of the facility that do not have 24-hour nursing during the night shift. From review of ABSSLC's nursing staffing assignments, at the time of the review, the Facility had 40 home nurses, 14 campus nurses, 13 infirmary nurses and 11 direct care nurses. The Chief Nurse Executive directly supervised the Hospital Nurse Liaison, Nurse Educator, the Infection Control Nurses, the Nurse Operations Officer, and	

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		six nurse managers. The minimum staffing requirements were based on a fixed number of nursing staff (RNs and LVNs) per specific Unit, but could be modified based on census, acuity, and staff workload related to individual or staff activities. Although the Facility's staffing data did not indicate that they had fallen below minimum staffing levels for nursing, the Facility was not using any tool to assess and track its acuity. Additional issues to consider regarding modification to staffing and acuity include the following: 1. The education and experience of the nurses; 2. The number of nurses in orientation; 3. The number of temporary/agency staff assigned to the Unit; 4. The particular shift, required activities, and duties; 5. The physical layout of the Unit; 6. Facility resources; 7. Available technology used on the Unit such as computers; 8. Unit volatility that includes admissions, transfers and discharges; 9. The number of high risk individuals on a Unit; and 10. A method to assess Unit acuity. <u>Quality Enhancement Efforts</u> At the time of this review, the Nursing Department had few monitoring systems in place to assess nursing care and clinical outcomes. ABSSLC had a Quality Enhancement nurse that conducted audits on various items in the areas of Medical Services, Preventative Care, Psychiatric Services, Incident Management and Nursing Services. From review of the tool and Nursing QE Quarterly Reports, the tool did not include items addressing the quality of items such as treatment plans or assessments, and the sample sizes audited appeared to be very small, ranging between three and seven percent. Since the items on the auditing tool only addressed completion of a task such as the presence or absence of documentation rather than addressing the quality of the documentation, the data generated provided little to no information regarding clinical practices. For example, one of the items on the tool asked if the RN assessed the individual as soon as possible after an LVN evaluation of a serious acute illness or injury. There was no mention, however, of how quickly the evaluation needed to be done, and if the evaluation was comprehensive and appropriate for the illness/injury. Another item asked if the RN assured that the individual with a serious acute illness or injury was assessed at least daily during the first 72 hours, but did not address the appropriateness of the assessments related to the specific condition. Consequently, the compliance scores generated from the current tool did not accurately reflect the quality of the nursing care.	

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		From conversations with the QE Nurse during the review, she was aware of the lack of quality items contained in the current QE monitoring tool, and had made a number of comments on the audit forms themselves indicating problematic issues with the quality of some of the items reviewed. Both the QE Nurse and the Chief Nurse Executive reported that after all baseline reviews have been conducted, the State has indicated that it will be developing some standardized monitoring tools that will include items addressing quality indicators in alignment with the SA and Healthcare Guidelines. In addition, although there is much potential in the auditing processes of the QE Nurse, ABSSLC's existing data regarding compliance could not accurately be interpreted since it did not include the total of the population being reviewed (N), and the sample of that population audited (n) to yield an the percentage of the population included in the sample. This is necessary to interpret the relevance of the compliance scores. Usually, compliance scores for samples under 20% cannot be applied to the total population. Thus, ABSSLC's QE data cannot be accurately interpreted, analyzed, or evaluated to determine if it is reflective of the practices being measured. A review of the Nursing QE Quarterly Reports for the past four quarters showed that it contained a brief narrative and associated graphs indicating the current compliance rates, and a comparison of the current data to past quarters. However, there was no documented analysis of problematic trends identified by the specific disciplines, such as nursing or medical. A review of ABSSLC's Nursing Meeting minutes demonstrated that there was no mention of issues identified through the QE audits. Likewise, there was no discipline-specific documentation, including the identification of the problematic issues, a summary of an analysis of such issues, descriptions and/or dates of actions implemented to correct the issues, and/or subsequent monitoring data indicating if the interventions implemented were effective. The disciplines meeting minutes could be modified to include these specific elements so that this information is in one succinct document. This will be particularly important as the QE nurse, in conjunction with the state, develops and implements additional monitoring tools, and generates additional clinical data. Based on the information reviewed and summarized above, ABSSLC needs to develop and implement a number of nursing monitoring tools that will accurately reflect the quality of nursing care being provided. This is necessary in order to allow the Facility to quickly identify problematic trends, and implement timely plans of correction. To facilitate this process, the State and the Facility should consider using the already established tools provided by the Monitoring Teams addressing compliance items with	

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		the SA and Healthcare Guidelines. In addition, the data generated from the monitoring tools should be regularly reviewed and addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems. In developing these monitoring systems to meet compliance with the SA, the Nursing Department needs to evaluate its current allocation of positions since it currently has only one QE Nurse assigned for auditing. <u>Nursing Assessments</u> One of the ways in which the monitoring team assessed nursing care was by selecting a sample of individuals who experienced acute care issues. By looking at how the Facility addressed some of the most significant nursing issues, strengths as well as weaknesses in the system can be identified. A review of seven (7) individuals' medical records who were transferred to a community hospital or Infirmary (Individual #212, Individual #114, Individual #117, Individual #535, Individual #546, Individual #289, and Individual #529) found that there were significant problems in the documentation regarding the nurses' assessment in the following areas: ▪ The lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms. ▪ The lack of documentation regarding an assessment of the individuals' status at the time of transfer to hospital or emergency room. ▪ No documentation indicating that a transfer packet was sent to the receiving hospital at the time the individual was transferred. ▪ Inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer. ▪ Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes. ▪ Lack of a complete nursing assessment upon return to the Facility. ▪ Lack of updating the Nursing Care Plan to reflect changes in status and new interventions. ▪ The lack of adequate descriptions of the site of injuries. ▪ The lack of lung sounds assessed and documented for respiratory issues. ▪ The lack of neurological checks and mental status documented for individuals with a significant change in mental status. ▪ Illegible progress notes. ▪ The lack of assessment of bowel sounds, and abdomen for individuals with constipation. ▪ The lack of documentation of status changes reported to team members. ▪ The failure to notify physicians regarding individuals' the change of status	

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		As an example of some of the problems noted: ▪ In the case of Individual #212, there were no consistent assessments of lung sounds after an episode of emesis for an individual with a G-Tube who had a high risk for aspiration. When she was transferred to the Infirmary, although there were a number of entries in the progress notes, there was no comprehensive assessment documented that included vital signs, lung sounds or mental status for over 14 hours prior to the transfer. In addition, there was no description or measurement of the swelling at the IV site, or the type of IV fluids that were started due to the swelling. In addition, there was no follow-up documentation indicating that the swelling was resolved. During the stay in the Infirmary, lung sounds were not routinely documented to indicate the nursing staff was monitoring for the possibility of aspiration pneumonia. Throughout the documentation, there was little to no mention of this individual's mental status, and/or level of consciousness. Overall, there were a number of significant problematic issues found regarding complete, adequate and appropriate nursing assessments of symptoms for acute changes in status. In some cases, there was no documentation indicating that an individual was sent to the hospital, and many had inadequate assessments upon return to the Facility. Reviews of two individuals' cases were done on-site with nursing staff who, at the reviewer's request, provided feedback regarding the documentation found in the medical records. The comprehensive and critical feedback provided by the nurses was impressive, and should be cultivated when the Facility begins to monitor this issue. ABSSLC had a Hospital Liaison Nurse who visited and documented the individuals' status while in the hospital in the Hospital Liaison Log. Although this is a significantly beneficial clinical position, especially when individuals are admitted to the community hospital, the documentation requirements as noted in the policy regarding "Role of Hospital Liaison/Discharge Planner" were not consistent between Facilities. Specifically, at other Facilities, the Liaison Nurse was documenting her/his contact and visits in the individuals' records. At ABSSLC, consideration should be given to placing the documentation of the Hospital Liaison in the individuals' medical records rather than in a Log to ensure all team members have access to the clinical information documented by the Hospital Liaison Nurse to ensure continuity of care. In addition, from a policy perspective, based upon a review of ABSSLC Nursing Policies, Procedures and Protocols, there was a policy entitled "Management of Acute	

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		Illness/Serious Injury F-08, ABSSLC Nursing Services, Revised October 29, 2009." However, there were no specific instructions included that defined the essentials that should be contained in the documentation of the assessments, including, for example, the name of the physician/practitioner who was notified, and timeframes for initiation of an Acute Care Plan (ACP). At the time of this review, the Facility had no system in place for monitoring nursing care and documentation for individuals who experienced acute changes in health status to ensure appropriate nursing practices were being implemented. As noted above, the Facility had a number of nurses with acute care experience that were very capable of critically reviewing this documentation. This area should be viewed as a priority when developing and implementing a monitoring system to ensure that adequate nursing practices are being conducted for those in this high-risk category. <u>Availability of Pertinent Medical Records</u> During the review, it was noted that a number of documents had to be located since they were not timely filed in the medical records. This was a consistent problematic issue throughout the review process while on-site. Both the Chief Nurse Executive and the QE Nurse verified that there were on-going problems with record keeping due to the lack of adequate staff assigned to file documents in the records. The Facility needs to ensure that documents are timely filed in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Nursing Peer Review</u> Based on an interview with the Chief Nurse Executive, he reported that there was no system currently in place for internal or inter-facility peer review for nursing. Case reviews of individuals who have had to be transferred to the Infirmary and/or hospital would be a clinically relevant area to target for resuming nursing peer reviews. From review of the revised policy regarding "Nursing Services, Implementation: 01/31 /10," there was no mention of Nursing Peer Review. In addition, from review of the ABSSLC Nursing policies and procedures, no policy was found addressing Nursing Peer Review. A statewide policy should be developed and implemented addressing regular nursing peer reviews. Such reviews should focus on the identification of strengths and weaknesses of the Facility's nursing practices, and include critical analyses of nursing practices, and identification of problematic trends. When problematic trends are identified, plans of correction should be generated, and clinical outcomes should be measured to determine if improvements are realized as a result of the corrective actions.	

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		Infection Control Infection Control (IC) is an area in which it is essential that proper nursing supports are in place at the individual-level, and that there are proper systems in place to prevent the spread of infections on a facility-wide basis. The failure to properly plan for and address infectious disease places individuals, staff, and all visitors to the Facility at risk. Many infections affect the short-term as well as long-term, and even life-long health of individuals who contract them. At the time of the review, ABSSLC did not have adequate infection control procedures in place at either the individual or systemic-level. With regard to IC at ABSSLC, at the time of the review, the Facility had two (2) registered nurses with a variety of infection control experience. The Infection Control Nurse has been in the position for the past two years and the Infection Control Manager has been in the position for the past five years. There were no other clerical or clinical employees in the department. Review of the Facility's IC program revealed that the basic areas regarding the surveillance of Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); HIV; Syphilis; immunizations; vaccines; and antibiotic use were being regularly tracked on a computerized database. However, there was no formal written system in place to ensure the reliability of the Facility's IC data. Based on interview with the IC Nurses, there were a number of systems that they could compare to ensure that they have accurate data. However, there was no procedure outlining this process. The Facility had an Infection Control Manual that outlined basic IC practices. However, there were no policies or procedures that outlined the operations and duties of the IC Department. In addition, there was no system in place that ensured that the residential units were accurately and promptly reporting required issues to the IC Department. For example, while on site at the Facility, two individuals (Individual #507 and Individual #272) were reported by nursing to have infections to their eyes, specifically Conjunctivitis. However, the IC Department had not been notified of the contagious infections by the unit staff. Without ensuring that the IC data are reliably and timely reported, the Facility cannot timely and accurately identify where training on appropriate IC practices are needed, or identify IC trends and where corrective interventions may be needed. The overall documentation of the activities of the IC Department is contained in both the	

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		IC Committee Meeting minutes and in the Pharmacy and Therapeutics Committee Meeting minutes. The Facility uses the IC Committee to address issues that pertain mainly to the direct care professionals, and the Pharmacy and Therapeutics Committee for some limited clinical IC issues. Although the IC Committee minutes included some data related to IC issues such as the numbers of individuals with MRSA, H1N1 flu, and Urinary Tract Infections (UTIs), there were no comprehensive analyses regarding the Facility's basic surveillance data. In addition, no report or committee meeting minutes were found that comprehensively analyzed and addressed the trends in the data, documented inquires into problematic trends, identified corrective actions addressing any problematic trends, or documented monitoring of outcomes in relation to the activities and interventions of the Infection Control Department in conjunction with the practices on the units. For example: ▪ The IC Committee minutes dated 9/17/09 indicated that two homes had five individuals with MRSA in August 2009. The minutes indicated that a follow-up would be done to determine if there was a problem with cross contamination. However, the next quarter's IC Committee minutes dated 12/17/09 did not address this issue. ▪ In addition, the December 2009 IC Committee minutes noted that although there was a drop in the number of UTIs for November 2009, the majority of cases were from the homes serving individuals with more medical complexities, and laboratory tests indicated the infections were all from Escherichia coli (E. coli), a Gram negative rod-shaped bacterium found in fecal material, indicating poor hygiene techniques performed by staff members on individuals who require assistance with personal care. There was no indication that staff retraining was provided to the homes affected in response to the trend identified. Although the IC Department had developed a number of graphs regarding the Facility's surveillance data that were included in the Infectious Disease Status documents, there was no documentation found that included any narrative descriptions and analyses of the meaning of the data related to trends, clinical practice and/or outcome issues. Consequently, the department's data only represented raw numbers, rather than clinical outcome indicators being used by the Facility to monitor and improve upon its infection control practices. At the time of the review, the Facility had just recently hired a new Clinical Pharmacist. It was reported that the person in this position would be taking over the Pharmacy and Therapeutics Committee. The minutes dated 1/28/10 indicated that the IC Manager would be presenting on epidemiology reports, antibiogram and reports of resistant	

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		organisms at quarterly meetings. As mentioned above, the Facility uses the IC Committee to address issues that pertain mainly to the direct care professionals, and the Pharmacy and Therapeutics Committee for review of some limited clinical IC issues. From review of the IC Committee Meeting minutes, the Pharmacy and Therapeutics Committee and the Infectious Disease Status reports, there was little to no information contained in these minutes/reports to demonstrate that the Facility was addressing issues related to Infection Control practices rather than merely presenting data. Modifying the format of the minutes so they contain pertinent information regarding issues discussed; corrective actions; dates, timeframes and assigned responsibility of action steps; expected outcomes; and how the implementation efforts will be monitored to ensure the desired clinical outcome is achieved would guide the Committees in addressing necessary IC issues, and significantly improve the related documentation. On a very positive note, review of the Facility's H1N1 Outbreak Response Timeline reports indicated that when a number of individuals as well as staff became ill with flu-like symptoms from 9/09 through 12/09, the Facility acted quickly and documented a number of interventions implemented at that time. The report indicated that all individuals have received the H1N1 vaccine and seasonal flu shots. The report also indicated that there was regular communication with the Abilene Taylor County Epidemiologist during this time. In addition, training rosters verified that staff was provided regular training and in-services by the IC Department. At the time of this review, Home Supervisors and the Housekeeping Manager were conducting monthly audits by using the ABSSLC Infection Control Monitoring Tool. However, the tool was merely a list of 29 items that were mainly focused on environmental issues. Although this tool may be helpful in monitoring for potential environmental concerns on the units, it did not comprehensively address the monitoring that should be completed. It did not address any issues regarding appropriate treatment practices for infection control issues. For example, there was no monitoring system in place to ensure that individuals with Hepatitis C were screened for immunizations for Hepatitis A and B, and, if needed, had received them, or that individuals with MRSA had received the appropriate antibiotic, and that contact precautions were appropriately followed on the units and in day programs. In addition, no tracking was found of individuals who refused treatments such as immunizations or PPDs indicating that their treatment teams were addressing the refusals and implementing interventions.	

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		In addition, from an interview with the IC Nurse and Manger, there did not appear to be any Infection Control information included as a part of key indicator data for Quality Management/Risk Management. As the Facility continues to develop these systems, Infection Control information should be integrated into this system as well as integrated into the other disciplines within the Facility to review regarding practices and clinical outcomes. From review of the IC documentation and data, there is a lack of a connection between clinical issues at the house level and the activities of the Infection Control Department. During an interview with the IC staff, they reported that there was no review of the Nursing Care Plans for individuals with infectious diseases by Infection Control or nursing to ensure that they are clinically appropriate, and that the interventions are actually being implemented. As is discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, of 19 individuals' records that were reviewed who had either a chronic or acute infectious disease, only one (1) individual had a Nursing Care Plan that addressed identified infectious diseases, and it was not adequate. The annual documentation by the physicians regarding a screening for any active signs or symptoms of Tuberculosis for individuals who are Purified Protein Derivative (PPD) positive were found to be completed inconsistently. In addition, a number of chest x-rays were noted to have been completed, but the x-rays were frequently not found in the records. Although the Facility's Infection Control Manual was revised in 11/09, the Manual needs to be reviewed to ensure it is alignment with the SA and Healthcare Guidelines addressing Infection Control requirements. As noted previously, there were no policies found that address the operations, duties and responsibilities of the Department. Based on the interview with the IC Nurse and Manger, there were a number of informal systems in place that needed to be formalized into policies and procedures to ensure consistency. In addition, there was only one policy found regarding the treatments and practices for infectious diseases, specifically the Human Immunodeficiency Virus (HIV) Prevention, Testing, and Treatment policy. A statewide Infection Control Manual would be very useful to the Facilities. A review of the Facility's Infection Control course description for orientation and annual refresher classes demonstrated that hand-washing and Standard Precautions were included in the curriculum as well as in the post-test. Although hand washing was	

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		included as an item on the Facility's current Infection Control Monitoring tool, there was no data indicating if staff was using the proper techniques, or if Standard Precautions were being routinely followed at the homes. From the lack of Nursing Care Plans found addressing infectious diseases, additional and on-going competency-based training regarding Infection Control issues is warranted for the Nursing staff. As noted previously, the Facility had a computerized database that included various data regarding the individuals at ABSSLC. However, there was no data found that verified that all vaccines and immunizations were administered in a timely manner, and according to Centers for Disease Control (CDC) guidelines. Since many of the individuals have been at the Facility for a number of years, the original lab work was not found in the records making it difficult, if not impossible, to determine if individuals received the appropriate administration of vaccines. Although the IC Nurse and Manager had some experience and background in Infection Control and were committed to making the changes necessary to ensure the IC Department functioned appropriately, additional expertise and staffing likely will be needed to implement systems to operationalize effectively the Infection Control Department in alignment with the Health Care Guidelines and the Settlement Agreement. In addition, the development and implementation of statewide Infection Control policies and monitoring tools would facilitate this process. <u>Code Blue Drills</u> From review of ABSSLC's Mock Medical Emergency Drill documentation, the Facility had been conducting drills on a monthly basis on different shifts. There was no indication regarding what type of emergency scenario constituted the drill. Without this information documented, there was no way to determine if a variety of scenarios were being used to illustrate different types of emergency situations, or if the same one was being consistently repeated. No analysis was found of the drills regarding trends identified, or plans generated to implement corrective actions, and then measure progress on anticipated outcomes. For example, on several occasions that staff refused to participate in the drill, including licensed nurses. However, there was no indication that these staff members were retrained on the policy regarding Medical Emergency Drills. In addition, there were a number of comments on drill forms indicating that there had been some issues with equipment not working properly. However, there was no indication that the faulty equipment had ever been repaired or replaced. The purpose of conducting regular	

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		medical emergency drills is to identify strengths and weaknesses of the Facility's response to emergencies by continuously assessing the process, as well as the staff's knowledge and competency in executing emergency procedures. It also was noted that during the drills, staff were not asked to actually turn on the oxygen. While on-site during the review, two out of three nurses asked to demonstrate the use of the emergency equipment were unfamiliar with how to turn on the oxygen. In addition, the suction machines were not being routinely checked to ensure that they were operational. The Facility needs to implement a system in which nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment. It is imperative that all licensed staff receives competency-based training regarding emergency procedures and equipment use. Observations of these skills should be conducted at least quarterly. In addition, the Facility does not incorporate the actual use of the emergency equipment in the competency-based emergency training and drills. This is essential, and ensures that when an emergency arises, the nurse will be familiar with the equipment and any medications that would be used. From conversations with nurses on the units, there were several who had not actually been inside the emergency equipment for a number of years. In the midst of an emergency, nurses should already have a working knowledge of the equipment, and should know exactly what supplies are needed, and where these supplies are kept in the emergency equipment. This will avoid delays in treatments during an actual Code Blue. In addition, there was no indication that physicians were participating in the Mock Medical Emergency Drills. It is essential that the physicians practice their role in a Code Blue medical emergency, be familiar with the Facility's emergency systems, and be familiar with the staff's knowledge of emergency procedures.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Fifteen (15) individuals' records were reviewed, including: Individual #212, Individual #114, Individual #117, Individual #535, Individual #546, Individual #289, Individual #529, Individual #104, Individual #294, Individual #408, Individual #130, Individual #437, Individual #361, Individual #331, and Individual #492. All had quarterly nursing assessments completed in a timely manner. However, the quality of these assessments required significant improvement. The nursing assessment form used checkmarks for most of the sections, and nursing staff frequently did not add any additional information to these sections. The Nursing Summary narrative section for all of the 15 quarterly assessments (100%) reviewed contained mainly raw data without any analysis of whether the individuals were doing better or worse than the previous quarter. For example:	

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		▪ Individuals who had lab work during the quarter only had the current values noted on the assessment without mention of a comparison to the previous lab values. ▪ An assessment for Individual #546 who was 70 pounds above his recommended weight range did not indicate if he had experienced any fluctuations in his weights from previous quarters. Attempts at increasing his activity level were not discussed. The assessment only contained his current weight. Overall, the nursing assessments need to include an analysis of progress made during the quarter rather than just listing raw data such as lab values and appointment dates. In addition, the Quarterly Nursing Assessments reviewed did not indicate progress or lack thereof regarding individuals' measurable objectives, and service and/or supports that are included in individuals' Nursing Care Plans. As discussed in further detail below, the current Nursing Care Plans at ABSSLC generally do not include appropriate measurable objectives. As Nursing works to improve these, it will be essential for the nursing quarterly assessments to include a discussion of the progress an individual is making or not making, strategies that are working or not working, and to recommend changes, if needed, in strategies, supports and services.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Review of eighteen (18) individuals' records (Individual #386, Individual #39, Individual #262, Individual #371, Individual #267, Individual #149, Individual #422, Individual #41, Individual #448, Individual #165, Individual #284, Individual #69, Individual #51, Individual #313, Individual # 243, Individual #198, Individual #76, and Individual #478) found that all of the Nursing Care Plans (100%) were of poor quality, and provided little to no direction regarding meeting the needs of the individuals experiencing a variety of health issues. Many had identical interventions listed on the treatment plans for issues such as skin integrity that included items such as: "administer medication as ordered", "notify physician when skin problems occur," and "document per Nursing Procedure Manual." These interventions are services that have to be provided to all individuals. The lack of individual-specific interventions based on individualized needs in the Nursing Care Plans render them meaningless in providing staff direction for caring for individuals, and being able to measure individuals' progress toward their goals. Although some of the objectives/goals contained in the Nursing Care Plans were noted to be somewhat measurable, behavioral and/or observable, most were not. In addition, documentation of the implementation of the interventions listed in the Nursing Care	

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		Plans was rarely found in the progress notes. None of the nursing interventions reviewed indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed and/or when they should be considered for modification. In addition, proactive interventions were generally not included in the Nursing Care Plans reviewed. Nursing Care Plans that included a problem noting that an individual was at risk for a specific issue such as aspiration included interventions that only addressed reactive care rather than preventative care. For example: ▪ The Nursing Care Plan for Individual #371 indicated that a description of skin problems will be documented in the "Observation Notes on a timely basis as long as a problem exists." However, there was no indication how often to document (e.g., hourly, daily, weekly), who will review the documentation and how often, and what constitutes "timely." In addition, the objective on the Nursing Care Plan stated that: "Lesions, lacerations, bruises, scratches, irritation will be avoided." Aside from the objective not being measurable, there were no proactive interventions included on the Nursing Care Plan addressing prevention of skin issues. ▪ In the case of Individual #386, his Nursing Care Plan indicated that he is at risk for constipation related to iron therapy. The interventions listed on the Nursing Care Plan included "monitor for signs and symptoms of constipation," "accurately document BMs [bowel movements]," "report if going more than 48 hours without a BM," and "administer stool softeners as ordered." The Nursing Care Plan makes no mention of providing appropriate fluid and nutritional intake, the need for positioning and activity, assessing regularly for bowel sounds and abdominal distention, or other proactive measures to prevent constipation from occurring. Again, the Nursing Care Plan indicated that nursing "will monitor," but did not include any specifics about what should be monitored, who will monitor this, how often it will be assessed, and where it will be documented. An additional sample of individuals' records was reviewed to determine if individuals with chronic and acute infectious diseases had appropriate care plans to address their needs. Specifically, a review was completed of 19 Nursing Care Plans for individuals diagnosed with a variety of infectious diseases including: Individual #126, Individual #240, Individual #216, Individual #134, Individual #346, Individual #139, Individual #407, Individual #338, Individual #544, Individual #545, Individual #502, Individual #127, Individual #411, Individual #322, Individual #434, Individual #316, Individual	

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		#283, Individual #515, and Individual #314. Of the 19 individuals, 18 had no Nursing Care Plans addressing these issues, and the one (1) Nursing Care Plan that was found for Individual #545 was clinically inadequate. Specifically, the Nursing Care Plan did not address any of the essential elements for a contagious illness, including the need for precautions to be used when taking care of the individual, teaching the individual and staff to prevent the spread and transmission of the infection, and the signs and symptoms to regularly assess and document. Based on this review, there was no system in place that ensures that individuals with infectious diseases were being provided the appropriate infection control procedures, or that clinically appropriate interventions to prevent the spread of infection were being consistently implemented. At the time of this review, ABSSLC did not have an adequate monitoring instrument addressing the quality and implementation of Nursing Care Plans. From the review, the current Nursing Care Plans did not provide an adequate and appropriate guide regarding the specific needs of the individuals. In addition, there was no evidence in the nursing notes that the interventions listed in the Nursing Care Plans were actually being implemented. There needs to be a monitoring system in place ensuring that appropriate Nursing Care Plans are in place, and that the nursing interventions are being implemented.	
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.	From review of ABSSLC's Nursing policies, procedures, and protocols, there appeared to be a lack of developed reporting protocols. For example, there was no protocol found addressing issues such as diabetes, cardiac conditions, seizures, and constipation. The current Nursing policies regarding nursing assessments and care plans were noted to have been reviewed/revised in 2009. However, as discussed above, the current nursing assessments and care plans were not adequate and need to be revised. In addition, the few nursing protocols that were provided by the Facility lacked specific criteria for what should be included in the progress note documentation, and/or other specifics such as timeframes for initiating and completing tasks, and specific parameters as to when to notify the physician of certain critical information. The Nursing Department should review all existing policies and protocols, determine what revisions need to be made, and, as necessary, develop additional policies and procedures addressing nursing care. The Nursing Department also needs to ensure that all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice, as well as requirements of the SA and Health Care Guidelines. Once that is accomplished, the department then needs to develop and implement associated monitoring instruments with established inter-rater reliability at 85% or above to ensure that these practices are being adhered to consistently.	

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M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	As noted in the section of this report that addresses Section I of the SA, the Facility was using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. However, this tool is simply scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. However, the tool was not an adequate risk assessment for any of the areas mentioned, and its implementation did not result in the appropriate identification of clinical risk indicators. The Facility was using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. Standardized risk assessments should be used by all the Facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.	
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.	From interviews with nursing staff and review of 162 Medication Administration Observation audits completed between September 2009 and February 2010, there had been some supervision provided for licensed nurses in the administration, monitoring, and recording of the administration of medications. However, the observation tool that was being used at ABSSLC to monitor medication administration was not comprehensive, and needed to be revised to include all the basic elements of medication administration orally, by injection, or via tube. For example, the tool does not include the procedure for observing medications given via tube, which constitutes a large number of individuals at the Facility. The tool also did not contain all the appropriate steps to administering medications, such as three checks of the MAR and initialing the MAR immediately after administration. In addition, the current procedure at ABSSLC for the Nurse Competency-Based Training Curriculum indicated that nurses are only observed administering medication annually, which is too infrequent to ensure that appropriate medication administration practices are being consistently followed. Nurses should be observed administering medication at least on a quarterly basis. The Facility will need to develop and implement a tracking system to ensure that each nurse is observed at least quarterly. When observing medication administration while on site for individuals who received their mediations via tube, the following significant issues were identified. Specifically, the nurse did not:	

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		▪ Consistently provide privacy to individuals during medication administration; ▪ Provide information to the individual prior to medication administration; and ▪ Ensure the individual was in the proper positioning prior to medication administration. While ABSSLC's monitoring instrument for medication administration is not in alignment with appropriate practices, their data for the time period between September 2009 and February 2010, reflected close to 100 percent compliance for all of the monitoring items on all but four (4) out of 162 Medication Administration Observations audits reviewed. This is not realistic, nor does it comport with the observations of the reviewer while on-site.	

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

1. The Nursing Assessment forms and processes should be revised to ensure that a comprehensive nursing assessment is conducted. The current form consists of a checklist that does not set the expectation for a comprehensive analysis of information. As noted above, the current format for nursing assessments results in only raw data being reported, but not analyzed.
2. Nurses and any other staff responsible should be required to complete competency-based training on:
    - Nursing Assessments;
    - Writing and monitoring Nursing Care Plans; and
    - The proper administration and documentation of medication.
3. Regular Nursing peer review should be completed.
4. Nursing Care Plans should be revised to include specific goals/objectives that are objective and measurable, as well as interventions that identify who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are reviewed, and when they should be modified.
5. A monitoring system should be developed and implemented to ensure:
    - Completion, quality and timeliness of Nursing Assessments;
    - Nursing Care Plans are individual-specific and meet professional standards of care;
    - Interventions listed in Nursing Care Plans are proactive, are being timely and appropriately implemented, and are modified in response to the individuals' progress;
    - Individuals who experience changes of status are reviewed, including reviews of individuals who were sent to community hospitals and Emergency Rooms;
    - All nurses who administer medications are appropriately supervised in the administration, monitoring, and recording of the administration of medications and any errors. Such review should occur at least quarterly to be consistent with generally accepted professional standards. The current medication administration monitoring tool should be modified to reflect appropriate standards of practice.
    - Infection Control practices are being appropriately and timely implemented.
6. Inter-rater reliability for all monitoring tools should be established at 85 percent or better.

7. The current allocation of nursing positions should be evaluated to meet requirements for developing departmental monitoring activities.
8. The role of nursing in the interdisciplinary treatment team process should be expanded to ensure that treatment plans are derived from an integration of the individual disciplines' assessments, and that goals and interventions are consistent with clinical assessments.
9. Nursing Procedures/Protocols should be revised and/or developed and implemented to ensure that:
    - The appropriate assessments and documentation requirements are in alignment with generally accepted standards of practice, as defined in the requirements of the SA and Health Care Guidelines; and
    - Address acute change in status.
10. Documents should be filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
11. Currently successful efforts in recruiting and maintaining a stable nursing staff should continue.
12. Consideration should be given to securing the services of an expert in the area of Infection Control to provide consultation to the State and the Facilities.
13. The need for additional staff for the Infection Control Department at ABSSLC should be evaluated.
14. The IC policies and procedures should be revised as needed to reflect current standard of practices and requirements outlined in the Settlement Agreement/Health Care Guidelines.
15. A departmental monitoring system should be developed and implemented in alignment with IC standards of practice and Facility policies.
16. Statewide IC monitoring instruments should be developed and implemented to ensure that individuals with infectious diseases are adequately treated, protected from additional infections or re-infection, and that other individuals who live in the same buildings as well as staff and visitors are appropriately protected from transmission of infections.
17. Systems should be developed and implemented to ensure reliability of IC data.
18. The structure of the IC minutes should be revised to include a systematic review of data trends for individuals and employees that include an analyses, an inquiry into the issue, a plan of action that includes the name of the person responsible for follow-up and the date when it will be implemented, and updates on the desired outcomes.
19. The nurse(s) in the Infection Control Department should collaborate with nursing regarding the development and implementation of individualized–specific, appropriate Nursing Care Plans for IC issues.
20. The nurse(s) in the Infection Control Department should collaborate with nursing to ensure that unit staff receive appropriate on-going competency-based IC training.
21. Infection Control Environmental Checklist audits should accurately reflect the environmental conditions, and corrective actions should be taken and documented.
22. IC data should be integrated into the Facility's Quality Management system.
23. The Facility's policy should require that Medical Emergency Drills are conducted at least quarterly, on every unit, and every shift and include the use of the emergency equipment.
24. A policy/procedure should be developed and implemented outlining the levels of committee review for Medical Emergency Drills, actual Code Blues and emergency procedures.
25. A system should be developed and implemented to ensure that Medical Emergency Drills and actual Code Blues are critically analyzed, and plans of correction developed and implemented to address problematic issues.
26. Competency-based training should be implemented regarding emergency procedures that include the use of emergency equipment.
27. Competency-based training should be provided to all licensed staff regarding the appropriate procedures for checking emergency equipment.
28. A monitoring system should be developed and implemented requiring nurses to demonstrate the use of the emergency equipment when checking it to ensure that it is in good working condition.

29. Physicians should be involved in Medical Emergency Drills. Standards should be developed and implemented requiring physician participation in emergency drills at least once per quarter.

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 ABSSLC's Pharmacy policies; o Medication Error Committee meeting minutes, dated 6/25/09, 7/29/09, 8/26/09, 9/23/09, 10/28/09, 11/25/09, 12/16/09, and 1/27/10; o Drug Utilization Evaluation form; o Pharmacy and Therapeutics Committee meeting minutes dated 5/28/09, and 1/28/10; o Medication error data from July 2009 to January 2010; o Medical records for the following individuals: Individual #30, Individual #61, Individual #4, Individual #196, Individual #99, Individual #56, Individual #363, Individual #181, Individual #324, Individual #179, Individual #264, Individual #182, Individual #304, Individual #357, Individual #36, Individual #122, Individual #282, Individual #518, Individual #378, Individual #506, Individual #55, Individual #499, Individual #75, Individual #185, Individual #283, Individual #314, Individual #515, Individual #521, Individual #443, Individual #38, Individual #346, Individual #435, Individual #275, Individual #71, Individual #316, Individual #54, Individual #468, Individual #510, Individual #165, Individual #304, Individual #320, Individual #205, Individual #241, Individual #108, Individual #139, and Individual #247; o Quarterly Drug Regimen Review forms; and o Nursing Services Quality Enhancement Monitoring tool ▪ **Interviews with**: o Leah Robinson, R.Ph., Pharmacy Director; and o Marla Knight, Pharm. D., Certified Geriatric Pharmacist, Clinical Pharmacist
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Whenever an individual is prescribed a new medication, a system appears to be in place to check for potential issues. However, a system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented. Although improvements in recent months were seen with the Drug Regimen Reviews (DRRs), this is an area that requires improvement. In addition, a system needs to be instituted to ensure that physicians and/or nurse practitioners respond to recommendations included in the quarterly Drug Regimen Reviews.

	At the time of the review, ABSSCL did not have a system to monitor: a) the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically-justifiable manner, and not as a substitute for long-term treatment; b) the use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justifications and attention to associated risks; and c) metabolic and endocrine risks associated with the use of new generation antipsychotic medications. There appears to be significant underreporting of medication errors. Nursing staff did not consistently agree on which errors needed to be reported. Since medication error reporting is not yet reliable, a spot check system should be initiated. The spot check system needs to include a review of the Medication Administration Records (MARs) and narcotics log at some time during the shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately and that both the on-coming and off-going nurse has signed the narcotics log.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	A review of the Facility's pharmacy policies found that they had not been reviewed since 2006, and had not been revised to include the requirements of the SA and Healthcare Guidelines. In addition, the pharmacy's policy regarding Medication Errors was not the same as the policy found in the Nursing policy documents. An interview with the Pharmacy Director indicated that when a new medication was ordered for an individual, the pharmacist received a fax of the order, and entered it into the WORx software system that did an automatic review of the new medication. This review assessed the medication regarding the appropriate dosing, listed allergies, and potential interactions with the individual's current medication regimen. If a problem was identified, the physician was notified, and the pharmacist used the physician's order to document the problematic issue. However, from the information provided by the Pharmacy Director, the notification of the physician by the pharmacist may at times have been informal without supporting documentation. A system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug	A review of the Quarterly Drug Regimen Reviews was completed for 37 individuals, including: Individual #30, Individual #61, Individual #4, Individual #196, Individual #99,	

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	Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	Individual #56, Individual #363, Individual #181, Individual #324, Individual #179, Individual #264, Individual #182, Individual #304, Individual #357, Individual #36, Individual #122, Individual #282, Individual #518, Individual #378, Individual #506, Individual #55, Individual #499, Individual #75, Individual #185, Individual #283, Individual #314, Individual #515, Individual #521, Individual #443, Individual #38, Individual #346, Individual #435, Individual #275, Individual #71, Individual #316, Individual #54, and Individual #468. This review identified a number of concerns, including: ▪ The DRRs from August 2009 and December 2009 had no signature from the pharmacist who conducted the review, or from the physician indicating that he or she had reviewed the DRR. ▪ It had been the practice at ABSSLC not to have the individual's primary physician review the DRRs, and to only forward those with recommendations to the individual's psychiatrist. However, there needs to be documentation that the prescribing practitioners have reviewed the DRRs. ▪ Only four (4) of the DRRs reviewed had comments from the pharmacist. This raises concerns regarding the thoroughness of the review conducted by the pharmacist. ▪ There was no mention on the DRRs about the need for the Dyskinesia Identification System: Condensed User Scale (DISCUS) to be conducted for individuals prescribed Reglan. ▪ For other comments and recommendations found on these DRRs addressing lab work that was not found, or the Monitoring of Side Effects Scale (MOSES) or DISCUS that needed to be completed, there was no documentation found that a physician reviewed the DRRs, or addressed any of the recommendations. ▪ A number of the DRRs were not completed quarterly as required. Although more current DRRs from 2/2010 contained more information from the pharmacist regarding the individuals' drug regimens, there was no indication that the physician reviewed the form, and responded to the pharmacist's recommendations. The Facility needs to develop a system to ensure that the prescribing practitioners review the DRRs and revise the form to include a space so that the prescribing practitioners can document a response to any recommendations made from the pharmacy.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18	A review of the ABSSLC's Pharmacy Policies found no policy that addressed the elements of this requirement. At the time of the review, the Pharmacy and Therapeutics Committee was in process of having the Clinical Pharmacist take over as the Chair of the	

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	months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Committee. Thus, the Committee was in the process of restructuring the agenda items to be discussed during the meetings. At the time of this review, however, there were no systems in place addressing this requirement.	
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.	As is noted above in the section that addresses Section N.2 of the SA, at the time of the review, medical practitioners were not documenting that they had reviewed the pharmacist's recommendations, and/or provided a justification for any recommendations not followed.	
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.	At the time of the review, ABSSLC's had a current policy in place addressing this requirement. In addition, a number of the DRRs reviewed noted if a MOSES or DISCUS was needed. Also, the Facility's QE Nurse was monitoring this using the Nursing Services Quality Enhancement Monitoring tool. A review of four (4) individuals (Individual #30, Individual #518, Individual #185, and Individual #75) found that two (50%) had a current MOSES and DISCUS completed, and two (50%) did not have the MOSES completed timely as required. In addition, a review of nine individuals (Individual #510, Individual #165, Individual #304, Individual #320, Individual #205, Individual #241, Individual #108, Individual #139, and Individual	

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		#247) found only two (22%) had Nursing Care Plans that addressed side effects of psychotropic medications, and the need to conduct quarterly MOSES and DISCUS monitoring. These issues need to be included in the Nursing Care Plans.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	At the time of this review, ABSSLC had a policy addressing Adverse Drug Reactions in place that was revised 2/2010. From the report of the Pharmacy Director, there had been no reported Adverse Drug Reactions reported to the Food and Drug Administration in the past few years.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	At the time of this review, the Facility was in the beginning stages of conducting its first drug utilization evaluation (DUE) for Depakote. The State's Medical Director had been working on this requirement with all the SSLCs in deciding on which medications to review, as well as developing the process in alignment with the SA and Health Care Guidelines.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	At the time of this review, ABSSLC had implemented a revised policy addressing medication errors and reporting in 1/10. From review of the Facility's medication error data from July 2009 to January 2010, there appeared to be a significant issue with the under-reporting of medication errors based on the census, and the number of medications given on a daily basis. The Facility's data indicated that there were between 13 and 21 medication errors per month. From the reviewer's discussion with the Chief Nurse Executive, the Facility had only recently changed its policy regarding medication errors in an attempt to make a self-reporting system non-punitive. This should assist in addressing the issue of under-reporting. From conversations with nurses' who administer medications, there was substantial	

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		confusion regarding what constitutes a medication error, and the procedure to be used when Medication Administration Record (MAR) blanks were found. When the unit nurses were asked if these missing initials constituted a medication error, some thought they did and others thought they had a certain timeframe to initial the MAR. However, most stated that they were not responsible for completing a Medication Error Report when they identified a blank space on the MAR. There was clearly a resistance to report medication errors at ABSSLC. The Facility needs to develop and implement a system to ensure that MARs are regularly checked to determine that medications were given as prescribed. When issues such as missing initials on the MARs are identified, a review needs to be completed to determine whether the individual actually received the medication, and a Medication Error Report needs to be submitted since the MAR blank constitutes a variance from the appropriate procedure. Unfortunately the punitive nature of the past medication error system will continue to affect the reliability of the medication error data. Since medication error reporting was not yet reliable, a spot check system should be initiated to include a review of the MARS and narcotics logs during each shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately, and that both the on-coming and off-going nurses have signed the narcotics log indicating that the narcotic count was conducted by both nurses. In addition, the State should give consideration to moving from a medication error system to a medication variance system. Such a system focuses on all aspects of the medication delivery system, and places an emphasis on identifying potential areas that could lead to errors. Once such areas are identified, the focus would be on implementing proactive measures to prevent such errors from occurring. In reviewing the minutes from the Medication Error Committee, there was no documentation of a comprehensive narrative analysis, or plans of correction that included interventions and/or anticipated outcomes as a result of actions taken. The minutes merely represented a review of the numbers of medication errors each month without any of the necessary clinical analysis.	

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

1. A system should be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen, as well as the physician's response to this notification. If the physician makes the decision not to follow the recommendations made by the pharmacist, an

entry must be made in the progress notes clinically justifying such a decision.

2. The pharmacy needs to ensure that they are noting and addressing, as appropriate, laboratory results, and identifying abnormal or sub-therapeutic medication lab values on the Quarterly Drug Regimen Reviews in a timely manner.
3. A system should be developed and implemented to ensure physicians/nurse practitioners provide adequate responses regarding pharmacy recommendations on the Quarterly Drug Regimen Reviews. A modification to the Quarterly Drug Regiment Review form may need to be made to facilitate this system.
4. A system should be developed and implemented to ensure that the prescribing medical practitioners and the pharmacist collaborate: a) in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically-justifiable manner, and not as a substitute for long-term treatment; b) in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justifications and attention to associated risks; and c) in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.
5. The Facility should continue to ensure that there is timely identification, reporting, and remedial action regarding all significant or unexpected adverse drug reactions.
6. State Office and the Facility should continue to develop and implement a system to ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care, as defined by the SA and Health Care Guidelines.
7. The Facility should ensure that policies regarding medication errors/variances identify all failures to properly sign the Medication Administration Record and/or the Narcotics Logs as errors/variances, and that appropriate follow-up occurs to their prevent recurrence. The Facility should move from a medication error system to a medication variance system to be compliant with the SA.
8. The Facility should implement documented spot checks to ensure the MARs and Narcotic Count Logs are documented appropriately.
9. Nurses should conduct counts of narcotics and document such counts in the Narcotic Log at the beginning/end of each shift, as well as when the keys are passed to another nurse for breaks and when the keys are returned to the originally assigned nurse.
10. The Facility should conduct an analysis and implement a plan of correction with nursing to address the underreporting of medication errors/variances.
11. Training should be provided to all nursing staff regarding the reporting of medications errors.
12. The Medication Error Committee should conduct regular analyses regarding medication errors to identify trends and implement plans of correction aimed at the prevention of such errors.
13. The Facility, specifically nursing, should develop and implement a monitoring system to ensure that MOSES or DISCUS are conducted quarterly, and that for individuals who require this, that there is a Nursing Care Plan addressing these needs.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
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 New Employee Orientation Agenda; o Lifting Checksheet; o Lifting/Transferring Consumers: Pre-Class Written Assessment; o Lifting/Transferring Consumers: Post-Class Written Assessment; o Stand Pivot Transfer Checksheet; o Two-Person Manual Lift Checksheet; o Mechanical Lift Checksheet; o Bathing Trolley Checksheet; o Oral Hygiene Training Handout; o Since 7/1/09, list of individuals who have sustained a bone fracture, including the individual's name, date of incident, the location of the injury and the cause of the injury; o Leadership Council Notes (February 1, 2010); o Abilene State Supported Living Center High Risk Individuals (no date on document; person-specific meeting dates were identified); o Communicable Disease Report for Aspiration Pneumonia and Pneumonia, dated 01/20/10; o Choking Incidents (July 1, 2009 to present); o Abilene State School Individuals with gastrostomy tubes (G-Tubes)/jejunostomy tubes (J-Tubes) and/or Tracheostomies; o List of Habilitation Therapies staff; o Habilitation Therapies Physical Nutritional Management, (Karen Hardwick, Ph.D., OTR, FAOTA, Revised 2009); o Evaluation of Dysphagia (Section VII.A.1) I. Presenting Problem, History, Predisposition, II. Oral, Pharyngeal, Esophageal, Gastric/Intestinal and Pulmonary III. Medical Review Consultation, External Oral Exam/Meal Observation, Radiologic Studies, Other Medical Tests, and IV. Treatment (Karen Hardwick, Ph.D., OTR); o Using the NMC Database for Documentation: Nutritional Management Team Report; o Examples of NMT Review from Evaluation of Dysphagia; o Meal Time and Snack Monitoring (Policy Directive 08-005); o Lemon Ice Instructions; o Instructions for Videofluoroscopy; o Evaluation and Treatment of Dysphagia in Individuals with Developmental Disabilities (Karen Hardwick, PhD, OTR, FAOTA); o Texas Department of Aging and Disability Services Physical Management Training

	Modules; o Physical/Nutritional Management Checklist Instructions; o Abilene Habilitation Therapies Manual, revised 12/31/09, approved 01/31/10; o Nutritional Management Screening Tool; o Physical Nutritional Management Policy (#012); o Nutritional Management Team Policy (#013); o PNMP Definition and Purpose, Checklist for Internal Compliance Review of Critical Process Indicators Related to Physical/Nutritional Management of Consumers Requiring Such Services, dated 04/08/08; o Best Practices Guidelines (July 2008); o Curriculum Vitae's of Habilitation Therapies staff; o Wheelchair PNMP Clinic Logs for individuals; o At Risk Individuals Policy (#006); o Choking Incident Follow-up Policy/Procedure (Nutritional Management Team Manual Revised 0/27/10); o Health Risk Assessment Tool(s) for Aspiration/Choking, Weight, Nursing, Polypharmacy, Challenging Behavior, and Injury; o Health Risk Assessment Rating Tool, Health Status Team Recommendations/Signature Sheet and Healthcare Provider Statement; o PNMP Roster; o Non-PNMP List; o NMT PN Log (01/09 through 08/09); o NMT Review and Recommendations Log (09/09 through 12/09); o NMT Minutes from 01/07/09 to 12/30/09; o List of individuals with PNMP Screening in the last quarter; o Dining Plan Roster 2010 and Eating Evaluation/Nutritional Management Plans; o PNMP Monitoring Form-Routine; o PNMP Training Form; o PNMP Checksheet; o Monthly Health Monitoring Report Dehydration and Decubitus Report (October 2009) o Dining Plan Roster 2010 and Eating Evaluation/Nutritional Management Plans; o PNMP Monitoring Form-Routine o PNMP Roster; o PNMP Training Form; o PNMP Checksheet; o Wheelchair Cost Data Base; o Dining Plan Reference Page; o Person-Specific Dining Plans for the following individuals: Individual #360, Individual #78, Individual #235, Individual #544, Individual #344, Individual #57, Individual #472, Individual #92, Individual #350, Individual #424, Individual #290, Individual #188,

	Individual #394, Individual #164, Individual #118, Individual #13, Individual #123, Individual #338, Individual #524, Individual #344, Individual #138, Individual #214, Individual #493, Individual #254, Individual #13, and Individual #393; o PNMP Tracking: Persons with Unexplained Weight Loss of 10% or greater since 07/01/09; o Meal Serving Times Schedule; o Schedule for Personal Support Plan Meetings, Nutritional Management Meetings, Physical Nutritional Management Plan Clinic, Health Status Team Meetings and Department Staff Meeting; o Mechanical Lifts, and Bath Trolley Training Instructions; o Monitoring Tool for Use of Bath Trolley Safety Straps; o Bath Trolley Safety Strap Usage Written Test; o Training and Development Six Month Schedule (September 1 through February 28, 2009); o Training and Development Schedule (March through August 2009); o Person-specific PNMPs; PSPs; Food and Medication Interactions; Nutrition Consultation Reports; Annual Nutrition Assessment; Nutritional Status Progress Note; Nutritional Management Team Discharge Progress Note; Eating Evaluation/Nutritional Management Plan; Nutritional Management Team/Nursing Weight Management Progress Note for Individual #92, Individual #83, Individual #63, Individual #119, Individual #212, Individual #114, Individual #2, Individual #540, Individual #49, Individual #447, Individual #274, Individual #472, Individual #338, Individual #477, Individual #164, Individual #13, Individual #118, Individual #311, Individual #138, Individual #129, and Individual #117; o Percent of Facility Employees Completing Courses of Training Program, dated 02/01/10): o Color Coded Campus Texture List, dated 01/11/10; o Modified Barium Swallow Studies (01/01/09 through 12/31/09); o Abilene State Supported Living Center Food/Drink Policy (Policy Adopted 08/2004, Currently under revision 02/2010); o Mealtime Observation Form (SLP/OT Format 10-06, Rev. 1/07); o Follow-up completed by NMT for the last five choking incidents; o Person-specific consults, Modified Barium Swallow Study (MBSS), OT/PT/SLP Assessments; OT/PT/SLP Updates, PSP, PNMP with pictures, Special Considerations, PT/OT/SLP consults, Audiology assessment, NMT Review notes, therapy program data sheets for Individual #92, Individual #83, Individual #63, Individual #119, Individual #212, Individual #114, Individual #2, Individual #540, Individual #49, Individual #447, Individual #274, Individual #472, Individual #338, Individual #477, Individual #164, Individual #13, Individual #118, Individual #311, Individual #138, Individual #129, and Individual #117; and o Completed PNMP Monitoring Forms-Routine (October-December 2009);

	▪ **Interviews with**: o Debralea Sessions, MS, CCC/SLP, Chairperson of NMT; o Occupational Therapist (all); o Speech Language Pathologists (all); o Registered Dietitians on NMT (2); o Nurse on NMT; o Physical Therapists; o Director Habilitation Services, Glen G. Funkey, PT, DPT; and o Conducted meeting to discuss Section O with OTs, PTs, and SLPs and obtain information on current progress for implementation of Section O ▪ **Observations of**: o NMT Meeting on 02/24/10; o Health Status Team on 02/25/10; o Meals (Breakfast, Lunch and/or Dinner) in homes 6390, 5961, 5962, 5971, 5972, 6730,6750; and o Departmental Staff Meeting for OT, PT and SLP
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: At the time of the review, the Facility was not systematically identifying individuals with PNM concerns. There appeared to be pieces of an identification system in place, but not a comprehensive, integrated system to ensure that individuals with such needs were identified in a timely manner to allow for prompt development and implementation of plans to address their needs. The Facility also was not completing comprehensive assessments of individuals at risk with regard to physical and nutritional management concerns, or developing comprehensive plans with measurable, functional outcomes to address risk areas. The primary focus of the NMT was a paper review as opposed to an assessment team that completed comprehensive assessments, developed interventions based on functional outcomes, monitored these interventions to ensure efficacy, and modified interventions if they are not working. ABSSLC's Physical Nutritional Management Team did not include a physical therapist. PNMT members will need increased continuing education opportunities to enhance their competencies in working with individuals with complex physical and nutritional management needs. Many of the individuals at the Facility had mealtime and/or positioning plans in place. However, many of these plans did not address all activities in which swallowing difficulties can present risk. Moreover, many of these plans did not consistently address alignment support in wheelchair and/or alternate positions, strategies for oral hygiene, medication administration, snacks, personal care and/or bathing/showering. More than one PNMP may need to be in place for an individual. For example, it might be appropriate for a

	PNMP to be designed and implemented just for nursing staff who are responsible for the administration of medication. A review of the PNMP Monitoring Form-Routine forms for three months, documented issues/concerns from one monitoring session to the next without resolution. In addition, these forms were not analyzed to determine the need for individual-specific staff re-training, and/or to determine systematic concerns that needed to be resolved. ABSSLC policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, definition of measurement for PNMP indicators, compliance level expected, and/or process to be followed if PNMPs are not being implemented as written. It did not appear that monitoring of staff's competence with regard to the implementation of PNMPs was being completed on a structured schedule. At the time of the review, documentation could not be found to show that comprehensive annual reviews had been conducted of individuals currently receiving enteral nutrition to determine the medical necessity of the tube. An initial step had been taken in this review process for some individuals who were receiving enteral nutrition. Between September and December 2009, the NMT reviewed and documented its recommendations in this regard for some individuals. This would be considered one part of a comprehensive assessment that would also need to include a nursing assessment, and medical assessment, with full discussion by the individual's PST. This comprehensive review should result in documentation by the team of the team's recommendation/decision.

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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	Due to the multiple requirements included in this provision of the SA, each requirement is discussed in detail below: PNM team consists of qualified SLP, OT, PT, Registered Dietician (RD), and, as needed, ancillary members [e.g., Medical Doctor (MD), Physician Assistant (PA), Registered Nurse Practitioner (RNP)]: The policy on the Nutritional Management Team (NMT) (Policy #013) defined the composition of the NMT as: "physician, occupational therapist, speech language pathologist and dietitian. Other disciplines as indicated by need, including but not limited to, Physical Therapy, Certified Occupational Therapy Assistant, Licensed Vocational Nurse (LVN), psychologist, QMRP, home staff, and others." The policy also documented the specific roles of team members as primary care provider, occupational therapist, speech language pathologist, registered nurse, registered dietitian, and qualified mental retardation professional, but did not identify the role of a physical therapist.	

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	professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	Per report of the NMT Chairperson and observation of the NMT meeting, a Physical Therapist was not a member of the Nutritional Management Team. The members of the NMT were a Speech Pathologist, Occupational Therapist, Registered Dietitian and Nurse Case Manager. At some NMT meetings, there were two Speech Language Pathologists and two Registered Dietitians. A review of NMT meeting minutes and attendance documentation for meetings from 01/01/09 to 12/30/09 did not show any ancillary members attending NMT meetings. There is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management needs: Although documentation was not provided for all of the NMT members, based on the review of the available documentation, the NMT Chairperson and Occupational Therapists had completed clinical instruction related to physical and nutritional supports, and should continue to be provided opportunities enhance their skills in supporting individuals with complex physical and nutritional support needs. Other NMT members had limited continuing education related to supporting people with complex physical and nutritional support needs. According to information provided by the State, bi-weekly webinars, periodic regional training/new therapist training and an annual conference were offered to all therapy staff. These sessions reportedly offered training on specific issues related to working with individuals with complex physical and nutritional support needs. Based on information gathered through this review, this training had not resulted in the provision of adequate supports to individuals supported by ABSSLC. The Chairperson of the Nutritional Management Team, completed the following continuing education courses: Introduction to Autism (11/9/09), Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10/8 to 10/9/09), Ethics for SLPs (10/8/09), Communication Issues for Individuals with Developmental Disabilities in a Residential Setting (10/7/09), Physical and Nutritional Management for SLPs (7/29/09), Working the Puzzle: Understanding Autism Spectrum Disorder (2/12/09), Sensory Processing Disorder (SPD) (12/4/08), PNMP for SLP and Augmentative Communication (5/21 to 5/23/08), and Texas Speech-Language Hearing Association 2008 Convention (2/21 to 2/23/08). The Curriculum Vitae for the Occupational Therapist on the NMT documented continuing education from 1995 to 2010, including: Habilitation Therapies Annual Conference	

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		(2005), Sensory Learning for the Multiply Impaired/Visually Impaired (MIVI) Student (2005), Habilitation Therapies Annual Conference (2006), Autism from a Developmental Pediatric Perspective (2006), Habilitation Therapies Conference (2007), Autism Spectrum Disorders: Everything You Ever Wanted to Know but Were Afraid to Ask (2007), Habilitation Therapies Annual Conference (2008), Sensory Issues Impacting Behavior and Learning for Students with Autism (2008), Habilitation Therapies Annual Conference (2009), and Five Keys to Proactive with Hearing Loss (2009). Continuing Education documentation was not submitted for registered dietitian(s), or nursing NMT members. PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results (HCG VIII.C.9): The PNMT/NMT was functioning primarily as a paper review committee for a large group of individuals. The PNMT/NMT's primary focus should be to identify those individuals at an increased risk level, including individuals who have risks other than nutritional risks. The PNMT/NMT should be responsible for completing a comprehensive assessment leading to the development of an individualized PNM action plan that adequately and appropriately addresses positioning and nutritional support needs throughout the 24-hour day for those individuals at most significant risk. The PNMP should have individual-specific criteria, risk indicators and functional outcomes that are tracked to determine the efficacy of problem resolution and the continued success of strategies implemented. The outcomes and criteria must be clearly recorded and utilized for monitoring. The information gained from this process should be analyzed to determine the effectiveness of the supports provided at both the individual-specific and systemic levels. The PNMT/NMT should ensure this process is integrated into the individual's PSP. The NMT at ABSSLC was not fulfilling these duties at the time of the review. The Nutritional Management Team Policy (#013), Section H, entitled Schedule for Meetings stated that: "meetings are held monthly, but may also occur: when problems arise; upon changes in risk level by the HST; after esophagrams or other medical or diagnostic tests are performed; before final treatment decisions are made; to perform follow-up activities, and at any phase in the Nutritional Management process." Nutritional Team Meeting attendance records submitted from 1/7/09 through 12/31/09 documented 51 NMT meetings. These meetings occurred on a weekly basis (51 out of 52 weeks in the year). The NMT members expressed frustration with the current process of reviewing many	

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		individuals within all three risk levels. They reported they were meeting weekly for many hours and, in some cases, going well into the evening hours. As a result, the NMT was not able to focus and provide intensity for those individuals with the most complex needs. The NMT PN Log from 01/09 to 08/09, contained the following categories: Name and case number; date; PN type; weight, within, above, or below recommended weight range (RWR); choking hotline calls; modified barium swallow study (MBSS); vomiting; pneumonia; infirmary admissions, illness other; discussion; recommendations; and follow-up. The NMT Review and Recommendation Log data base from 09/09 to 12/09, contained the following categories: name and case number, date and PN type, weight, MBS, Pneumonia, Medical/Status Review, discussion, recommendation, risk level, and projected next review. According to this documentation, although the NMT met frequently, individuals who had a change in status were not consistently reviewed. For example, individuals with a diagnosis of aspiration pneumonia upon return from an infirmary stay and/or hospitalization were not reviewed by the NMT, but should have been. Discipline assessments may have been completed (for example, Eating Evaluation/Nutritional Management Plan Addendum, Nutrition Assessment, Food and Drug Interaction, Nutrition Status Progress Note, Nutritional Management Team/Nursing Weight Gain/Loss Notification Consultation Report), but the NMT did not review and integrate these assessments into one complete and comprehensive assessment. In addition, individual-specific monitoring by NMT members was not documented. Furthermore, NMT recommendations did not include individualized, measurable, functional outcomes. The following six generic recommendations were identified in the NMT database: 1. Continue oral eating; 2. Continue current diet and feeding techniques; 3. Oral eating is not recommended; 4. Continue oral and non-oral feedings; 5. Continue tube feedings; and 6. Continue current formula. In reviewing individuals' records, these generic recommendations were assigned repeatedly to individuals with no revision or individualization, and without resolution of an identified health concern.	

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		PNM plans are incorporated into individuals' Personal Support Plans: Physical Nutritional Management Policy (#012) Section III, entitled Physical Nutrition Management (PNMP) Critical Elements documented: "the PNMP shall be addressed at the annual planning meeting and as often as needed, approved by the Personal Support Team, and included as part of the Personal Support Plan." However, PNMPs were not fully integrated into the PSP. They remained separate documents that were often referred to in the PSP. The strategies were not set forth, however, as measurable objectives within the PSP. One hundred seven (107) Personal Support Plans were submitted for people for whom PNM assessments and updates have been completed during the last quarter. A sample of 22 PSPs and PNMPs were reviewed (for Individual #100, Individual #138. Individual #199, Individual #19, Individual #116, Individual #55, Individual #500, Individual #271, Individual #174, Individual #464, Individual #306, Individual #266, Individual #524, Individual #41, Individual #109, Individual #292, Individual #344, Individual #214, Individual #83, Individual #54, Individual #498, and Individual #333). It was determined that for zero out of 22 (0%) of these individuals, were their PNMPs incorporated into their PSPs. Identification, assessment, interventions, monitoring, training as outlined in sections O.2 through O.8 of the SA occurs (HCG VI.1 and 2.): A review of individuals' records identified concerns related to the delivery of physical and nutritional supports in the areas of identification, assessment, interventions, monitoring, and training. The following are examples of these concerns, but these concerns were noted for other individuals as well: ▪ Individual #92 was reviewed by the NMT on the following dates, was assigned the following risk levels for the reasons listed, and recommended for review by the NMT within the stated timeframes: o 03/25/09, at Risk Level 1, to return for monthly review by NMT, due to weight; o 05/20/09, at Risk Level 2, to return every two months for review by NMT, due to weight; o 08/19/09, at Risk Level 3, to return for monthly review by NMT, due to weight; o 09/23/09, at Risk Level 1, to return for monthly review by NMT, due to weight; o 11/04/09, at Risk Level 1, to return for monthly review by NMT, due to	

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		weight o 11/24/09, at Risk Level 1, to return in six weeks for review by NMT, due to weight; o 01/06/10, at Risk Level 1, to return for monthly review by NMT, due to MBSS results, and weight; and o 02/03/10, at Risk Level 1, to return for monthly review by NMT, due to weight, and Baclofen increase. The NMT did not consistently complete reviews in a timely manner for Individual #92 per their established schedule. It was not clear why her Risk Level changed from review to review. Individual #92 had documented choking incidents on 6/11/08, 7/5/08, 12/8/08, and 4/29/09. These incidents should have been reviewed and addressed by the NMT, but did not appear to be properly assessed and addressed. Per observation, Individual #92's seating system did not provide her with optimal alignment and support. The NMT review on 11/04/09, documented an Eating Evaluation on 10/19/09, completed with mealtime strategies adjusted, but the Eating Evaluation submitted was 07/28/08, not the most recent Eating Evaluation. Her PNMP, dated 05/12/09, and Dining Plan/OT Update, dated 02/17/10, did not present consistent information on the mealtime techniques to be implemented. This had the potential to place her at risk during mealtimes. Recommendations made by the NMT, from review to review, were to continue oral eating, current diet and feeding techniques, which did not adequately address her high risk health concerns of poor alignment and support in her seating system, and choking during mealtimes. The recommendations made by the NMT were not individual-specific to her identified health concerns, and did not provide comprehensive interventions to address her identified needs. The NMT review on 05/20/09, recommended providing in-service training to nursing staff to contact the choking hotline whenever coughing or choking occurred with oral intake, but there were no follow up notes to document if this recommendation was completed. No evidence was found that the NMT completed a comprehensive assessment to address Individual #92's complex physical and nutritional support needs leading to the development of individual strategies to be implemented throughout a 24-hour day to minimize her health risks. These strategies would include written documentation of measurable, functional outcomes including individual-specific monitoring, and competency-based staff training to ensure the adequate implementation of the plans. ▪ A Modified Barium Swallow was completed for Individual #199 on 12/03/09, but the NMT did not complete a review prior to or after this study.	

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		▪ Individual #524 had a Modified Barium Swallow completed on 10/15/09, but was not reviewed by the NMT after the study. ▪ Individual #540 had a documented choking incident on 10/29/09. Per the Nutritional Management Screening Tool, any choking incident places the person at Level 1, High Risk, to be reviewed at the next scheduled NMT. Individual #540 was not reviewed by the NMT. ▪ The NMT reviewed Individual #100 nine times in 2009 on the following dates: 01/07, 02/25, 03/25, 04/29, 05/27, 07/22, 08/19, 09/23, and 10/21. During the year, he was diagnosed with multiple episodes of pneumonia/aspiration pneumonia, and was hospitalized on multiple occasions. He received a Percutaneous Endoscopic Gastrostomy (PEG) tube on 07/14/09. The NMT recommendations for Individual #100 were: o On 01/07/09, correct diet/texture order, Risk Level 1; o On 02/25/09, continue oral eating and current diet and feeding techniques, Risk Level 1; o On 3/25/09, continue oral eating and current diet. Change feeding techniques, Risk Level 1; o On 4/29/09, continue oral eating, and current diet and feeding techniques, Risk Level 1 o On 5/27/09, change diet order, Risk Level 1; o On 6/24/09, continue oral eating and current diet and feeding techniques. Ammonia levels were to be ordered, and results sent to dietitian, Risk Level 1; o On 7/22/09, oral eating was not recommended; continue tube feedings and current formula, Risk Level 1 o On 8/19/09, same recommendations as on 7/22/09, with the addition of no oral gustatory stimulation as per the most recent Eating Evaluation NMP/Addendum; and continue Frazier Water Protocol, Risk Level 3; o On 9/23/09, oral eating was not recommended, continue tube feedings, current formula and Frazier Water Protocol, Risk Level 1; and o On 10/21/09, same recommendations as 09/23/09, Risk Level 2. The NMT met on a monthly basis for Individual #100, but did not complete a comprehensive assessment to address his risks for the placement of a feeding tube, or his repeated diagnoses of pneumonia/aspiration pneumonia. The NMT recommendations focused on diet texture and mealtime techniques, which did not provide a comprehensive approach to minimizing his health risk indicators. Individual #100 needed individual-specific recommendations, measurable	

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		functional outcomes, and strategies to address his significant nutritional risk for placement of a feeding tube, and aspiration pneumonia. The PNMT/NMT comprehensive assessment should have addressed the development of strategies to encompass a 24-hour day, such as alignment and support, oral hygiene, bathing/showering, medication administration, personal care and routine activities to minimize identified health risk indicators. None of this was completed for Individual #100.	
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.	A process is in place that identifies individuals with PNM concerns (HCG VI.C.2 and 3.) The process includes levels of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk levels (HCG VIII.C.1; VI.B.1): There were various documents that provided slightly different direction for the assignment of risk categories, including: ▪ The Habilitation Therapies Manual, Section VII, entitled Nutritional Management described the Discovery/Referral Phase of the NMT as: "All individuals residing at the facility will be screened for risk factors and assigned a risk level. Risk levels are 1-High Risk, 2-Medium Risk, and 3-Low Risk. The Nutritional Management Screening Tool lists risk factors as: Level 1 (High Risk) will be seen by the next scheduled NMT, Level 2 (Medium Risk) will be seen in 30 days to one year, and Level 3 (Low Risk) is as needed (PRN)." ▪ The Nutritional Management Team Policy, Section D, entitled Discovery/Referral Phase (#013) provided additional guidance. Specifically, it indicated that during the discovery/referral phase individuals should be screened for risk factors, and assigned a risk level corresponding to: o 1-High Risk: The individual would be seen by next scheduled NMT. Issues that would place an individual in this category were listed as acute respiratory illness, diagnosed aspiration pneumonia, weight loss more than five pounds in three months, chronic low weight with cause undetermined, any choking incident, uncontrolled diabetes, iron supplementation, respiratory illness requiring treatment/ pneumonia, emesis more than three times per month of unknown etiology, and recent videoesophgram/GI procedure/surgery. o 2-Medium Risk: The individual will be seen in 30 days to one year. Issues that would place an individual in the category were listed as chronic low weight with cause determined, regular episodes of emesis, chronic restrictive/reactive airway disease, history of aspiration pneumonia, chronic respiratory illnesses, follow-up gastrointestinal (GI) procedures/surgeries, history of gastroesophageal reflux disease	

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		(GERD), diabetes controlled. o 3-Low Risk PRN: Issues that were listed for this category were no active aspiration pneumonia for two years, no significant emesis for one year, stable enteral feeding, weight within 10% to 5% decrease, and resolved anemia. ▪ The Nutritional Management Screening Tool identified the following risk factors: history of choking, respiratory illness requiring treatment, history of reflux/vomiting, down syndrome, history of GI problems, dependently fed, enteral feeding, low weight/weight loss, anemia of unknown origin and altered diet texture. ▪ The Nutritional Review and Recommendation Log documented four risk levels: o 1-High; o 2-Moderate; o 3-Low; and o 4-PRN. An analysis of the NMT Review and Recommendations Log did not support risk levels being assigned per the established criteria in the Nutritional Management Screening Tool as evidenced by the following individual examples: ▪ Individual #294 was reviewed by the NMT on the following dates in 2009: o On 03/04/09, he was determined to be at Risk Level 2, and was reviewed for meal refusals. The NMT agreed to a trial of an all-liquid diet to assist with swallowing. o On 5/13/09, he was assessed at Risk Level 2. The reason for follow-up was frequent emesis, pneumonia, possible aspiration, coughing, bronchitis, and lower leg edema. Per the Nutritional Management Screening Tool, this would have placed him at Level 1, High Risk, and required that he be reviewed at the next NMT. He was not reviewed until two months later. o On 7/08/09, the NMT assessed him at Risk Level 1. A GI consultation for the PEG tube was pending, but the team did not recommend a comprehensive assessment. Recommendations were to continue oral eating, continue current diet and feeding techniques, and monitor closely for signs and symptoms of aspiration due to feeding during periods of low arousal. o On 08/12/09, he was assessed to be at Risk Level 3. The reason for follow-up was pneumonia and possible aspiration. Recommendations on the NMT PN Log were: "Please list on SC/PNMP the	

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		recommendations from the 3/08 MBS and the most recent Eating Evaluation NMP/Addendum; and ensure he is awake and alert before providing food or liquid." o On 09/09/09, he was assessed at Risk Level 3. The reason for follow-up was health status, and PEG placement pending. It was noted that he remained in the infirmary at this time awaiting PEG placement. The team's recommendation was diet as per physicians' order both pre- and post- surgery. o On 10/14/09 he was assessed at Risk Level 1. The reason for follow-up was health status, PEG placement, and enteral feeding tolerance. Recommendations were that oral eating was not recommended, continue enteral feedings, and continue current formula. No discussion was documented to confirm that PNMP was updated per previous recommendation from 09/09 NMT meeting. o On 11/10/09, he was determined to be at Risk Level 1. The reason for follow-up was enteral feeding tolerance and weight. Recommendations were that oral eating was not recommended, to continue enteral feedings, and make a change in formula. o On 12/30/09, he was assessed at Risk Level 2. The reason for follow-up was weight and enteral feedings. Recommendations were that oral eating was not recommended, continue enteral feedings and continue current formula. The preceding assigned risk levels for Individual #294 did not follow established criteria on the NM Screening Tool, because he was diagnosed with aspiration pneumonia that would place him at High Risk, Level 1. It was unclear why he would change risk levels from review to review. ▪ Individual #208 was reviewed by the NMT on 09/02/09, for vomiting and in response to a GI consultation. He went to the Emergency Room (ER) for respiratory distress with a diagnosis of aspiration pneumonia. Despite these significant issues, his assigned risk level was Level 3 (low risk). ▪ Individual #76 was reviewed by the NMT on 09/02/09, for a choking incident that occurred on 08/30/09. The risk level the NMT assigned was Low Risk-3, although any choking incident was identified as Level 1-High Risk on the Nutritional Management Screening Tool. ▪ Individual #114 was reviewed by the NMT on 11/10/09 for follow-up related to pneumonia, elevated blood sugar, respiratory issues and enteral feeding tolerance. She was assigned Risk Level 2, which was not consistent with the risk level criteria on the Nutritional Management Screening Tool.	

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		▪ Individual #22 was reviewed by the NMT on 11/16/09, for a follow-up to aspiration, a MBS in 07/09, and health status. She was assigned Risk Level 2. Again, this did not accurately reflect her risk level. Abilene State Supported Living Center High Risk Individuals document identified people at high risk within identified categories, including aspiration, cardiac, challenging behavior, choking constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures skin integrity, urinary tract infections, and weight. Abilene State Supported Living Center High Risk Individuals documented the following individuals at high risk for aspiration: Individual #119, Individual #452, Individual #212, Individual #497, and Individual #114. Two of these individuals (Individual #119 and Individual #497) were not reviewed by the NMT. It was unclear why only five people were identified at high risk for aspiration as evidenced by the information below: The Abilene State School Individuals with G-Tubes/J-Tubes document identified 95 people who were enterally nourished. Their PNMPs addressed the risk for aspiration pneumonia. Examples of strategies included in the PNMPs were: instructions for elevation of the heads of their wheelchairs and beds; no oral gustatory stimulation due to recurrent vomiting, GERD and pneumonia; no positioning supine in bed or stretcher; and use of Sterident (vacuum) toothbrush for oral hygiene to reduce risk of aspiration. The great majority of these individuals were not on the list of individuals at risk for aspiration. The Communicable Disease Report, dated 1/20/10, documented the following people with a diagnosis of aspiration pneumonia: Individual #90, Individual #201, Individual #105, Individual #505, Individual #414, Individual #70, Individual #31, Individual #292, Individual #100, Individual #346, Individual #114, Individual #212, and Individual #208. The Nutritional Management Screening Tool indicated that individuals with a diagnosis of aspiration pneumonia should be assigned to the category of Level 1 - High Risk. These individuals were to be reviewed at the next scheduled NMT meeting. Nine of the 13 individuals (69%) identified in the Communicable Disease report as having aspiration pneumonia were not reviewed by the NMT, including Individual #90, Individual #105, Individual #505, Individual #414 (two episodes of aspiration pneumonia on 2/27/09, and 8/17/2009), Individual #70, Individual #31, Individual #90, Individual #346, and Individual #114.	

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		The following people who were diagnosed with aspiration pneumonia were reviewed by the NMT, but the team's recommendations did not address strategies to minimize the risk of aspiration: Individual #201, Individual #100, Individual #212 (episodes of aspiration pneumonia on 1/5/09, and 7/6 to 7/27, 09), Individual #208 (three episodes of aspiration pneumonia 8/2 to 8/7/09, 9/12/09 to 10/11/09, and 12/4, 2009). Individuals that the Facility had identified at high risk for choking were: Individual #119, Individual #452, Individual #212, Individual #497, Individual #114, and Individual #88. Three people had documented choking incidents requiring the use of the Abdominal Thrust (Individual #540, Individual #5, and Individual #44), but were not identified at high risk for choking. At the time of the review, the strategies utilized by the NMT did not ensure that people at highest risk were reviewed. The NMT must establish guidelines to further define categories of high, moderate and low levels of risk for physical and nutritional health risk indicators, including thresholds to trigger initial and further evaluation, and establish intervals of review based on the degree of an identified risk level. These guidelines need to define the criteria for entrance onto the NMT agenda to ensure the individualized physical and nutritional support needs of an individual are addressed. Furthermore, exit criteria should be defined as meeting the measurable, functional outcomes established by the NMT. In defining such criteria, the NMT should review The Health Care Guidelines, Section VI, on Nutritional Management Planning that provides criteria for risk categories. Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team: The Nutritional Management Team Policy (#013) documented the Evaluation Phase as: "Appropriate assessments are completed by the physician, therapists, nurses or consultants to address identified problems. Evaluation procedures may include mealtime evaluations, videoesophagrams or other radiological procedures, esophagogaastroduodenoscopies (EGDs), colonoscopies, lab work and others." The Checklist for Internal Compliance Review of Critical Process Indicators Related to Physical/Nutritional Management of Consumers Requiring Such Services documented the following: "Clients who are at nutritional risk will receive services from a Nutritional Management Team including identification of problems, recommendations for treatment, and follow-up/monitoring of interventions to ensure timely delivery of appropriate	

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		services. Assessment and designation of a risk level will be performed for all individuals. The risk level will be utilized to determine the frequency of review and intensity of services." The NMT Review and Recommendations Log(s) consistently referred to "Eating Evaluation NMP/Addendum" results, but oral care, medication administration, bathing/showering, personal care, and proper alignment and positioning during the course of a 24-hour day were not addressed in NMT recommendations. <u>All comprehensive assessments:</u> • <u>Are conducted by the PNM Team;</u> • <u>Identify the causes of such problems; and</u> • <u>Contain proper analysis of findings and measurable, functional outcomes</u>: As noted above, the Nutritional Management Team Policy (#013), Section E, entitled the Evaluation Phase, provided direction regarding the evaluation process. However, the policy did not identify comprehensive assessment domains and methods, guidelines for analysis, the framework for making recommendations, timeframes for completion, intervals for reassessment, and/or the process to integrate findings and recommendations into the PSP. The PNMT/NMT reviewed discipline-specific assessments such as nutrition and/or eating assessments, which may have been completed by NMT members. These assessments did not document collaboration between the disciplines, nor was there involvement by a physical therapist. The NMT did not complete comprehensive assessments that should lead to the development of measurable, functional outcomes for those individuals at highest risk. For the most part, generic recommendations were made by the NMT, such as continue oral eating, continue current diet and feeding techniques, oral eating is not recommended, combine oral and non-oral feeding, continue tube feedings, and/or continue current formula. Such generic recommendations did not provide comprehensive strategies to minimize health risk indicators. The following provides an example of an individual for whom the NMT failed to complete an adequate assessment to determine if proactive, preventative actions could be taken: ▪ Individual #294 was reviewed by the NMT eight times in 2009. His nutritional status was at high risk, and resulted in the placement of a feeding tube. The NMT did not complete a comprehensive assessment prior to the placement of a PEG tube. <u>Assessment results are integrated into the design of the appropriate PNM support plans</u>	

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		as outlined in HCG VI and VIII, and SA O.3 through 0.8: The NMT recommendations did not address the integration of assessment results into a individual's PNMP. The primary assessments utilized by the NMT were the Eating and/or Nutrition Assessment, which did not support a comprehensive approach to assessing people at highest risk within established risk categories. Two hundred and sixty (260) PNMPs were submitted for review. Many of these PNMPs did not address strategies for oral care, bathing/showering, personal care and medication administration. For example: ▪ Individual #294's PNMP, revision date 11/06/09, indicated he was enterally nourished, and at risk for aspiration. He did not have instructions for bathing, alternate positioning, bedtime positioning, medication administration, and/or oral hygiene. ▪ Individual #454 was at high risk for aspiration. Her PNMP, dated 08/27/09, did not address strategies for oral care and medication administration. Updates are provided as needed or at a minimum annually for all individuals with identified PNM supports: As discussed in above in the Section that addresses O.1 of the SA, individuals who were at risk due to physical and nutritional support needs were not reviewed as frequently as they need to be.	
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.	All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP) (HCG VIII.B.1): The Checklist for Internal Compliance Review of Critical Process Indicators Related to Physical/Nutritional Management of Consumers Requiring Such Services documented the following: ▪ "Physical/Nutritional Management Programs (PNMPs) must be developed by qualified staff and approved annually by the PST. ▪ All clients who require physical/nutritional management services shall be furnished with a PNMP. ▪ PNMP is a set of techniques and instructions that addressed the use of assistive equipment, transferring/lifting, positioning handling, nutritional concerns and other activities which span a 24-hour day, seven days a week, to assure optimal health, function and comfort." The Facility/members of PSTs identified people at high risk as well as the NMT, which used the Nutritional Management Screening Tool. The absence of a standardized risk assessment tool presented the following scenario whereby the Facility/members of	

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		teams had identified individuals at high risk within identified categories, but the NMT was not made aware of these individuals. The following individuals are examples of individuals who were identified at high risk, did not have a PNMP developed, but required one: ▪ Abilene State Supported Living Center High Risk Individuals list identified Individual #119 at high risk for aspiration. She did not have a PNMP developed to identify strategies to minimize her risk of aspiration pneumonia. ▪ Abilene State Supported Living Center High Risk Individuals list identified Individual #212 at high risk for aspiration. She was reviewed by the NMT for vomiting and aspiration pneumonia. The following generic recommendations were made during reviews: 1) oral eating is not recommended, 2) continue enteral feedings, and 3) continue current formula. A recommendation was made to change formula order on 01/04/10, but no follow-up was documented to confirm formula change was initiated. Individual #212 did not have a PNMP. ▪ Abilene State Supported Living Center High Risk Individuals list identified Individual #2 at high risk for weight. A Nutrition Evaluation was not submitted per reviewer request. She did not have a PNMP to address this identified health concern. Many individuals identified at high risk on the Abilene State Supported Living Center High Risk Individuals list were not reviewed by the PNMT/NMT, and PNMPs were not developed. There must be a process to ensure there is consistent and accurate identification of individuals across all disciplines to ensure individuals at the highest risk are provided appropriate physical and nutritional supports. As appropriate, PNMP consists of interventions /recommendations regarding: positioning/alignment; oral intake strategies for mealtime, snacks, medication administration, and oral hygiene; food/fluid texture; adaptive equipment; transfers; bathing; personal care; in-bed positioning/alignment; general positioning (i.e., wheelchair, alternate positioning); communication; and behavioral concerns related to intake (HCG VIII.B.2-3; VIII.C.3) Two hundred sixty (260) PNMPs were submitted for review. A review of these PNMPs showed that they did not consistently address the following interventions: ▪ Degree of elevation of bed, wheelchair and alternate positions for individuals with a diagnosis of GERD or other health concerns such as a diagnosis of and/or at risk of aspiration pneumonia; ▪ Many identified the oral hygiene strategy of using a strident toothbrush to reduce risk of aspiration, but generally no additional interventions were	

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		identified for oral hygiene, such as positioning or fluid consistency; ▪ No oral intake strategies/interventions for medication administration, including, for example, diet texture, fluid consistency and positioning; ▪ No bathing/showering strategies for individuals at risk of aspiration and/or for those who have a diagnosis of GERD; and ▪ Strategies for personal care were lacking, such as dressing and grooming. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that comprehensively meet their needs</u>: Eight-nine (89) PNMPs for people who are enterally nourished and/or receive recreational feedings were submitted for review. A review of these PNMPs found that they did not consistently address the following interventions: ▪ Degree of elevation of bed, wheelchair and alternate positions for people receiving enteral nutrition; ▪ The oral hygiene strategy to use a strident toothbrush to reduce risk of aspiration was included, but <u>no</u> additional interventions identified for oral hygiene such as positioning and fluid consistency; ▪ No oral intake strategies/interventions for medication administration ▪ No bathing strategies for people at risk of aspiration and/or have a diagnosis of GERD; and ▪ Strategies for personal care were lacking. <u>PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team</u>: The PNMP Definition and Purpose documented the PNMP should be based on evaluation by Habilitation Therapies, with input from the PST, home staff, medical/nursing staff, and the Nutrition Management Team. The Plan should be based on the identified needs of individuals, and should be approved through the Person-Directed Planning Process. Recommendations from the Nutritional Management Team were not incorporated into the PNMPs. This appeared to be a systemic issue. A process is needed to ensure that PNMT/NMT recommendations are consistently incorporated into PNMPs. The following individuals are examples of this issue: ▪ The Nutritional Management Team reviewed Individual #271 on 09/02/09, due to multiple episodes of J-tube dislodgment leading to the need for surgical replacement. The following recommendation was made "in an effort to decrease dislodgement of J-tube, please consider having nurse disconnect tubing when staff are changing clothes, bathing, transferring, etc." Individual #271's	

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		PNMP, attached to PSP dated 10/12/09, did not reflect this recommendation. ▪ Individual #148 was reviewed by the NMT on 09/09/09, for a MBSS study and vomiting. The recommendation was made to change his diet order to reflect "all liquids and soups thickened to milkshake consistency. May spoon feed liquids if he refuses to drink." His PNMP, last revision date 5/18/09, was not updated to reflect this recommendation. ▪ The NMT reviewed Individual #504 on 11/4/09, for weight and diet orders. A recommendation made was for "no toast." The PNMP, revised 1/25/10, did not reflect this recommendation. ▪ The NMT reviewed Individual #109 on 04/29/09, due to an undesirable weight gain of 11 pounds in one quarter. The recommendation was to provide opportunities for exercise throughout her day (lifting hand weights, arm exercises, folding her clothes). Her PNMP revised in 11/09, did not incorporate this recommendation. ▪ Individual #40 was reviewed by the NMT on 05/27/09, following an MBSS in 03/09, which recommended a change in chair position. The recommendation was to "position in most upright position of wheelchair (30° from horizontal) for all meals and snacks and for 30 minutes after meals. His PNMP revised 1/7/10, did not contain this recommended degree of elevation. ▪ Individual #366 was reviewed by the NMT on 06/03/09, due to her stay in the infirmary from a "cardiac episode with probable aspiration pneumonia which may be related to vomiting which has continued despite change in formula." Recommendation was made to consider order to remain upright after medication administration and possible addition of other soothing agent, especially at medication pass. This recommendation was not documented in her PNMP attached to her PSP date 06/09/09. ▪ The NMT reviewed Individual #257 on 07/22/09, to clarify her recreational eating order to ensure staff were offering appropriate texture. The recommendation was to "restate recreation eating order as follows: Recreational eating pureed morning and afternoon snacks no more than 4 oz. every snack." Her PNMP attached to her PSP dated 1/11/10, did not reflect this recommendation. <u>PNMPs are reviewed annually at the PSP meeting, and updated as needed</u>: The PNMP Definition and Purpose indicated the PNMP should be addressed at the annual planning meeting for every individual who has mobility impairment, assistive, equipment or any special physical or nutritional problems.	

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		As is noted in the section above this one, changes in status do not necessarily result in plans being updated or modified. PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results (HCG VIII.C.9): This is addressed above in the section that discusses the development of PNMPs in conjunction with the PST. As is noted there, changes in status do not necessarily result in plans being updated or modified. There is congruency between Strategies/Interventions/ Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment: The PNMT/NMT will need to ensure that comprehensive assessment recommendations are reflected in the PNMP strategies.	

O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan (HCG VIII.C.4) Diet/Dining Cards include the following information: Individual's name; home; diet; texture for meat, vegetable, and bread; instructions for food to be served during breakfast, lunch and supper; dislikes; list of adaptive equipment; instructions for preparation of fluids; presentation techniques for food and fluid; focus statement; and "important information." An example of a focus statement would be "reduce coughing by offering an all liquid diet and with custom eating techniques." Important information may state: "ice cold thin liquids only served over packed ice. She has a delayed swallow-feed slowly. Position wheelchair slightly away from table due to reflex patterns." The following individuals were observed at mealtimes: Individual #360, Individual #78, Individual #373, Individual #235, Individual #447, Individual #478, Individual #544, Individual #344, Individual #57, Individual #472, Individual #401, Individual #250, Individual #92, Individual #350, Individual #424, Individual #290, Individual #524, Individual #338, Individual #349, Individual #138, Individual #214, Individual #493, Individual #13, Individual #254, Individual #188, Individual #517, and Individual #393. The following mealtime errors were consistently observed: • Individual in poor alignment and support in wheelchair or regular dining chair, and staff not repositioning the individual before or during the meal; • Staff presenting incorrect diet texture, and/or fluid consistency; and • Staff not following dining plan presentation techniques.	

		These errors have the potential to place an individual at risk during mealtime. The Facility used a color-coded system for diet textures to support safety during campus-wide events where food is served outside the dining room. Individuals living at Abilene wore a colored button that denoted their diet texture. The button (with a humorous statement) was designed to assist staff in ensuring an individual received their prescribed diet texture. This is a creative way to ensure individuals receive the correct diet, while maintaining individuals' dignity. Per interview, parents/guardians may present food and/or fluid to individuals that has not been prescribed, and has the potential to place a person at risk. For example, a person may be prescribed a pureed diet, but a family member visiting campus may give the individual food that is a regular texture. There should be a formal policy/procedure to address this unsafe mealtime practice that could be shared with parents/guardians. <u>Individuals are in proper alignment and position</u>: As noted above, a frequent mealtime error that was noted involved individuals not being in proper alignment, and staff not correcting this. <u>Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and or increased risk of aspiration</u>: PNMPs did not consistently address alignment/support in alternate positions; strategies for oral hygiene, medication administration, snacks, personal care and/or bathing/showering. For the majority of individuals, there were no strategies for oral hygiene and medication administration. For example: ▪ The PNMP, revised 11/18/09, for Individual #20 who is enterally nourished documented the "use of Steridentoothbrush for oral hygiene to reduce the risk of aspiration" but did not document strategies to minimize the risk of aspiration during tooth brushing such as optimal positioning, and fluid consistency. The PNMP did not address strategies for medication administration, bathing/showering, or personal care routines to minimize the risk of aspiration. ▪ The PNMP, revised 8/5/09, for Individual #378 who receives enteral nutrition documented the "use of Steridentoothbrush for oral hygiene to reduce risk of aspiration. Please brush teeth to reduce acid in mouth after vomiting episodes have subsided." The PNMP did not address strategies to minimize the risk of aspiration during tooth brushing, medication administration, bathing/showering, or personal care routines.	

		Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP: Per interview with therapy staff and observations by the reviewer, therapy staff were able to articulate the reason(s) for a PNMP. This indicator will require ongoing review at the next on-site 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.	Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff: New employee orientation provided training in the area of physical and nutritional supports, but the time devoted did not appear adequate to ensure staff have the requisite mealtime skills to support mealtime safety. For example, a review of the PNMP Monitoring forms from October to December documented an ongoing problem from monitoring review to review with staff not using Thick-It. The use of Thick-It is critical to ensure that individuals receive their prescribed fluid consistency, and are safe during mealtimes. The Facility was implementing PNMP monitoring, although it was not on a consistent basis, and there were no policies/procedures developed to define the process. Furthermore, the process was not linked to Quality Enhancement or to the need to re-train staff. New Employee Pre-Service Training documented the following training related to PNM: • Body mechanics/Lifting (four-hour duration); • Physical Management Classroom (one-hour duration); • Nutrition/Food Textures (one-hour duration); • Physical Management (thee-hour duration); and • Deaf Awareness/Orientation Mobility (four-hour duration). There did not appear to be sufficient time to provide foundational training for mealtimes to new employees. This was reinforced by the observation of mealtime errors in dining rooms. Training materials submitted did not document mealtime training content. Mealtime foundational training should include: the importance of position and alignment during mealtimes, diet texture and consistency, care and use of adaptive equipment, presentation techniques to enhance nutritional intake and hydration, aspiration and choking precautions, strategies to minimize the risk of aspiration and choking, presentation of the Facility choking policy, presentation techniques to support safe swallowing for medication administration and oral hygiene, techniques to promote optimal levels of independence and skill acquisition during mealtimes, tooth brushing, and medication administration. This training should provide foundational skills and knowledge to support safety during mealtimes, tooth brushing and medication administration. Staff should be required to successfully complete a skill performance	

		check-off to document staff competency with learning objectives. <u>Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable</u>: The following checklists for staff training were submitted and reviewed: • Lifting Check sheet; • Lifting/Transferring Consumers: Pre-Class Written Assessment; • Lifting/Transferring Consumers: Post-Class Written Assessment; • Stand/Pivot Transfer Checklist; • Two-Person Manual Lift Checklist; • Mechanical Lift Checklist; and • Bathing Trolley Checklist. These check sheets documented staff skill performance, but did not provide criteria for pass/fail. No competency-based checklists were submitted for foundational mealtime training. As noted above, many errors were noted during mealtime observations. <u>All foundational trainings are updated annually</u>: Per documentation submitted, refresher training was related to physical management (lifting and transfers), and did not address mealtimes, tooth brushing and medication administration. <u>Staff are provided person-specific training of the PNMP by the appropriate trained personnel, and re-trained when changes occur to the PNMP:</u> The PNMP Training Form identified the following training areas: 1. Location of PNMP; 2. Adaptive equipment and usage of equipment (show wheelchair, walker, helmet, hand care, etc.); 3. Bed positioning instructions (show location of positioning pictures); 4. Wheelchair positioning instructions/alternate positioning; 5. Transfer status/special handling instructions; 6. Movement section (level of assistance person needs/programming person has); 7. Relaxation techniques; 8. Eating equipment (show equipment, where stored in kitchen); 9. Feeding position; 10. Eating/feeding status; 11. Food texture/liquid consistency; 12. Feeding techniques; 13. Communication equipment (where stored or kept);	

		14. Location of communication dictionary; 15. Communication instructions; and 16. PNMP check sheet reviewed and how to document on it. The PNMP Training Form did not address oral care and medication administration. There were no policy/procedures submitted to define who is responsible for person-specific PNMP competency-based training, definition of staff competencies for each of the identified indicators, established thresholds for staff successful completion of competency-based training, and/or re-training when the PNMP is revised. <u>PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual:</u> There were no policies/procedures identifying people at increased risk to only be supported by staff who had successfully passed competency-based person-specific training.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>A System is in place that monitors staff implementation of the PNMPs HCG VIII.C.7-8)</u>: The Abilene Habilitation Therapies Manual indicated that mealtime monitoring should be completed by Home Program Technicians, Occupational Therapists, Speech Language Pathologists, Home Supervisors, QMRPs, Psychologists, RNs, and other designated staff. The mealtime monitor should focus on their area of expertise when completing the mealtime monitoring form. The completed forms were to be forwarded to the designated OT for review and follow-up on concerns. The Manual did not address competency-based training for mealtime monitors. In terms of the frequency of the monitoring, Abilene Habilitation Therapies Manual indicated that PNMPs "should be monitored as scheduled by supervisors for implementation and to report any problems. As scheduled/needed, professional staff should monitor PNMPs for proper techniques to ensure effectiveness, and to correct problems. PNMPs should be assess for continued need and appropriateness by specified staff as least annually and as otherwise indicated." The Physical Nutritional Management Policy, Section VI, entitled Monitoring (#012) indicated the following: ▪ "PNMPs should be monitored as scheduled and as needed by Residential supervisors, Team, Nursing, Specialized Therapy and other professional staff to asses effectiveness of plans, to ensure ongoing implementation, and to make changes as necessary; ▪ PNMPs should be monitored by supervisors for implementation and to report any problems and training needs;	

		▪ PNMPs should be monitored by professional staff for proper application of equipment and techniques, to ensure effectiveness of Plans and proper implementation, and to correct problems; and ▪ Equipment used in physical management programming (e.g. Positioning and feeding equipment, wheelchairs, braces, slings, etc.) will be monitored daily by direct contact staff for cleanliness, wear, and needed repair." <u>On a regular basis, all staff will be monitored for their continued competence in implementing the PNMPs:</u> The Abilene Habilitation Therapies Manual and/or the Physical Nutritional Management Policy did not define the frequency of staff monitoring to support continued staff competency in implementing PNMPs, but it should. <u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted</u>: As discussed in further detail below, a monitoring protocol for mealtimes was in use at ABSSLC. The Abilene Habilitation Therapies Manual and state policies did not define competency-based training for identified monitors, validation of monitors, the frequency of monitoring, and/or linkage to quality improvement/enhancement systems to resolve person-specific and systemic issues that arise during monitoring. <u>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities)</u>: Per the request of the reviewer, completed PNMP Monitoring Forms-Routine were submitted for October through December 2009. Three hundred and fifty-six (356) PNMP Monitoring Forms were analyzed and the following observations were made: The *PNMP Monitoring Form-Routine* contained the following indicators: PNMP indicators: 1. PNMP is kept in home, group book and/or wheelchair bag. 2. PNMP is present. 3. Care Provider's initials are on PNMP document sheet. 4. Photos and equipment match. 5. All Assistive/Supportive equipment is available, clean and in good working condition (do not forget walkers and canes). 6. Care provider is following schedule on the PNMP. If not, explain. 7. Care provider utilized proper transfer/walking techniques. Describe/demonstrated. 8. Care provider acknowledges training in use of assistive equipment. Describe/demonstrated. 9. Individuals are well positioned.	

Meal Monitoring indicators:

10. Individuals are in optimal position for eating and are repositioned before meals. Describe/demonstrated.
11. Food texture is correct.
12. Appropriate dining equipment is used.
13. Feeding Techniques/instructions are implemented.
14. Thick-it is used.
15. Individuals are monitored for pace/bite size.
16. Incidents of coughing/choking episodes are noted and nursing has been notified.

The form had a section for comments/problems found this month (falls, vomiting, coughing, etc.). The PNMP Monitoring Form indicators were not sufficiently discreet to support consistent monitoring results.

The following table presents the number of monthly monitoring forms completed by home:

Home	**# October Monitoring Forms**	**# November Monitoring Forms**	**# December Monitoring Forms**
1. 5961	0	0	23
2. 5962	0	0	18
3. 5971	0	10	11
4. 5972	0	17	24
5. 6360	0	0	4
6. 6370	0	5	13
7. 6390	6	0	16
8. 6400	0	0	4
9. 6450	0	4	7
10. 6460	5	5	10
11. 6480	0	15	23
12. 6500	0	9	3
13. 6510	23	22	27
14. 6521	0	28	14
15. 6720	0	4	0
16. 6740	0	2	0
17. 6750	0	2	0
18. 6760	0	2	0
TOTAL (356)	**34**	**125**	**197**

		There were no Facility-specific policies/procedures submitted to define this monitoring system. The preceding table of PNMP monitoring by homes did not reflect a systematic, organized approach to PNMP monitoring. For example: • 83% of the homes were not monitored in October (15/18); • 28% of the homes were not monitored in November (5/18); • 22% of the homes were not monitored in December (4/18); and • 22% of the homes were not monitored for two consecutive months (4/18). An analysis of the 356 PNMP Monitoring Forms consistently documented the following concerns: • *Indicator #3: Care provider initials were on PNMP document sheet*: This was recorded in three different ways such as "Yes (135), "No" (19) or "Yes/No" (184) responses. Further clarification would be needed to specifically quantify whether or not these tasks are being substantially completed. It was unclear if the compliance ratio was substantially in and/or out of compliance due to the way this indicator was scored. • *Indicators #10: Individuals are in optimal position for eating and are repositioned before meals*: This was marked "No" on less than one percent of the forms, although during meal observations the Monitoring Team observed multiple individuals in less than optimal alignment and support. The conclusion could be drawn that Facility monitors had not been adequately trained to recognize optimal positioning. • *Indicator #14: Thick–it used*: This was marked "No" on 13% of the forms. This would indicate that staff were not presenting the correct fluid consistency to individuals during meal, which placed the individual at risk during mealtime. No recommendations on monitoring forms were made for staff training, or other strategies to correct the problem. Multiple monitoring sheets identified issues of concern without documentation of follow-up or resolution. It is essential when monitoring identifies either individual or systemic problems with the implementation of mealtime protocols or PNMPs that actions are taken to correct such issues, and that such follow-up activities are documented. For example, as discussed above, the identification of Thick-It not being used by staff should trigger a discussion of the need for competency-based training for staff within particular homes and/or campus-wide refresher training. The monitoring system should be systematic, routine and provide for system-wide analysis with the implementation of strategies to correct identified problems.	

		Monitors should be provided with competency-based training on the completion of the monitoring process. There should be a validation process to ensure that forms are being accurately and consistently scored, and ensure a high level of inter-rater reliability. Thresholds should be established that would require re-training for staff on foundational skills and/or person-specific plans. The monitoring policy should describe a monitoring system that includes criteria for and identification of who will complete the monitoring, competency-based training for monitors, description of each indicator with strategies for measurement, definition of staff re-training thresholds, a validation/inter-rater reliability the use of monitoring reports to assist in the identification of problematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoring system into facility Risk Management and Quality Enhancement systems. Another process that needs to be monitored to ensure continuity of services is when recommendations are put in place by the NMT. Recommendations from previous NMT meetings should be reviewed and when recommendations are not implemented from review to review, action needs to be taken to ensure recommendations are followed. This did not appear to be happening at ABSSLC. Specifically, a review of the NMT Review and Recommendation Log did not show monitoring of the implementation of NMT recommendations from review to review. For example: ▪ Individual #529 was reviewed by the NMT on 11/04/09, for health status, vomiting and EGD results. The resulting recommendation was due to increased vomiting, consideration should be given to a proton pump inhibitor. Her next review was on 12/14/09. The status of the preceding recommendation was not discussed in the NMT Review and Recommendation Log. ▪ Individual #92 was reviewed by the NMT on 05/20/09, related to a nursing note dated 4/29/09, which documented "choking during meals secondary to spasticity; watched take PO [by mouth] meds and noted [Individual #92] having difficulty controlling movement. Asked her if she chokes and she said yes and that she gets scared." The Occupational Therapist and the Choking Hotline were not contacted. Recommendations were to: 1) continue oral eating, 2) continue current diet and feeding technique; and 3) have RN in-service nursing staff regarding notification of choking hotline whenever coughing or choking occurs with oral intake, including medication pass. It should be noted that it was unclear why a comprehensive assessment was not recommended to address her risk of choking at mealtime. She was reviewed again by the NMT on 08/19/09, for a PT consultation due to improvement of range of motion (ROM) with Baclofen treatment. Notes indicated that further weight gain was desired as her	

		weight remained below RWR. New high calorie cereal was to be added to her diet to promote weight gain. Recommendations were to: 1) continue oral eating, and 2) continue current diet and feeding techniques. The NMT did not follow-up on nursing training recommendation from the previous review. It also was of concern that the NMT did not see Individual #92 for almost three months after a choking incident, and did not develop interventions to address her risk of choking. All members of the PNM team conduct monitoring (HCG VIII.C.8): Per interview and review of submitted documentation, NMT monitoring was not defined and/or formalized. At the time of the review, monitoring by the NMT consisted of document review during NMT meetings. Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team, and the PNM team identifies trends, and addresses such trends, for example, to enhance and focus the training agenda: No documentation was submitted to verify that the NMT identified trends, and/or addressed such trends, for example, to enhance and focus the training agenda. Immediate intervention is provided if the person is determined to be at risk of harm: In order to review the Facility's response to individuals' needs for immediate intervention, response to choking incidents was reviewed. During future reviews, other indicators of such need will be reviewed as well. As is illustrated below, the Facility has procedures in place to address choking incidents that are generally adequate, but need some modifications. A review of some recent choking incidents, however, showed that the Facility had not consistently followed the procedures necessary to protect individuals who had experienced a choking incident. The Choking Incident Follow-Up Policy/Procedure (Nutritional Management Team Manual-Revised 1/27/10) included the following headings: • Who should call? • What is a significant coughing/choking incident? • What is a serious choking incident? • Follow-up procedures completed by staff; • Follow-up procedures completed by nursing; • Follow-up procedures completed by NMT members upon receiving call; and • Follow-up procedures completed by QMRP and PST.	

		A review of choking incidents for Individual #540, Individual #5, and Individual #44 documented the following: ▪ Unusual Incident Investigation-Incident Tracking Number: 1780 documented a choking incident for Individual #540 on 10/29/09. An updated Occupational/Speech Therapy Eating Evaluation/Nutritional Management Plan was not submitted with the documentation. A review of the NMT Review and Recommendation Log did not document that Individual #540 was reviewed by the NMT after her choking incident. ▪ A choking incident was documented for Individual #5 on Unusual Incident Investigation-Incident Tracking Number: 1523, dated 06/05/09. Staff, including a direct support professional and an LVN, performed the Abdominal Thrust. The home supervisor called the on-campus emergency number (x4444), and the choking hotline. A nurse arrived at the home in response to the 4444 call for a choking incident. She was sent to Individual #5 for further evaluation. The SLP and OT followed up in response to a call to the Choking Hotline. Meals were to be monitored on Saturday and Sunday by respective staff. On 6/8/09, PST meeting was called to discuss the incident, and an addendum was completed. Her PNMP, dated 10/28/09, did not indentify her at risk for choking and did not incorporate the PSP Addendum recommendation "to prevent later choking or aspiration, she is to have her teeth brushed, using the Steridient, to ensure she is not keeping food in her mouth following the meal. An updated Occupational/Speech Therapy Eating Evaluation/Nutritional Management Plan was not submitted with the documentation. A review of the NMT Review and Recommendation Log did not document that Individual #5 was reviewed by the NMT after her choking incident. ▪ Unusual Incident Investigation-Incident Tracking Number 1618 documented a choking incident for Individual #44 on 07/27/09. An Occupational/Speech Therapy Eating Evaluation/Nutritional Management Plan, dated 07/28/09, recommended suggested eating techniques for dining plan that were integrated in her current dining plan, dated 07/29/09. However, a review of the NMT Review and Recommendation Log did not document a review of Individual #44 after her choking incident. The preceding three choking incidents did not consistently follow the Facility's Choking Incident Follow-Up Policy/Procedure. One of the three individuals had an Occupational/Speech Therapy Eating Evaluation/Nutritional Management Plan completed, but the other two individuals did not. The section in the policy/procedure entitled Follow-up Procedures Completed by NMT Members Upon Receiving Call should be revised to include the completion of an updated mealtime assessment after a choking incident as well as automatic referral to the NMT. The section entitled Follow-Up	

		Procedures Completed by QMRP and PST should be revised to ensure all recommendations from the mealtime assessment are integrated into the individual's PNMP and Dining Plan within a defined time period. Consideration should be given to training this procedure during new employee orientation and annual refresher training as well as conducting intermittent drills with staff to ensure staff are aware of the Choking Incident Follow-Up Policy/Procedure.	
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.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk (HCG VIII.C.9; VIII.A.1): As is discussed in further detail above with regard to Sections O.1 and O.2 of the SA, the NMT meets frequently, but there were concerns related to the process it was using to identify individuals at risk. The assignment of risk levels was not congruent with the Nutritional Management Policy or Nutritional Management Screening Tool. For example, a number of individuals who had a diagnosis of aspiration pneumonia were not reviewed by the NMT. Individuals were assigned risk levels of Medium Risk – 2, or Low Risk - 3 with health risk indicators that would place them at high risk. Per interview, the NMT was struggling to define who they review and when to discharge a person from the NMT. The NMT will need to identify entrance criteria (standardized process for identifying people at risk) for referral to the NMT, as well as exit criteria (achievement of functional outcomes) to discharge a person from the NMT. The primary focus of the NMT was a paper review as opposed to an action team that clearly defines people at significant risk, completes a comprehensive assessment, develops interventions based on functional outcomes, monitors theses interventions to ensure efficacy, and modifies interventions if they are not working. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators (HCG VIII.C.9; VIII.A.1): Despite the fact that Facility policy envisioned a process for person-specific monitoring, formalized person-specific monitoring was not being conducted by the NMT. With regard to Facility policy, the Nutritional Management Team Policy Section III.G. Review Phase (#013) documented during the review phase as follows: ▪ A schedule for review is established and follow-up services are provided as needed; and ▪ The risk level is reviewed and reassigned as appropriate; and ▪ The schedule for review is established. The Physical Nutritional Management Policy, Section VI, entitled Monitoring (#012) supported this by stating: "Clients with nutritional management issues will be monitored	

		regularly by the Nutritional Management Team." Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted (HCG VIII.A.1): The NMT Review and Recommendations Log did not illustrate that the NMT had followed up on the status of recommendation(s) implemented from review to review. A review of the NMT log did not show that recommendations for competency-based training were consistently monitored through to completion to minimize identified person-specific health risk indicators, such as aspiration pneumonia. The individual's PNM status is reviewed annually at the PSP, and all PNMPs are updated as needed (HCG VIII.C.3; VIII.A.1): As discussed above with regard to section O.3 of the SA, PNMPs are not fully integrated into individuals' annual PSPs. They remain separate documents that are referenced in the PSP. On at least a monthly basis or more often as needed, the individual's PNM status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results (HCG VIII.C.9; VIII.A.1): Due to the fact that PNMPs do not consistently include measurable, functional outcomes, and are not fully incorporated into individuals' PSPs, individuals' PSTs were not reviewing them regularly. In addition, review by the NMT was not consistent due to the lack of clear entrance and exit criteria, as well as failures to adequately identify individuals who were at risk and/or who had experienced a change in status. Immediate interventions are provided when the individual is determined to be at an increased risk of harm (HCG VIII.A.1) As discussed above, individuals who received a diagnosis of aspiration pneumonia from an infirmary stay and/or hospitalization were not consistently reviewed by the NMT. These individuals were at great risk of harm, but did not receive a NMT comprehensive assessment leading to the development of PNMP support strategies. These strategies should be integrated into the PSP to predict, minimize or remediate concerns, and measure progress through the implementation of written, measurable, functional outcomes. The PNMP then should be monitored to assure the strategies are working and if not, revisions should be made to support those individuals at highest risk. These essential interventions are not consistently being provided at ABSSLC.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18	All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status (HCG VI.C.3.c.1.d) and the need for continued eternal nutrition is integrated into the PSP:	

	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.	PSPs were reviewed for 29 individuals receiving enteral nutrition, including Individual #83, Individual #520, Individual #297, Individual #100, Individual #20, Individual #296, Individual #480, Individual #281, Individual #55, Individual #378, Individual #271, Individual #208, Individual #506, Individual #174, Individual #75, Individual #101, Individual #183, Individual #266, Individual #346, Individual #253, Individual #10, Individual #33, Individual #458, Individual #204, Individual #71, Individual #83, Individual #431, Individual #117, and Individual #498. None of the 29 PSPs (0%) addressed the appropriateness of receiving enteral nutrition, justification to continue receiving enteral nutrition, and/or strategies that had been developed to transition an individual to oral intake, if appropriate. An initial step had been taken in this review process for some individuals who were receiving enteral nutrition. Between September and December 2009, the NMT reviewed and documented its recommendations in this regard for some individuals. This would be considered one part of a comprehensive assessment that would also need to include a nursing assessment, medical assessment, and assessments by the individual's SPL and OT, with full discussion by the individual's PST. This comprehensive review should result in documentation by the team of the team's recommendation/decision. <u>When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used</u>: A review of submitted documents did not identify any individual who had a plan to return to oral feeding. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT):</u> Per policies submitted, there were no policies that defined the frequency and depth of evaluations related to enteral nutrition to be completed by the following disciplines: nursing, physician, speech/language pathologist and occupational therapist. <u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake</u>: As is discussed above, the following is an example of an individual for whom the NMT did not clearly document a plan to maintain oral intake: ▪ Individual #294 was reviewed by the NMT eight times in 2009. His nutritional status was at high risk, and resulted in the placement of a feeding tube. The NMT did not complete a comprehensive assessment prior to the placement of a percutaneous endoscopic gastrostomy tube (PEG).	

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

1. The PNMT membership should include the expertise of a physical therapist. Ancillary members should be actively involved in the PNMT process, when appropriate.
2. Additional opportunities should be provided for continuing education for PNMT members to support their responsibilities in working with individuals with complex physical and nutritional support needs.
3. The PNMT should establish guidelines to define further the categories of high, moderate and low levels of risk for physical and nutritional health risk indicators. Such guidelines also should establish thresholds to trigger initial and further evaluation, and the intervals of review based on the degree of an individual's identified level of risk. These guidelines should define the entrance criteria for review by the PNMT to ensure the individualized physical and nutritional support needs of a person are addressed. Furthermore, exit criteria should be defined as meeting the measurable, functional outcomes established by the PNMT for each individual. In developing these guidelines, the PNMT should review the Health Care Guidelines, Section VI, on Nutritional Management Planning, which provides criteria for risk categories.
4. Recommendations made by the PNMT should be consistently integrated into individuals' PNMPs and PSPs.
5. The State and/or Facility should consider development of a policy/procedure to address parent(s)/guardian(s) who provide an individual food and/or fluid at the Facility that is not within his/her prescribed diet texture or fluid consistency, thereby placing that individual at risk.
6. PNMPs should incorporate strategies for individuals for oral intake for mealtime, snacks, medication administration, oral hygiene, as well as any other activities that present potential risks such as bathing, or water activities. More than one PNMP may need to be in place for an individual. For example, it might be appropriate for a PNMP to be designed and implemented just for nursing staff who are responsible for the administration of medication.
7. Orientation training and annual refresher training should be reviewed to ensure the content is sufficient to provide staff with the knowledge and skills to support competency in the implementation of mealtime and positioning plans.
8. Mealtime foundational training should include: the importance of position and alignment during mealtimes, diet texture and consistency, care and use of adaptive equipment, presentation techniques to enhance nutritional intake and hydration, aspiration and choking precautions, strategies to minimize the risk of aspiration and choking, presentation of the Facility choking policy, presentation techniques to support safe swallowing for medication administration and oral hygiene, and techniques to promote optimal levels of independence and skill acquisition during mealtimes, tooth brushing, and medication administration. This training should provide foundational skills and knowledge to support safety during mealtimes, tooth brushing and medication administration. Staff should be required to successfully complete a skill performance check-off to document staff competency with learning objectives.
9. PNMP and Mealtime Monitors should be provided with competency-based training. An on-going validation process for mealtime monitors should be established. The goal would be to achieve accurate mealtime monitoring scoring and ensure a high-level of inter-rater reliability.
10. Consideration should be given to establishing compliance benchmarks for mealtime monitoring results. Results falling below established benchmarks should require the development and implementation of person-specific, staff re-training and/or the development of an action plan to address systemic concerns.
11. The monitoring policy should describe a monitoring system that includes criteria for and identification of who will complete the monitoring, competency-based training for monitors, description of each indicator with measurable criteria, definition of staff re-training thresholds, a validation/inter-rater reliability the use of monitoring reports to assist in the identification of problematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoring system into facility Risk Management and Quality Enhancement systems.
12. The Choking Incident Follow-Up Policy/Procedure should be included in new employee and annual refresher training. Intermittent drills should be conducted with staff to ensure staff are competent to implement these procedures.
13. Procedures should be developed and implemented to ensure individuals at risk of receiving enteral nutrition are referred to the PNMT.
14. Comprehensive evaluation should be conducted of individuals who are enterally nourished to determine the appropriateness of receiving

enteral nutrition, and, if not, to identify strategies to transition an individual to oral intake, if appropriate. This will require assessment/evaluation by a number of team members, and review by the entire PST.

15. Procedures should be developed for individuals who are receiving or are at risk of receiving enteral nutrition to include assessment domains, intervention strategies, required documentation, monitoring and analysis to ensure that decisions regarding individuals receiving enteral nutrition are appropriate, and that all appropriate preventative strategies have been implemented.

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 Berg Balance Test Evaluation; o Physical Therapy Bicycle Assessment; o Cratty Perceptual Motor Test Evaluation; o Seating System Assessment; o Occupational/Physical Therapy Annual Evaluation; o Performance Oriented Assessment of Balance and Gait; o Eating Evaluation/Nutritional Management Plan; o PSP Packet - Risk Screening Tool; o Request for Consent for Restraint; o PT Service Plan; o Positioning Instructions; o Lifting/Transfers Assessment; o Home Exercise Instructions; o Adaptive Equipment Service Objectives; o List of Individuals with PNMP Screening in the last quarter; o Dining Plan Roster 2010 and Eating Evaluation/Nutritional Management Plans; o PNMP Monitoring Form-Routine; o PNMP Roster; o PNMP Training Form; o PNMP Checksheet; o Wheelchair Cost Data Base; o Dining Plan Reference Page; o Individual-specific Dining Plans, training documentation sheets, and PNMPs for the following individuals: Individual #360, Individual #78, Individual #235, Individual #544, Individual #344, Individual #57, Individual #472, Individual #92, Individual #350, Individual #424, Individual #290, Individual #188, Individual #394, Individual #164, Individual #118, Individual #13, Individual #123, Individual #338, Individual #524, Individual #344, Individual #138, Individual #214, Individual #493, Individual #254, Individual #13, and Individual #393; o PNMP Tracking; o Occupational/Physical Therapy Annual Evaluation Format; o Individual-specific PSPs o Individual-specific Occupational/Physical Therapy Annual Evaluations; o Occupational/Speech Therapy Eating Evaluation/Nutritional Management Plan Addendum format;

	○ Occupational/Speech Therapy Eating Evaluation/Nutritional Management Plan format; ○ Chart showing number of individuals with adaptive equipment; ○ Abilene State Supported Living Center Food/Drink Policy; ○ Mealtime Monitoring Form; ○ Follow-up completed by NMT for the last five choking incidents; ○ Individual-specific consults, including MBSS, OT/PT/SLP Assessments; OT/PT/SLP Updates, PSP, PNMP with pictures, Special Considerations, PT/OT/SLP consults, Audiology assessment, NMT Review notes, therapy program data sheets for 21 individuals, including: Individual # ○ PNMP Monitoring Form-Routine (October-December 2009); ○ Update on Audiology Vacancy; ○ Rehabilitation Technician OT/PT Job Description; ○ PNMP Coordinator Job Description; ○ Habilitation Therapies Manual (Revised 12/31/09, Approved 1/31/09); ○ List of individuals with wheelchairs; ○ Abilene State Supported Living Center Skin Integrity Data Tracking; ○ Fall Trending Data; ○ Charts of individuals with custom shoes and orthotics; ○ Habilitation Therapy Wheelchair Log documentation sheet; ○ Sterident Monitoring Log documentation sheet; ○ HPT Tracking Sheet; ○ Adaptive Eating Equipment Inventory Sheet; ○ Wheelchair Check Sheet; ○ PNMP Clinic documentation sheet with instructions for completion; ○ Positioning Instructions for supine, right semi-sidelying and left semi-sidelying; ○ Individual-specific PNMP clinics; ○ Individual-specific Habilitation Therapy Wheelchair Log; ○ Individual-specific Seating Assessments; ○ PNMP Tracking Data Sheet; ○ Revision PNMP Tracking Data Sheet; ○ New PNMP Tracking Data Sheet; ○ Adaptive Eating Equipment and Positioning Data Sheet; ○ OT/PT Program Review Objective Data Sheet; ○ OT/PT Checksheet for Programs; and ○ Water Temperature Checksheet; ▪ **Interviews with**: ○ Glen G. Funkey, PT, DPT, Director Habilitation Services; ○ Occupational Therapists (all) and Physical Therapists (all); and ○ Meeting to discuss Section P with OTs, and PTs, and receive information on current progress for implementation of Section P; and

	○ Individual #447 ▪ **Observations of**: ○ OT/PT Assessment of an individual who was newly admitted ○ Individual-specific clinic observations of walking with Habilitation Technicians; ○ Positioning of individuals
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Occupational Therapy vacancies were impacting the current caseloads of Occupational Therapists on staff and diminishing their ability to provide direct therapy. Occupational/Physical Therapy Assessments did not consistently present an analysis of findings to provide a rationale for recommendations and intervention strategies. Recommendations did not consistently provide objective, measurable and functional outcomes. Individuals with identified physical and nutritional support needs did not have PNMPs developed.

#	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 Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience: There were six budgeted positions for Occupational Therapists. Two full-time Occupational Therapists were on staff, including one Occupational Therapist who was part time, and one Occupational Therapist who was three-quarters time. There were two vacant OT positions. Per interview, a staff Occupational Therapist had been working diligently to recruit OTs. The OT vacancies significantly impact the Habilitation Therapy Department and the Facility in achieving compliance with the Settlement Agreement. There were four budgeted positions for Physical Therapists. At the time of the review, there were four Physical Therapists on staff with no vacant PT positions. Per report, there were Habilitation Technicians and PNMP Coordinators to provide assistance to the OTs and PTs. Per interview, therapists did not have clerical support. PNMP Coordinator positions had been approved, and were being recruited, but the overriding concern the therapists expressed was the dual supervision of these positions. They reported it resulted in confusion related to job responsibilities specific to the implementation of physical and nutritional supports.	

#	Provision	Assessment of Status	Compliance
		The Occupational and Physical Therapists should analyze the universe of unmet needs, as well as the requirements of the Settlement Agreement to identify therapy support human resource needs, and make requests for such support, as necessary and appropriate. <u>All people have received an OT and PT screening. If newly admitted, this occurred within 30 days of admission</u>: One person who was newly admitted was reviewed. For this individual, all OT and PT screenings had occurred within the 30-day time period. Specifically: ▪ When Individual #477 was recently admitted to ABSSLC, the following evaluations were completed within 30 days: o Lifting/Transfer Assessment; o Eating Evaluation/Nutritional Management Plan; o Physical Therapy Update; o Performance Oriented Assessment of Balance and Gait; and o Audiological Screening Evaluation. A Consultation Request documented that Individual #477 was scheduled for an initial OT/PT evaluation, but this assessment was not submitted for review so it is unclear if it occurred. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification</u>: The Occupational/Physical Therapy Services Policy (#014), Section A, entitled Screening and Assessments documented the following: • "Individuals will be screened for occupational and physical therapy needs within 30 days of admission by occupational and physical therapy staff; • Individuals identified with therapy needs must receive a comprehensive, integrated occupational and physical therapy assessments will be completed within 30 days of identification of the needs; • Assessments will consider significant medical issues and health risk indicators in a clinically justified manner; and • Clinical data or information contained in the assessments will be analyzed and interpreted in the assessment report." The Abilene Habilitation Therapies Manual, revised 12/31/09, did not document the specific content of an Occupational/Physical Therapy Assessment, or an Eating Evaluation/Nutritional Management Plan. The Habilitation Therapies Manual did not	

#	Provision	Assessment of Status	Compliance
		reference the Habilitation Therapies Physical Nutritional Management Handbook (Revised 2009) An Occupational/Physical Therapy Annual Evaluation format was submitted with information under each heading of the evaluation. For example, under General Information, the "Active Problems" section of the form instructed the therapist to list only active problems that are related to OT/PT. This direction does not support integration of medical issues and health risk indicators into the assessment process. The inclusion of such information is necessary for appropriate analysis, and the establishment of integrated recommendations/therapeutic interventions. In addition, there were numerous assessment forms submitted such as Cratty Perceptual Motor Test Evaluation, Berg Balance Test, Seating System Assessment, Performance Oriented Assessment of Balance and Gait, and Lifting/Transfers Assessment. These assessments were not referenced in the Occupational/Physical Therapy Annual Evaluation format. Per the initial document request, 28 Occupational/Physical Therapy Annual Evaluations were submitted for review and were completed within the past two years. Individual #206's OT/PT assessment was not submitted:	

Individual	OT/PT Evaluation Date	PNMP
1. #536	02/03/10	No
2. #160	01/26/10	No
3. #163	01/26/10	No
4. #326	01/26/10	Yes
5. #274	10/29/08	No
6. #421	01/12/10	No
7. #438	01/12/10	No
8. #132	09/18/09	No
9. #70	01/07/10	Yes
10. #480	01/12/10	Yes
11. #265	01/20/10	Yes
12. #33	01/06/10	Yes
13. #117	12/8 and 12/18/09	Yes
14. #506	01/14/09	Yes

#	Provision	Assessment of Status	Compliance

15. #55	12/30/09	Yes
16. #364	12/09/09	No
17. #126	01/12/10	No
18. #306	12/29/09	Yes
19. #21	11/16/09	Yes
20. #98	12/02/09	No
21. #264	12/3 and 12/22/09	No
22. #277	12/01/09	No
23. #24	12/28/09	Yes
24. #163	01/26/10	No
25. #27	12/14/09	Yes
26. #478	02/08/10	Yes
27. #206	No assessment	No
28. #326	01/26/10	Yes

A review of the individuals OT/PT assessments listed above, documented there were individuals with physical and nutritional management needs for whom a PNMP had not been developed. Many of the recommendations were for maintenance of skills or a suggested recommendation to the PST. The recommendations, in many cases, did not include measurable, functional outcomes.

<u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three years, with annual interim updates or as indicated by a change in status</u>: One hundred and seven (107) PSPs were reviewed to determine when the most recent OT/PT assessments had been completed for individuals receiving direct or indirect OT and/or PT services. The following chart demonstrates that 28 individuals (26%) were not provided with a comprehensive OT/PT assessment every three years. In addition, there were no assessment dates for seven additional people (6.5%).

Year	OT/PT Assessment	Percentage
2000	2/107	1.9%
2001	1/107	.9%
2002	4/107	3.7%
2003	8/107	7.5%
2004	5/107	4.7%
2005	8/107	7.5%

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<tr><td>2006</td><td>0/107</td><td>0%</td></tr>
<tr><td>2007</td><td>2/107</td><td>1.9%</td></tr>
<tr><td>2008</td><td>15/107</td><td>14%</td></tr>
<tr><td>2009</td><td>55/107</td><td>51.4%</td></tr>
<tr><td>No Date</td><td>7/107</td><td>6.5%</td></tr>
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<u>Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral:</u> This indicator will receive further review during the next on-site visit.

<u>Findings of comprehensive assessment drive the need for further assessment such a wheelchair/ seating assessment:</u> A review of the 28 Occupational/Physical Therapy Annual Evaluations identified 14 individuals with a wheelchair narrative that documented the wheelchair was in good repair, or discussed a seating assessment in PNMP clinic. The remaining 14 individuals OT/PT assessments did not include a wheelchair section. The following is an example of an individual for whom appropriate follow-up assessment was recommended and initiated:
▪ Individual #27's OT/PT Evaluation, dated 12/14/09, indicated that she had sustained a fracture of her foot/ankle that resulted in her inability to initiate a stand/pivot transfer. As a result, her low frame to floor height seating system was no longer appropriate for her. A Seating System Assessment was initiated in conjunction with the OT/PT evaluation for more comprehensive recommendations.

<u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions:</u> The Occupational/Physical Therapy General Information/Active Problems format documented "to only list those pertinent to OT/PT" which did not support ensuring the OT/PT assessment "will consider significant medical issues and health risk indicators in a clinically justified manner" per the Occupational/Physical Therapy Services Policy (#014).

<u>Evidence of communication and or collaboration is present in the OT/PT assessments:</u> Based on the records reviewed, Occupational Therapists and Physical Therapists completed a collaborative Occupational/Physical Therapy Evaluation.
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<tr><td>P2</td><td>Within 30 days of the integrated</td><td><u>Within 30 days of a comprehensive assessment, or sooner as required for health or</u></td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
	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.	safety, a plan has been developed as part of the PSP: A review of the 28 Occupational/Physical Therapy Annual Evaluations documented individuals with identified physical and nutritional support needs, but PNMPs were not recommended for 10 out of the 28 (36%). These individuals were: Individual #536, Individual #160, Individual #163, Individual #274, Individual #438, Individual #126, Individual #98, Individual #264, Individual #277, and Individual #163. Within 30 days of development of the plan, it was implemented: As noted above, many individuals who needed PNMPs did not have them, and, therefore, they were not being implemented. Appropriate intervention plans are: ▪ Integrated into the PSP; ▪ Individualized; ▪ Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and ▪ Contain objective, measurable and functional outcomes: Due to the lack of appropriate plans, this indicator was not met. Interventions are present to enhance: ▪ Movement; ▪ Mobility; ▪ Range of motion; ▪ Independence; and ▪ As needed to minimize regression: Due to the lack of appropriate plans, this indicator was not met. The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used: Due to the lack of appropriate plans, this indicator was not met. Therapists provide verbal justification and functional rationale for recommended interventions: The indicator will receive further review during the next on-site visit. On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results:	

#	Provision	Assessment of Status	Compliance
		Occupational/Physical Therapy Services Policy (#014), Section IV, entitled Monitoring indicated: "The State Center shall implement a system to monitor and address: 1) The status of individuals with identified occupational and therapy needs; 2) the condition, availability, and appropriateness of physical supports and assistive equipment; 3) the effectiveness of treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and 4) the implementation of programs carried out by direct support staff." No specific review or monitoring schedule was stated in the policy. Per interview, the Occupational and Physical Therapists did not complete a monthly review of a person's status.	
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.	Staff implements recommendations identified by OT/PT: As noted above in the Section that addresses O.4 of the SA, staff were not consistently implementing PNMPs. Staff successfully complete general and individual-specific competency-based training related to the implementation of OT/PT recommendations: As is discussed in further detail above with regard to Sections O.4 and O.6 of the SA, the training that staff were being provided was not sufficient, Staff verbalizes rationale for interventions: This indicator will receive further review during the next on-site visit.	
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	System exists to routinely evaluate: • Fit; • Availability; • Function; and • Condition of all adaptive equipment/assistive technology: Per interview, observation and document review, the Orthotics Department was not able to complete new construction, routine maintenance, alterations and preventative maintenance in a timely manner as documented by examples below. There were two vacancies in the Orthotics Department since November 2009. Per interview, the Director of Orthotics was in the process of recruiting for these positions. These vacancies were impacting the timely delivery of new wheelchairs, as well as completing routine maintenance, alterations and preventative maintenance. A collaborative work plan will need to be developed by therapists and Orthotic staff to	

#	Provision	Assessment of Status	Compliance
	each individual; and the implementation by direct care staff of these interventions.	identify the universe of individuals who may require new seating systems and alternative positioning devices, as well as to ensure the timeliness of routine maintenance, alternations and preventative maintenance. It will be important to prioritize people who are at highest risk for aspiration, and/or gastroesophageal reflux to ensure they receive optimal and appropriate seating and alternate positioning to minimize or reduce these health concerns. The following examples illustrate the impact that these failures were having on individuals at ABSSLC: ▪ There were two work orders for Individual #212. The first work order, dated 03/20/09, documented Individual #212's mother's request from a recent PSP meeting for a new wheelchair frame constructed to help her reduce her tone. The second work order, dated 10/12/09, documented the same request from the preceding work order. ▪ Individual #13 had two work orders for alterations. The first work order, dated 03/30/09, requested a pad along his pelvic positioning belt (along the webbing) to decrease the risk of injury/lesions. The second work order, dated 06/05/09, requested a decrease in the abductor along the left side of his trunk to prevent rubbing. Also, it requested a decrease in the size of the foot box per recommendations from the PNMP clinic. Per documentation submitted, these work orders had not been completed. ▪ Per interview, Individual #472's Occupational Therapist had submitted a work order to revise to her dining chair approximately four months prior to the review, but the work order had not been completed. Per observation, she was in poor alignment and support, and coughed during the meal. ▪ Per interview and observation with Individual #447, she complained that her wheelchair was too small and was uncomfortable. The Wheelchair Log documented a new wheelchair delivery on 11/05/07. Physical Therapy Update Evaluation, dated 06/17/09, documented wheelchair concerns. The OT requested modifications to the position of her headrest. The Wheelchair Log entry, dated 08/04/09, documented a clinic to trim down the foam-in-place system to allow better access to the wheels for independent mobility. No revisions were made to her headrest. A comprehensive seating assessment was not submitted. <u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted:</u> Occupational/Physical Therapy Services Policy (#014), Section IV, entitled Monitoring	

#	Provision	Assessment of Status	Compliance
		stated: "The State Center shall implement a system to monitor and address: ▪ The status of individuals with identified occupational and physical therapy needs; ▪ The condition, availability and appropriateness of physical supports and assistive equipment; ▪ The effectiveness of treatment interventions that address the occupational therapy, and physical and nutritional management needs of each individual; and ▪ The implementation of programs carried out by direct support staff. There was no formalized Facility-specific monitoring system beyond the implementation of the PNMP Monitoring Form Routine and Mealtime Monitoring. These forms need to be analyzed to determine if each of the indicators is sufficiently discreet to achieve the desired monitoring outcome. There was no policy/procedure developed to define the process for the utilization of these forms. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs: There were no formalized monitoring systems beyond the PNMP Monitoring Form and Mealtime Monitoring form. As noted above with regard to Section O.6 of the SA, PNMP Monitoring conducted from October through December 2009 was not conducted on a regular basis. For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff: Competency-based training for individual-specific positioning plans for those individuals at increased risk was not formalized. Responses to monitoring findings are clearly documented from identification to resolution of any issues identified: As noted above with regard to Section O.6 of the SA, clear documentation was not found to address responses to monitoring findings and recommendations to ensure resolution of issues identified. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available: Wheelchair PNMP Clinic Log(s) documented Clinic Date, Individual's Name, Home, Evaluation Reviewed, Wheelchair/Headrest Recommendations and Attendance Signatures (OT, PT, Habilitation Technician, and Orthotic staff). The PNMP Clinics occurred on a regular basis to assess current wheelchair seating. Per interview, the major barrier to providing	

#	Provision	Assessment of Status	Compliance
		appropriate equipment related to the turnaround time by the Orthotics department. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs*:* The PNMP Monitoring Form Routine is designed to monitor general staff competency skills, but did not address individual-specific monitoring of the plan's effectiveness and how the plan addresses the identified needs. Data collection method is validated by the program's author(s): This indicator will receive further review during the next on-site visit.	

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

1. When an individual's OT/PT assessment(s) documents physical and nutritional support needs, a PNMP should be developed.
2. The Occupational/Physical Therapy comprehensive assessment format should integrate strategies for specific health risk indicators to minimize or reduce the effects of identified health issues.
3. The State should work with Abilene State Supported Living Center to determine what barriers need to be removed to assist in the successful hiring of Occupational Therapists.
4. Individuals should be provided with a comprehensive OT/PT assessment every three years, with annual interim updates, or as indicated by a change in status.
5. Ensure that dual supervision of PNMP coordinators does not present a barrier to implementation of physical and nutritional supports for people.
6. A comprehensive plan should be developed that ensures timely delivery of new seating systems, repairs/modifications to seating systems and routine/preventative maintenance. Such a plan should identify the actions that need to be taken to ensure the outcome of individuals having the equipment they need in a timely manner. Such a plan may include, for example, additional resources, such as staffing or equipment, or may describe the reconfiguration of existing resources to accomplish the necessary tasks.
7. For individuals with OT/PT needs, there should be an update of the individual's OT/PT status, on at least a monthly basis or more often as needed, to review and update plans as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results.
8. Please refer to recommendations above in Section O of this report related to monitoring.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Dental Daily Logs and associated data; o Attendance at scheduled Day Program activities data regarding refusals; and o Medical records for the following individuals: Individual #212, Individual #114, Individual #117, Individual #535, Individual #546, Individual #289, Individual #529, Individual #104, Individual #294, Individual #408, Individual #130, Individual #437, Individual #361, Individual #331, and Individual #492 ▪ **Interviews with**: o Jerry L. Griffin, DDS, Dental Director
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: From the records reviewed, it appeared that individuals generally were being seen by dental every six months, and many of the individuals reviewed had had restorative dental care completed. One problematic issue was the number of individuals refusing dental care. There needs to be a system in place to identify individuals who refuse dental care so that their teams can address this issue. At the time of the review, psychology had just started collaborating with dental regarding dental refusals. The disciplines in the Facility need to collaborate to develop desensitization programs/strategies to assist in decreasing refusals, as well as the use of pre-sedation and restraints for dental and medical procedures.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care	At the time of the review, the Dental Department at ABSSLC had one full-time dentist, two Dental Assistants, and one Dental Hygienist. In addition, the Facility maintained 17 consultant dentists. The Facility had one vacant dentist position, and one Dental Hygienist was starting on March 16, 2010. A review was conducted of fifteen (15) individuals' dental progress notes, including Individual #212, Individual #114, Individual #117, Individual #535, Individual #546, Individual #289, Individual #529, Individual #104, Individual #294, Individual #408, Individual #130, Individual #437, Individual #361, Individual #331, and Individual #492. All were seen and provided dental care at least every six (6) months. Many individuals were seen much more frequently for restorative care. The dental notes reviewed were	

#	Provision	Assessment of Status	Compliance
	guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	very comprehensive and descriptive regarding the findings of the exam. In addition, the notes clearly indicated the individual's oral hygiene status and condition of the teeth. Also, the dental notes included the individual's response to the examination, and included the medication, dose and route of any pre-sedation given prior to the appointment. Although the dental notes were very clear regarding the care provided, it was difficult to determine the dental treatment plan from the documentation. According to the interview with the Dentist, he monitors monthly the number of dental procedures done, number of annual exams conducted, scheduled visits, number of individuals that were rescheduled, training session conducted and out- patient procedures done. In addition, the dentist uses the Daily Log to document and track no – shows, and refusals for dental appointments. The Facility QE Nurse also has begun to monitor some dental items. This process needs to continue to develop to ensure that dental notes and practices are being implemented in alignment with generally accepted standards of practice. The Dental Department needs to review all of its policies and procedures to ensure that they are in alignment with current practices, the SA and Health Care Guidelines.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals'	As noted above, the Dental Department needs to review all of its policies, procedures and protocols to ensure that they are in alignment with current practices and the requirements of the SA and Health Care Guidelines. In addition, a monitoring system needs to be developed and implemented to ensure that these policies are consistently being implemented. There also needs to be collaboration between the disciplines such as nursing and psychology and the Dental Department regarding the monitoring of certain policies/procedures since other disciplines have shared responsibilities addressing certain issues such as missed and refused appointments. At the time of the review, psychology had just started collaborating with dental regarding dental refusals. From review of the dental data, there had been 47 individuals who had refused to attend their dental appointments from July through December 2009. The Facility was in the process of developing a system similar to a system being developed to track attendance at scheduled Day Program activities to also track dental refusals. The disciplines in the Facility need to collaborate to develop desensitization programs/strategies to assist in decreasing refusals, as well as the use of pre-sedation and restraints for dental and medical procedures. This collaboration needs to continue and be expanded. During future visits, the Monitoring Team will review these revised policies, procedures and practices as they are implemented.	

#	Provision	Assessment of Status	Compliance
	refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	ABSSLC did not have a form in place to track individuals requiring pre-sedation. There also was not a system in place to review individuals requiring pre-sedation.	

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

1. Dental policies, procedures and protocols should be reviewed/revised to ensure that they are in alignment with current practices, as defined in the requirements of the SA and Health Care Guidelines.
2. Monitoring systems should be developed and implemented to ensure that dental practices are in alignment with generally accepted standards of practice, and the requirements of the SA and Health Care Guidelines.
3. A formal system needs to be developed and implemented addressing refusals or missed dental appointments so that the PSTs can develop strategies to help the individual tolerate dental care.
4. Dental treatment plans need to be clearly articulated, integrated into PSPs, and implemented.
5. Dentistry should continue to collaborate with other disciplines such as nursing and psychology, regarding the implementation of certain policies/procedures that have shared responsibilities regarding dental issues, such as the development of plans to reduce the need for pre-sedation medications.
6. Dentistry should collaborate with nursing regarding the development and implementation of a monitoring system to ensure that individuals are appropriately monitored when receiving pre-sedation medication for medical/dental procedures.

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 Sweet Sixteen Poster; o List of Habilitation Therapies Staffing; o Communication Services Policy (#016); o Speech Alternative Augmentative Communication (AAC) and Environmental Control Units (ECU) Equipment Spreadsheet and Monitoring Lists for November, December 2009, and January 2010; o Speech Language Evaluation Annual Review format; o Communication Adaptive Equipment Evaluation format; o Speech Language Evaluation format; o Speech Language Evaluation Update Addendum to Speech Language Evaluation; o Communication Dictionary format; o Adapted Environmental Control Evaluation; o Individual-specific Communication Adaptive Equipment Evaluation for Individual #93, Individual #287, Individual #109; o Individual-specific Modified Barium Swallow Results Speech Language Pathologist Report for Individual #471, Individual #147, Individual #166; o Individual-specific Speech Language Evaluation for Individual #181, Individual #163, Individual #226, Individual #188, Individual #71, Individual #280, Individual #154, Individual #81, Individual #463, Individual #532, Individual #179, Individual #410, Individual #227, Individual #160, Individual #289, and Individual #355; o Individual-specific Speech Language Update Addendum to Speech Language Evaluation, for Individual #118; o Individual-specific Adapted Environmental Control Evaluation, for Individual #118, Individual # 373, Individual # 294, and Individual #297; o Individual-specific Communication Dictionaries for 486 Individuals; o Analysis of Monitoring of Speech (AAC) Equipment, dated 02/10/10; and o Recruitment strategies for Audiologist/Speech Language Pathologist positions at Abilene State Supported Living Center ▪ **Interviews with**: o Cheryl Balanay, Director of Speech and Language Services; o Speech Pathologists (all); o Speech Assistant; o Conducted meeting to discuss Section R with SLPs, and obtain information on current progress for implementation of Section R; and o Interview with 12 direct service personnel representing six residences, and three different

	shifts; including seven MRA I staff, two MRA II staff, two MRA III staff, and one staff member did not indicate her position, on 2/26/10 ▪ **Observations of**: o Individual-specific communication systems; o Vocational activities in the workshop, diner, and laundry areas; o Residences: 5961, 5962, 6330, 6350, 6380, 6390, 6400, 6700, 6710, 6730, 6740, 6750, 6760; o Sensory Gym at the Beehive; and o Activity Centers
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: It was apparent that the communication department had made an attempt to provide information to staff regarding alternative communication systems. In most settings, Monitoring Team members observed posters identifying basic signs, or icons to communicate a variety of needs or locations. Unfortunately, individuals and staff did not access these to support functional communication. There needs to be a system of oversight and monitoring to ensure that all individuals have a means of communicating their basic wants and needs. It appeared that a number of individuals who did not currently have access to alternative and augmentative communication systems might benefit from such systems. However, they had not been assessed, and/or plans developed to meet their needs due to inadequate staffing levels. Given the needs of the individuals living at ABSSLC, staffing for speech and language did not appear to be sufficient.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and	<u>The Facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience</u>: There were five budgeted positions for Speech Therapy. At the time of the review, there were four Master Level Speech Language Pathologists with Certificates of Clinical Competence (CCC), and one Speech Language Assistant to provide support to 465 people living at Abilene State Supported Living Center. Per interview, the Speech Language Pathologists struggle to complete routine evaluations, and did not have sufficient time to develop and implement person-specific AAC communication systems. Further discussion revealed that the Director of Speech and Language Services would prefer to have three additional speech therapists in order to best meet the needs of the population served. With the staffing at the time of the review, the resulting caseloads of over 60 individuals per therapist (including the Director), may not meet the needs of the individuals at ABSSLC. Further,	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>implement programs, provide staff training, and monitor the implementation of programs.</td><td>additional technicians may be required to ensure that all alternative systems and augmentative devices are kept in good working order.

Per report, there were three technicians and PNMP Coordinators to provide assistance to the SLPs. PNMP Coordinators positions had been approved, and were being recruited for, but the overriding concern expressed by the therapists was the dual supervision of these positions. They reported it resulted in confusion related to job responsibilities specific to the implementation of communication supports.

There was one contract Audiologist. Per documentation submitted, the Facility had been working to recruit a full-time Audiologist since August 2008. The primary barrier appeared to be salary compensation.

The Speech Language Pathologists should analyze the universe of unmet needs as well as the requirements of the Settlement Agreement to identify human resource needs. If additional resources are needed, then requests should be made.

<u>Supports are provided to individuals based on need and not staff availability</u>: The Speech Language Pathologists provided generic communication devices in multiple environments throughout the Facility, and 36% of the individuals had individual-specific communication systems. These left a number of individuals who were not being provided individual-specific communication systems due to the time constraints of the SLPs.

Four hundred and sixty-eight (468) individual Communication Dictionaries were submitted for review. The Communication Dictionaries provide an explanation of how each individual communicates. For example, if an individual communicates using gestures, the gestures and their meanings are identified. It should be noted that although these Communication Dictionaries are mentioned in individuals' PSPs, they are not incorporated or integrated into the PSPs.

The Speech Alternative Augmentative Communication (AAC) and Environmental Control Units (ECU) Equipment Spread sheet and Monitoring List identified the following homes and number of individuals with AAC and/or ECUs:

<table>
<tr><th>Home</th><th>Number of Individuals with AAC and/or ECU</th></tr>
<tr><td>5961</td><td>14</td></tr>
</table>
</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance

5962	10
5971	6
5972	6
6330	6
6350	7
6360	5
6370	2
6390	9
6400	6
6450	3
6460	3
6480	15
6500	14
6510	16
6521	9
6690	1
6700	9
6710	5
6720	4
6730	4
6740	6
6750	4
6760	2
TOTAL	166

Only thirty-six percent (36%) of the people living at ABSSLC have either an AAC system and/or an environmental control unit. This appears to be low given the population served by the Facility.

Per interview, SLPs complete quarterly progress notes, and a case note when a consultation request was made.

Each home had generic communication equipment such as talking frame for Pepsi on vending machine, wall mount bathroom sequence strips, Big Red switches, sign language help on hooks, sensory boxes on rolling stands, wall-mounted communication boards, bathing sequence charts, etc. One of the greatest barriers, however, to supporting the implementation of functional communication was the lack of staff engagement with

#	Provision	Assessment of Status	Compliance
		generic communication devices, and person-specific communication systems. The speech pathologists need to review icons being used in generic systems to ensure that they are functional, and would be understood by the individuals living at ABSSLC. To achieve success with functional communication, there must be intensity using generic and individual-specific devices throughout the day and evening. This did not appear to be occurring. These issues may be driven by an insufficient number of speech pathologists to provide needed assessment(s) for assistive technology, implementation and documentation systems, staff training, and formal monitoring processes.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>All individuals have received a communication screening. If newly admitted, this occurred within 30 days of admission</u>: Per interview with the SLPs, assessments were completed for each individual as opposed to a communication screening. For the following individual who was newly admitted, this had been completed. Specifically: ▪ Individual #477 was admitted to Abilene State Supported Living Center recently. A Speech Language evaluation was completed within 30 days of admission. <u>All individuals identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills: Per interview, the speech therapists are struggling to maintain a current evaluation schedule</u> The following evaluation formats were submitted: ▪ Speech Language Evaluation Annual Review; ▪ Communication Adaptive Equipment Evaluation; ▪ Speech Language Evaluation; ▪ Adapted Environmental Control Evaluation; and ▪ Speech Language Evaluation Update Addendum to Speech Language Evaluation. Communication assessment formats did not include a section to address medical issues and/or and risk indicators, which may have an impact on therapy interventions. In addition, the assessment format needs to include sections for appropriate analysis to establish rationale for recommendations and therapeutic interventions. <u>If receiving services, direct or indirect, the individual is provided a comprehensive Speech-language assessment every three years, with annual interim updates or as indicated by a change in status</u>: One hundred and seven (107) PSPs were reviewed to determine when the most recent SLP and audiology assessments completed. The	

#	Provision	Assessment of Status	Compliance
		following chart demonstrates that 68 people (64%) were not provided with a comprehensive SLP assessment every three years. In addition, there were no SLP assessment dates for four additional people (3.7%). Audiology assessments provide a foundation to support functional communication. The following chart is based on review of 107 PSPs, and the dates that were documented in the PSPs for the completion of speech assessments, and audiology evaluations. It appeared that Audiology assessments significantly increased in 2008 and 2009 as documented below.	

Year	SLP Assessment	Percentage	Audiology	Percentage
2000	2/107	1.9%	0	0
2001	1/107	.9%	0	0
2002	21/107	19.6%	0	0
2003	13/107	12.1%	0	0
2004	14/107	13.1%	0	0
2005	8/107	7.5%	2/107	1.9%
2006	9/107	8.4%	2/107	1.9%
2007	5/107	4.8%	17/107	15.9%
2008	9/107	8.4%	49/107	45.8%
2009	20/107	18.7%	36/107	33.6%
No Date	4/107	3.7%	1/107	.9%

For persons receiving behavioral supports or interventions, the Facility has a screening and assessment process designed to identify who would benefit from AAC. Note: This may be included in PBSP: This indicator will be further reviewed during the next on-site review.

Individuals determined via comprehensive assessment to not require direct or indirect Speech Language services receive subsequent comprehensive assessment as indicated by change in status or PST referral: This indicator will be further reviewed during the next on-site review.

Policy exists that outlines assessment schedule and staff responsibilities: Communication Services Policy (#16) documents the following: "The State Center must:

A. Provide an adequate number of speech language pathologists with specialized training or demonstrated competence in augmentative and alternative communication, to conduct assessments, develop and implement programs,

#	Provision	Assessment of Status	Compliance
		provide staff training and monitor the implementation of program. B. Comprehensive communication assessments will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need." The ABSSLC Habilitation Therapies Manual did not document an assessment schedule for communication assessments. <u>Findings of comprehensive assessment drive the need for further assessment in Augmentative Communication:</u> A review of nine Speech Language Evaluations (for Individual #71, Individual #118, Individual #280, Individual #154, Individual #81, Individual #463, Individual #532, Individual #179, and Individual #188) incorporated a section on augmentative communication or stated the person was not a candidate for augmentative communication.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP:</u> The following examples documented how communication interventions were not consistently integrated into a person's PSP and/or PNMP: ▪ Individual #138's Communication Adaptive Equipment Evaluation, dated 01/14/09, documented his "communication book and Cheap Talk are considered the primary communication system he needs to communicate most effectively. This item was reviewed for correct format, accessibility and condition. The equipment was found to be appropriate for his needs and in good condition." An Adapted Environmental Control Evaluation, dated 02/02/10, found his environmental control unit to be appropriate for his needs and in good condition. His PSP, dated 01/14/10, stated: "speech language therapy is not indicated as his needs can best be addressed in the context of daily living activities." The PSP did not discuss his communication systems. ▪ Individual #118's PSP was not submitted for review. His Speech Language Evaluation Addendum, dated 01/14/10, documented communication strategies to be included in Special Considerations/PNMP, and integrated into daily programming as soon as possible ▪ Individual #463's PSP, dated 01/26/10, documented communication equipment, adapted environmental control equipment, language/modality preference, and communication/active treatment instructions. These recommendations were not consistently incorporated into her PSP. <u>AAC devices are portable and functional in a variety of settings:</u> Generic communication systems were not used for engagement with people during the review. Observations of	

#	Provision	Assessment of Status	Compliance
		individual-specific communication systems showed they were not being used, and/or were not working. For example: ▪ During an observation of Individual #92 with her Tough Talker, it was not functioning, and staff were not able to assist her to correct the problem. ▪ Individual #153's communication system was not functioning. <u>AAC devices are meaningful to the individual:</u> Observation of individuals with their AAC devices illustrated they were not functioning, and/or were not available, rendering them meaningless to the individual. For example, when visiting Home 6710, the Monitoring Team asked to see the augmentative device provided to Individual #153. The staff person went into the individual's room, found the device locked in his closet, and then discovered that it was not working. She explained that the individual did not use the device. It was apparent that the communication department had made attempts to provide information to staff regarding alternative communication systems. In most settings, Monitoring Team members observed posters identifying basic signs or icons to communicate a variety of needs or locations. What was concerning was that this seemed to be a blanket approach to developing systems for a wide range of individuals. In some cases, icons were posted on the walls of bedrooms that appeared to be unrelated to the individual residing in the room. For example: ▪ In the room of one young man, there was a laminated poster that included icons for the following: colors, put away, fold, tie, nail care, and jewelry. It was unclear how any of these icons provided the individual with a functional way of communicating his basic wants and needs. ▪ In this same house, there was a poster on the inside of the front door. Included were icons for McDonalds, Taco Bell, plane, and boat. While the first two may be preferred dining establishments for some of the individuals, it is unlikely that they can make the trip off campus whenever they request to go by pointing at the item. This may result in behavior problems that could easily be avoided. Plane or boat rides are clearly not readily available. ▪ In another home, a poster was on the wall near an individual's bed. The guidelines for its use indicated that the individual should remove and take with him the icon for the scheduled activity. It was to be returned when he completed the activity and proceeded to the next scheduled event. While this type of visual schedule may in fact be appropriate for this individual, the poster was laminated, so there were no icons to be removed. It should also be noted that this individual had moved to another room three to four weeks previously, but	

#	Provision	Assessment of Status	Compliance
		the poster remained in his old room. Staff are trained in the use of the AAC: Per interview with the speech therapists, staff were in-serviced in the use of individual-specific communication systems, and written instructions were available on all generic communication systems. Observations by the reviewer did not support that training had been effective. In addition, it did not appear that formal monitoring systems were in place to support staff compliance with the use of generic and individual-specific communication systems. In some case, AAC systems were not available and/or were not functioning. If the equipment was functioning, staff did not appear to understand how to use the equipment. Communication strategies/devices are implemented and used: Staff and the individuals living at ABSSLC were not using generic communication strategies/devices and individual-specific communication devices. General AAC devices are available in common areas: Multiple generic communication devices were available in the homes, but the reviewers did not observe staff engaging individuals with these devices.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Monitoring system is in place that: ▪ Tracks the presence of the ACC; ▪ Working condition of the AAC; ▪ The implementation of the device; and ▪ Effectiveness of the device. Policy currently defines a monitoring system to address the indicators listed above. For example, the Communication Services Policy (#016), Section V, entitled Monitoring indicated that the State shall implement a system to monitor and address: ▪ "The status of individuals with identified therapy needs; ▪ The conditions, availability and appropriateness of physical supports or assistive equipment; ▪ The effectiveness of treatment interventions, including whether the interventions address the individual's communication needs in a manner that is functional and adaptable to a variety of settings and that the identified communication systems are readily available to the individual; and ▪ The implementation of communication programs carried out by direct support staff."	

#	Provision	Assessment of Status	Compliance
		In addition, the Speech Alternative Augmentative Communication (AAC) and Environmental Control Units (ECU) Equipment Spreadsheet and Monitoring List documented the following categories: ▪ Home; ▪ Individual AAC device; ▪ Monitoring (in place, found, missing); ▪ Type of device (computer, electronic, manual); ▪ Equipment Description; ▪ Work order; and ▪ Repair needs/other issues/needs. According to the review of monitoring sheets submitted, these devices are monitored on a monthly basis as monitoring was submitted for November and December 2009, and January 2010. Per submitted documentation: "over the past two years the number of items that are found and out where they are supposed to be has improved. The use of equipment (as found in snapshot monitoring remains a problem area." The following action plan was presented to address the identified issue: ▪ "Teach shift leaders importance of equipment being out and in use; ▪ Teach home supervisors the importance of equipment being out and in use; ▪ Work with Unit Directors on importance of equipment being out and in use and need for expectation of supervisors; ▪ We hope to utilize at least one of the PNMP Coordinator positions to assist in this area. The plan is for the coordinator to do a simple monitoring sheet that notes if the equipment is out and whether it is in use. Then provide direct feedback to the shift lead, home supervisors and Unit Directors about the results." This plan was not comprehensive. Each of the proceeding bullets would require the development of action steps, person(s) responsible, initiation and completion date, and supporting documentation to ensure task is successfully completed. In addition, this plan needs to be linked to Quality Enhancement efforts. <u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home:</u> There was documentation of monthly monitoring of AAC devices and Environmental Control Units. The overriding issue was the non-utilization of generic and person-specific devices, which was consistently confirmed during multiple observations during the week of the review. During visits to homes and activity centers, it was clear that individuals were not using the systems that have been identified and developed for	

#	Provision	Assessment of Status	Compliance
		them. While the Speech and Language Department should be commended for following a consultation model for the delivery of communication services and training, there needs to be a system of oversight and monitoring to ensure that all individuals have a means of communicating their basic wants and needs. Staff reported infrequent visits by the speech staff, which may contribute to the limited use of alternative systems, and the lack of staff commitment to the same. The Director of Speech and Language Services cited the lack of staff commitment to the use of alternative and augmentative devices as a concern. Validation Checks are built into the monitoring process and conducted by the plan's author: The Facility-based monitoring system had not been formalized. The monitoring system should include competency-based training and validation process for monitors, a description of the monitoring tool (generic and individual-specific), strategies for monitoring each indicator, a process for staff to be trained if monitoring score falls below established thresholds, guidelines for the analysis of monitoring results, the formulation of corrective strategies to address systemic and individual-specific areas of deficiency, and integration of the monitoring system in the Facility Quality Enhancement system.	

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

1. The current staffing levels for SLPs and related support staff should be re-evaluated to determine if these positions are sufficient to implement individual-specific functional communication systems for individuals at ABSSLC, as well as to provide supports to individuals with mealtime needs. If additional resources are needed, then requests should be made.
2. All individuals who do not have effective means of communication should be provided with training objectives to address their needs. If augmentative devices are recommended, these should be individualized. All systems should provide the individual with a "voice" so that he/she can at a minimum make his/her basic wants and needs known. The use of the Picture Exchange Communication System is strongly encouraged as its effectiveness, and resulting benefits have been well documented in the literature.
3. The Speech Language Therapy comprehensive assessment format should be revised to ensure it integrates strategies for specific health risk indicators to minimize or reduce the effects of identified health issues.
4. The ABSSLC Management Team, in collaboration with the Speech Pathologists, should develop and implement a plan to support the implementation of generic and individual-specific communication systems across a 24-hour day.
5. To address the difficulty in keeping communication books equipped with necessary icons, consideration should be given to making this a work opportunity for individuals at Abilene State Supported Living Center. Depending on an individual's skills and safety awareness, individuals could be taught to print, laminate, cut, and attach Velcro to icons to ensure an adequate supply of materials for communication books.
6. A system of oversight and monitoring should be developed and implemented to ensure that all individuals are consistently using their communication skills. Included should be a schedule of regular visits by speech therapy staff to all settings in which the individual resides, works, and recreates. The monitoring system should include competency-based training and validation process for monitors, a description of the monitoring tool (generic and individual-specific), strategies for monitoring each indicator, a process for staff to be trained if monitoring

score falls below established thresholds, guidelines for the analysis of monitoring results, the formulation of corrective strategies to address systemic and individual-specific areas of deficiency, and integration of the monitoring system in the Facility Quality Enhancement system.

7. Individuals' communication strategies should be consistently integrated into their PNMPs and PSPs.

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 Personal Support Plans and accompanying Training Documentation Reports for the following individuals: Individual #163, Individual #517, Individual #43, Individual #105, Individual #242, Individual #209, Individual #464, Individual #438, Individual #93, Individual #81, Individual #272, Individual #276, Individual #286, Individual #355, Individual #153, Individual #313, Individual #442, Individual #231, Individual #461, Individual #278, Individual #486, Individual #277, Individual #287, Individual #537, Individual #252, Individual #160, Individual #525, Individual #146, Individual #132, and Individual #504; and o Personal Support Plans for Individual #367, Individual #323, and Individual #94. ▪ **Interviews with**: o Juan Herrera, QMRP Coordinator; and o Interview with 12 direct service personnel representing six residences, and three different shifts; included seven MRA I staff, two MRA II staff, and two MRA III staff, and one staff member who did not indicate her position, on 2/26/10 ▪ **Observations of**: o Vocational activities in the workshop, diner, and laundry areas; o Residences: 5961, 5962, 6330, 6350, 6380, 6390, 6400, 6700, 6710, 6730, 6740, 6750, 6760; o Sensory Room at the Beehive; o Activity Centers; and o Personal Support Plan Meeting for Individual #461 (2/25/10)
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Currently, skill acquisition objectives are not written in a manner that provides a clear understanding of the expected outcome. The following elements are missing: a) specific conditions under which the behavior will occur; b) a definition of the behavior in observable and measurable terms; c) identification of the criteria that will be used to indicate mastery of the skill; and d) a plan for the maintenance and generalization of the skill. Additionally, specific guidelines for teaching the skill must be provided. This should include relevant discriminative stimuli, prompting strategies, shaping guidelines, and steps for teaching behavioral chains.

	None of the 210 Training Documentation Reports that were reviewed specified training in the community. While some purchasing programs may have indicated that the objective could be implemented in the community, there was no indication that this was mandatory or expected.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	A total of 210 Training Documentation Reports for a total of 30 individuals were reviewed. While most contained task analyses, a schedule for implementation, and guidelines for documenting the individual's performance, as currently written, the following critical information was missing or incomplete: ▪ First, there were no behavioral objectives that clearly indicated what behavior the individual was to emit, nor the conditions under which the behavior should occur. ▪ Further, there were not clear criteria to indicate when skill acquisition has occurred. ▪ The teaching conditions were vague and did not provide adequate guidelines for actual implementation of the objective. ▪ In all but 10 cases, reinforcement for demonstration of a skill was listed as verbal praise, social praise, gestural praise, or a pat on the back. The exceptions were for objectives identified as making a purchase, cooking, or using an Ablenet switch. While positive feedback, often in the form of verbal praise, should always be given for desirable behavior, verbal praise from any adult probably does not function as a reinforcer in every instance of desirable behavior. Motivating individuals to learn new skills is always a challenge. Therefore, careful consideration needs to be given to the consequence delivered for both correct and incorrect responding. ▪ In no cases were there plans for ensuring the maintenance or generalization of skills learned. When visiting residences and work areas at the Facility, the reviewer frequently conducted Planned Activity Checks (PLACHECK) to determine the degree to which individuals were actively engaged. In the residences, PLACHECK scores ranged from 0% engagement to 60% engagement with a mean of 21% engagement. In one home, the reviewer observed individuals seated around a table with nothing in front of them as a staff member reviewed a recipe. In another residence, there were over 20 individuals in a large room in which two television sets were on. Loud music was also heard coming from the CD player that was positioned on top of one of the television sets. In one room in another residence, there was a staff member seated with five individuals, none of whom were actively engaged. When the reviewer asked the staff member to introduce	

#	Provision	Assessment of Status	Compliance
		the women, she could not because she did not know their names. PLACHECKS conducted in the vocational areas ranged between 50% and 100% with a mean of 65% engagement. During visits to homes and day/vocational sites on campus, the reviewer did not observe staff implementing or documenting any of the teaching objectives. During the reviewer's interview with direct service personnel, they reported that there is little training provided to staff on the specifics of the individuals' training objectives. Here, too, is an area that would be best addressed through competency-based training. Staff also indicated that they would like assistance in identifying age-appropriate activities that are of interest to the individuals served. Lastly, in order to best ensure implementation of training objectives and active engagement throughout the day, it will be necessary to ensure adequate staffing. Staff noted that they are often required to work long hours, as the result of voluntary overtime or mandatory holdovers. Even the staff recognize that this can set the stage for less than optimal conditions for the individuals served, and likely contributes to a lack of active engagement and teaching of skills.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	At the time of the review, current practice at Abilene State Supported Living Center was that I-CAP assessments should be completed at a minimum of once every three years. Additionally, Personal Support Plans identified results of occupational therapy, physical therapy, and speech and language therapy assessments. Based on observation of a Personal Support Planning Meeting, it was clear that individuals from many different disciplines participated in the process of determining goals and objectives for the coming year. At this point in time, however, it appeared that a comprehensive assessment of adaptive behavior was not completed annually. The QMRP Coordinator indicated that the goal was to begin using the Positive Assessment of Living Skills (PALS) to help guide the identification of needed skills for every individual at Abilene State Supported Living Center. This is an excellent first step in enhancing the habilitation services provided to those in residence at the Facility. In addition, while all Behavior Support Plans included a section in which suggested reinforcers were listed, there was no indication as to the manner in which these preferences were identified. Further there appeared to be no plan for annual assessment of individuals' adaptive behavior or existing barriers to living in the community. The psychologist should take an active role in ensuring that all of these areas are addressed. At a Personal Support Planning Meeting, the psychologist stated that the family was not willing to explore possible community placement for the individual, but did not	

#	Provision	Assessment of Status	Compliance
		proactively suggest options for potentially overcoming the parent's reluctance. When another staff member inquired further, it was noted that many years prior the family had a disappointing experience with community options. It was this second staff person who suggested a plan of action to ensure that consideration of placement in a less restrictive setting be pursued with the guardian. At the Unit Meeting the reviewer attended, note was made that a particular individual did not like the job to which she was assigned. Rather than suggesting that an assessment of job preference be completed, the psychologist stated that she wanted the individual to continue with the job as she was a capable individual, and this was the most interesting job available. Psychologists, as well as other team members, should always be proactive in trying to provide the most interesting and satisfying environment for the individuals they serve. Individual preference as it relates to living, working, and leisure environments and activities should always be considered.	
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:	During an interview with the QMRP Coordinator, he reported that the Facility was going to begin using a comprehensive assessment (Positive Assessment of Living Skills – PALS) to determine an individual's strengths and needs. This is a commendable undertaking. Staff should ensure that the needs identified in the assessment are then incorporated into the individual's training objectives. While many training schedules call for daily implementation of the teaching program, data was only collected on specified days of the week. Without daily assessment of individual performance, it is difficult to ensure that the program is implemented often enough and consistently enough to ensure skill acquisition. It is unclear whether graphs are generated to reflect the data that is collected.	
	(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	As noted previously, guidelines for implementing training objectives frequently did not provide specific teaching methodology. Reinforcement for correct responding was often not individualized. As a result, skill instruction may be inconsistent across staff and correct responding may not be effectively reinforced. Further, it appears that most training occurs in the residence, thereby limiting the development of skills in integrated settings.	
	(b) Include to the degree practicable training	None of the 210 Training Documentation Reports that were reviewed specified training in the community. While some purchasing programs may have indicated that the	

#	Provision	Assessment of Status	Compliance
	opportunities in community settings.	objective could be implemented in the community, there was no indication that this was mandatory or expected.	

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

1. Currently, skill acquisition objectives are not written in a manner that provides a clear understanding of the expected outcome. It is recommended that training objectives be written to include the following: a) specific conditions under which the behavior will occur; b) a definition of the behavior in observable and measurable terms; c) identification of the criteria that will be used to indicate mastery of the skill; and d) a plan for the maintenance and generalization of the skill. Additionally, specific guidelines for teaching the skill must be provided. This should include relevant discriminative stimuli, prompting strategies, shaping guidelines, and steps for teaching behavioral chains.
2. Assessment of adaptive behavior should occur at least annually. The I-CAP is limited in the range of domains assessed. Therefore, the use of the PALS or some other more comprehensive assessment is recommended. Preference assessments should also be completed on a regular basis to ensure that potentially effective reinforcers are applied for all desirable behavior.
3. It will also be necessary to develop a system to ensure that all direct support professionals are adequately trained to teach each of the individual identified skills. This form of training should include both didactic instruction, and on-the-job competency-based training.
4. Data on skill acquisition programs or training objectives should be presented graphically to ensure that there is appropriate monitoring of individual progress, and resulting program revision when necessary. Data should also be collected on skill maintenance and generalization.
5. Strategies also should be developed to help enhance overall active engagement. This may include the hiring of additional staff, acquisition of additional and varied materials, expanded range of activities available, including vocational opportunities, and enhanced supervision of staff and training in all environments. A system of conducting regular PLACHECKS will allow the Facility to gain important information, while also providing positive feedback and constructive criticism to ensure continued improvement.
6. During PSP meetings, community settings should be identified in which skill acquisition goals and objectives will be implemented to enhance the goal's meaning and function.
7. As Abilene State Supported Living Center is a government-operated Facility, with no religious affiliations, religious artifacts or references should be removed from all communal living, working, and recreational areas, for example, a psalm that was painted on the wall in a newly renovated meditation room, and a plaque that stated "trust in the Lord." Individual preferences for such artifacts or references should be respected in individuals' personal space.

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 List of Individuals Assessed for Placement since 7/1/09; o List of Individuals Recommended by His/Her Team for Community Placement since 7/1/09; o List of Individuals Referred for Placement since 7/1/09; o List of Individuals who Have Requested Placement since 7/1/09; o List of Individuals with Transition/Discharge Planning between 7/1/09 and 12/11/09; o List of Individuals who Have Been Transferred to a Community Setting since 7/1/09; o List of Individuals Discharged Pursuant to an Alternate Discharge; o List of Individuals who Have Been Transferred pursuant to an Alternative Discharge since 7/1/09; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09; o Community Living Options Information Process (CLOIP) Tracking form, dated 10/30/09; o Permanency Plan (PP) Tracking System form, dated 10/30/09; o Living Options Discussion Record form; o Identified Obstacles to Individual's Movement form; o Post-Move Monitoring Checklist form; o Community Living Discharge Plan form; o Job descriptions for: QMRP III – Post-Move Monitor, and Admissions/Transfer/Placement Coordinator; o Completed CLOIP Assessment Tracking System forms for July 2009 through January 2010; o List of individuals served and tours of community alternatives visited between July 10, 2009, and December 18, 2009; o Staff Record of Community Interaction between 9/18/09, and 12/18/09; o Sign-in Sheets for Community Placement Training with Mental Retardation Authorities (MRAs) for September 22, 2009; o Provider Fair flyer and sign-in sheets for 9/22/09; o The following blank assessment forms: Draft Living Options Considerations Checklist, updated 7/7/09; Audiological Evaluation; Audiological Screening; Reiss Screen for Maladaptive Behavior Scale; Dental Exam Shell; Annual Medical Summary and Physical Examination Evaluation; Speech-Language Evaluation; Nursing Assessment; Adaptive Equipment Assessment; Adaptive Equipment Services Objectives; Lifting/Transfers Assessment; PT Services Plan; Request for Consent for Restraint; Risk Screening Tool; Performance Oriented Assessment of Balance and Gait; Occupational/Speech Therapy

	Eating Evaluation/Nutritional Management Plan; Cratty Perceptual-Motor Test; Physical Therapy Bicycle Assessment; Home Exercise Instructions; Positioning Instructions; o Facilitator's Notes for training entitled "Personal Support Teams: PDP Process," Copyright 9/29/09; o PSPs, related assessments, Community Living Discharge Plans, and Post-Move Monitoring documentation for Individual #341, Individual #358, Individual #380, Individual #389, Individual #404, Individual #421, Individual #456, and Individual #496; o PSPs and related assessments for Individual #27, Individual #69, Individual #83; Individual #117, Individual #189, Individual #199, Individual #268, Individual #277, Individual #357, Individual #381, Individual #408; Individual #429; Individual #452; Individual #475; Individual # 504; and Individual #514 ▪ **Interviews with**: o Pat Smith, Admissions/Placement Coordinator (APC); o Laura Wilford, Post-Move Monitor; and o Juan Herrera, QMRP Coordinator ▪ **Observations of**: o Individual #227's PSP Annual Review Meeting; o On 2/24/10, post-move Monitoring visit for Individual #421; and o On 2/24/10, post-move monitoring visit for Individual #389
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Individuals' PSPs did not consistently identify all of the protections, services and supports that need to be provided to ensure safety, and the provision of adequate habilitation. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. A new format for the PSP had been developed, and its use began in February 2010. One of the new sections of the plan reportedly includes documentation of the team's discussion with regard to obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. With regard to the timeliness of the Community Living Discharge Plans (CLDPs), it appeared that many were developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. The CLDPs reviewed included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable.

	The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility was at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to, and after the individual's transfer to the community. Post-move monitoring had been completed for all of the individuals who had transitioned to the community. A few had been completed late. With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator. The post-move monitoring identified some issues with regard to the provision of services at the community sites. The follow-up to rectify issues identified appeared to be rigorous, and included notifying the provider agency's management team of the issues identified, attempting to reach agreement with the agency on persons responsible and timeframes for the completion of needed actions, and notifying the community Mental Retardation Authority staff of the need for follow-up.

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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,	On 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement is appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding for community transition of individuals from	

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	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.	ABSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe.	
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:	In response to the document request for all Facility policies related to this section of the SA, the Facility submitted a copy of the State's policy.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such	The two major requirements of this section of the SA are discussed separately below: <u>Identification in PSP of needed protections, services and supports</u>: As is further discussed in the section of this report that addresses Section F of the SA as well as throughout other sections of the report, PSPs generally did not identify the comprehensive array of protections, services, and supports that individuals need to ensure safety and the provision of adequate habilitation. In all of the PSPs reviewed, concerns were noted with regard to their completeness. Some of these issues related to thorough and adequate assessments not being completed (e.g., nursing, physical and nutritional management, and communication); services and supports not being adequately integrated with one another (e.g., psychology and psychiatry, psychology and dental/medical, and occupational and physical therapy); protections, services, and supports not being adequately defined, such as a lack of specificity about the supports that direct support professionals need to provide to protect and support individuals with regard to behavioral, therapeutic, or healthcare issues; and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychology and habilitation, physical and nutritional supports, and communication). It is essential as teams plan for individuals to move to community settings that PSPs	

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	obstacles.	provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important for two 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; and 2) as the process progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move. If all of the necessary protections, supports and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition. <u>Identification of obstacles and strategies to overcome them</u>: In none of the PSPs reviewed, were obstacles to an individual's movement to the most integrated setting appropriate to his/her needs and preferences, and strategies to overcome identified barriers identified. Some plans identified some obstacles, but no plans to overcome them were identified. According to the QMRP Coordinator, beginning in February 2010, ABSSCL began using a new PSP format that included a section for obstacles to be listed and action plans to address such obstacles to be detailed. At the time of the review, such plans were not available for review. During upcoming monitoring visits, the Monitoring Team will review plans developed using this new format. Review of the training materials that the Facility submitted related to the revised PSP format revealed that extremely limited training was provided to QMRPs on the identification of obstacles to individuals' movement to the most integrated settings appropriate to their needs and preferences, and no training was provided on the development of strategies to overcome such barriers. In addition, the list of common barriers identified for individuals included some that were of concern. Specifically, two of the barriers identified in the training were a lack of social skills training, and inappropriate behavior (i.e., aggression, sexual behavior, and self-injurious behavior). Neither a lack of social skills training, or inappropriate behavior should be viewed as obstacles to an individual's transition to the community. If an obstacle exists related to such issues, it would be the lack of protections, services and supports to keep an individual and others safe. Training for teams needs to address the identification of actual barriers as well as appropriate plans to address such barriers. On a positive note, the Post-Move Monitor had begun to attend a sample of PSP meetings	

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		to provide teams with feedback regarding the community living options discussion. During the review, the reviewer observed the PSP meeting for Individual #227. The Post-Move Monitor participated in the meeting, and was helpful in structuring the discussion about the most integrated setting appropriate for the individual. According to the Post-Move Monitor, results of her reviews were being shared with the State Office. Based on the few PSPs that the Post-Move Monitor had monitored, she reported that teams required support in areas such as integrating information discussed during other portions of the PSP meeting into the community living options discussion, determining the choices of individuals who do not communicate verbally, and developing plans to overcome identified barriers such as the need for 24-hour nursing support.	
	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.	ABSSLC has engaged in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. This has taken a number of forms, including: ▪ On 9/22/09, a provider fair was held. It appeared from the sign-in sheets that it was well attended by providers, individuals, and Facility staff. According to the Admissions/Placement Coordinator (APC), not all families were sent an invitation. Some received invitations through the QMRPs, but a mailing did not go out to all families and LARs to notify them of the event. The APC indicated that in the future such mailings would be sent. ▪ Visits to community group homes and day programs were occurring approximately one to two times per month. Such visits offered individuals and Facility staff the opportunity to obtain first-hand knowledge of what community supports are available, to meet provider staff, and potentially other people with whom they could have the opportunity to live or work. More formal tracking had begun to occur with regard to who attends these visits, particularly with regard to staff attendance. ABSSLC is encouraged to continue offering regular visits to community homes and day programs. ▪ Individuals and their guardians also were provided information through the Mental Retardation Authority (MRA) Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process. ▪ In addition, MRAs also had met with PST members in meetings designed specifically to provide information about services and supports that are available in the community. For example, this occurred in conjunction with the provider fair on 9/22/09. ▪ ABSSLC was fortunate to have a number of staff, including the Post-Move	

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		Monitor who have had experience working in the community system. This allowed the Post-Move Monitor, for example, to assist in answering questions about the community that individuals, families/LARs, or other staff may have. The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of various individuals and guardians. For example, as individuals successfully transition to community settings, with their and their guardians' permission, newsletter articles could highlight such success stories. At times, it might be helpful to match individuals and/or guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This allows someone with first-hand knowledge about the process, including the challenges as well as the successes to share information and provide support.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	In response to a request for a list of individuals who had been assessed for placement since July 1, 2009, ABSSLC provided lists of individuals who had had PSPs developed within that timeframe. In reviewing a sample of PSPs, it appeared that teams had completed the Living Options Discussion record that included a section in which teams document their decision with regard to the "most appropriate living option for the individual at the current time." At times, though, it was unclear what criteria teams were using to make their decisions. This was complicated by the fact that barriers to placement were not consistently identified. The following provides an example of this issue: ▪ The Living Options Discussion Record in Individual #456's 1/28/10 PSP listed his current medical diagnoses as well as historical health information. His team concluded that Individual #456's "medical condition could prevent him from living in an alternate setting. Staff and medical staff are familiar with [Individual #456] and know when he is getting sick so they are able to respond promptly. He gets pneumonia frequently and has frequent stays (sic) the campus infirmary. The current setting has an LVN and RN assigned to the home. There is a treatment room on campus that is utilized for emergency situation and/or medical needs after hours. There is a physician on call. There is also an infirmary on campus that is familiar with [Individual #456] and his needs. This allows him to remain on campus while his needs continue to be met. It would be best if he were to remain at the Abilene State School. This information was obtained from the annual medical summary and input from team members." The team concluded that ABSSLC was the most appropriate living option for Individual #456. Review of the medical summary referenced in the team's	

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		discussion notes as well as the annual nursing assessment revealed that Individual #456's only hospital admission during the preceding year was for a colonoscopy. His physician concluded that: "Overall, [Individual #456's] medical condition is stable." His active problem list included "recurrent fevers with limited pneumonia." The nursing assessment did not note any infirmary admissions, and described appointments for follow-up with an ENT, an allergist, and an endocrinologist. It is unclear what specific health services the team believed were not available in the community to address Individual #456' needs. Such a lack of supports and services need to be specifically identified as obstacles, and an action plan developed to overcome the obstacle. During upcoming monitoring visits, the Monitoring Team will continue to review the Facility's progress in this regard, including the process being used by team to assess individuals for placement.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	With regard to the timeliness of the Community Living Discharge Plans, it appears that many were developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. For example: ▪ According to an interview with the APC and Post-Move Monitor, Individual #389 required additional transition visits to his new community home. A major reason for this was due to his visual impairment, and his need to become familiar with a new environment. Due to the timing of the development of the CLDP, these were not included as part of the plan. Staff reported that the additional visits occurred, but they were not part of a comprehensive transition/discharge plan. Community Living Discharge Plans were reviewed for six individuals. This sample was drawn from the list of 11 individuals whom the Facility identified as having had a CLDP developed since July 1, 2009.	
	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	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, many of the CLDPs did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals.	

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	provider staff.	The monitoring activities were identified in the CLDPs, including the role of the MRA, as well as the role of Facility staff in the post-move monitoring and follow-up process. The following provide examples of some of the concerns noted with regard to the CLDPs reviewed with respect to defining the role of the Facility staff in the transition process: ▪ Generally, all of the individuals who were transitioned had some plans being implemented at the Facility such as Behavior Support Plans, Physical and Nutritional Management Plans, and Nursing Care Plans. The CLDPs did not define Facility staff's role in assisting community provider staff to learn about these plans and their implementation. ▪ Although from interview, it appeared that ABSSLC staff were assisting in the transition by accompanying individuals to their new homes, and attending portions of pre-move visits, this was not formalized in the CDLPs reviewed. These are important transition steps for many individuals, and should be documented as required activities for those individuals who need this to make their transitions successful.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Based on the sample reviewed, teams generally identified target dates for the completion of actions steps included in CLDPs. However, teams did not consistently identify the persons responsible for action steps included in CLDPs for which Facility staff or others were responsible. Rather, the name of the provider agency or "MRA" was listed.	
	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.	From the sign-in sheets provided with the CLDPs that were reviewed, it appeared that teams consistently reviewed CLDPs with the individuals and their guardians prior to discharge. Community provider staff also participated in the meetings.	
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.	It was unclear what process was in place to ensure that written updates to assessments were completed within 45 days prior to the individual's leaving the Facility. As is illustrated below, although it appeared assessments were reviewed, documentation could not be found that any changes were memorialized in writing, or if there were no changes that this was committed to writing by each staff person responsible for the particular assessment. The following are examples: ▪ Individual #421 was transferred to the community on 1/23/10. All of the assessments included with the CDLP were over 45 days old. The CDLP referenced dates within the 45-day window, but these did not correspond with	

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		the dates on the assessments themselves. ▪ Likewise, individual #389 was transitioned to his new home on 1/29/10. All of the assessments included with his CDLP were over 45 days old. His CDLP referenced updated assessments, but these were not included in the information provided to the Monitoring Team.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility was at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways. The following provide examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ Individual #421's CDLP contained a number of essential supports related to staff training, for example, staff training on the BSP and his mealtime plan. These plan's implementation were not listed as essential, despite the fact that his PSP described, behaviors, for example, that if not addressed appropriately would potentially place him and others at risk. Specifically, a behavior support plan was in place at ABSSLC to address aggression, property destruction, and leave without authorization. The CDLP listed as a non-essential support an appointment with a community psychologist/psychiatrist within 90 days of placement. His PSP identified an "ongoing" need for psychology intervention. It is unclear why a similar requirement was not included as part of his CDLP. Again, based on the information provided about his behaviors, community staff, like Facility staff, would potentially need the intervention of a psychologist at any time. His staffing needs for 24-hour awake staff was listed as a non-essential support. It is not clear how his team would not have identified this as an essential support. It also would have been appropriate to list the level of supervision that the staff need to provide him, for example, line-of-sight, one-to-one, etc. Likewise, his 11/3/09 PSP indicated that he required weekly individual counseling to address a history of abuse and neglect. His team did not include this as an essential or non-essential support. ▪ For Individual #389, the following were examples of items included in his PSP dated 6/16/09, that would be considered essential or non-essential supports,	

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		but were not carried over to his CDLP: 1) psychiatry supports with monthly meetings with the team, and quarterly reviews; 2) an exercise program; 3) the involvement of Physical Therapy for the exercise program as well as shoe supports; 4) specialized dental services, as he required "sedation with whole body restraint;" 5) neurology follow-up in six months; and 6) water safety issues. Examples of supports that were inadequately defined in his CDLP included: 1) a requirement that he have blood pressure taken once a day, but the CDLP did not provide a description of the supports needed to accomplish this as he regularly refused to allow staff to take his blood pressure; 2) a requirement that he be seen by a psychologist within 90 days of transition despite the fact that he exhibited numerous behaviors on an ongoing basis, including food refusal, rectal digging, and self-injurious behavior; and 3) a requirement for "24 hour awake staff" with no definition of the level of supervision required by staff. As noted with regard to Section T.4 of the SA, the community provider was providing Individual #389 with a staff person devoted to him, and 30-minute checks when he was alone in his room. This was not due, however, to a clear requirement for this in the CDLP. As another example of the need for team to identify essential supports very specifically, according to the APC and Post-Move Monitor, during one of their visits to an individual who moved to the community, they identified that the medications were not locked. At ABSSLC, medications were consistently locked. However, in the community system, it appeared that this was not a requirement unless it was written into the specific provider policies. Because this was not a known issue to the Facility, locked medications had not been written into the individual's CLDP. As such nuances are learned with regard to the community system, individuals' CLDPs should include as essential supports the need for such environmental protections, as appropriate. Fortunately, the MRA worked with the provider agency to correct this issue for the particular individual whom it affected. With regard to monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, this will be reviewed at the next monitoring visit. The documentation to confirm this was not provided as part of the CLDP or post-move monitoring paperwork, likely because the Monitoring Team did not specifically request it.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the	As is discussed above in section T.1.b.1, the State had recently initiated a process of having the Post-Move Monitor attend a sample of approximately 20 PSP meeting a month to provide technical assistance as well as to monitor teams' living options discussions. It	

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	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.	did not appear that a formal process was in place, for example, a specific monitoring tool, to document the findings of this monitoring. As it was explained, information was going to be sent to the State based on observations of team meetings. From the documentation provided, it did not appear that the Facility had engaged in a quality assurance process to ensure that the community living discharge plans were developed, and the Facility was implementing the portions for which it was responsible. This will be reviewed further during upcoming monitoring visits.	
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.	The SA contemplated that it would take six months for policies to be developed and/or revised and implemented related to transition and discharge of individuals to more integrated settings, consistent with their needs and preferences. Based on policy and procedure changes at the State-level related to the individual planning process as well as the most integrated setting, at the time of the baseline review, ABSSLC had begun just recently to identify specific obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. Such changes began to be implemented for PSP meetings occurring in February 2010. As a result, the Facility had not yet had the opportunity to collect sufficient data for analysis and submission of a report to the State. The Monitoring Team looks forward to reviewing such reports as part of future reviews.	
T1h	Commencing six months from the	In response to a document request, the Facility submitted to the Monitoring Team a	

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	Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	Community Living Placement Report. The report listed individuals who had been referred by their teams for community placement between 7/1/09 and 12/31/09, including the individual's name, the date of referral, and, if applicable, the date the referral had been rescinded. The list included seven names of individuals referred, including one who had her referral rescinded due to "LAR choice." The second page of the document listed five individuals who had been transitioned to the community during this time period. A discrepancy noted between the Community Living Placement Report and an individual's PSP, included: ▪ Individual #504's PSP, dated 12/1/09, indicated in the Living Options discussion record that she had been referred to a community program. It appeared that a discharge date had been set earlier in 2009, but was cancelled due to "staff issues with the company." Individual #504 was not listed on the Community Placement Report. She also was not on the list of individuals referred for placement, or on the list of individuals who had requested placement, although her PSP clearly indicated Individual #504 had requested movement to a community home, and was asking about the status of her referral.	
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	Timeliness of Checklists: The SA anticipated that post-move monitoring would commence by December 26, 2009, for individuals transferred to community settings. To	

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	full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	obtain a baseline measurement with regard to this activity, the Monitoring Team requested a sample of the post-move monitoring checklists for six individuals. All of the individuals in the sample (100%) had had post move monitoring visits conducted. Of the 14 required visits, 11 (78%) had been documented as having been completed on time. Late visits were conducted for Individual #404 (the seven-day and 90-day visits), and Individual #421 (the seven-day visit). Content of Checklists: With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists completed had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator. For example, it was unclear from the monitoring checklists if onsite visits were conducted, which documents were reviewed, and if staff and/or the individual was interviewed. Other than a "yes" or "no" response, no additional information was provided to substantiate that essential and non-essential supports were in place. The primary reasons for conducting post-move monitoring are to identify if any protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. Generally, it appeared that issues were being identified, and followed through to conclusion. Notes identifying actions taken were documented on the forms. Often, this appeared to involve relentless follow-up activities, including calls to the provider agency, as well as the MRA. This illustrated a strong commitment to ensuring that individuals receive the protections, supports and services that they need. It is commendable, and should continue.	
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	On 2/24/10, the reviewer attended a post-move monitoring visit for two individuals who had moved to the same home, including Individual #389, and Individual #421. The 30-day meetings required by community providers were being held for each of the individuals. The Post-Move Monitor and the Admissions Placement Coordinator both attended the review. Both were helpful in providing information and guidance to the community team regarding the individuals' histories and preferences, as well as providing contact information for staff at the Facility who could be contacted to provide additional information. Although the 30-day meeting was a valuable way to gain information regarding the supports that were in place for the men, it was based on verbal report from the community team members as opposed to confirmation through document review or	

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	monitoring and shall occur before the 90th day following the move date.	observation that certain items, appointments, or staff training had occurred or been scheduled. Some of the concerns with regard to the lack of thoroughness of the CDLPs became apparent during the meetings for each of the individuals. For example: ▪ During the 30-day meeting for Individual #421, a question arose about how often he should see the dermatologist. This was not included in his CDLP, but should have been. His CDLP merely included a statement that the provider should establish services with a primary care physician within 30 days, and a dentist within 90 days. To ensure the adequate provision of medical supports in the community, all required medical contacts should have been listed with timeframes for each. His PSP dated 11/3/09, identified seven additional health care contacts in addition to primary care and dental. ▪ During the 30-day meeting for Individual #389, the community provider expressed surprise that the individual engaged in fecal digging and smearing. Facility staff indicated that this was included in the paperwork provided. As the community provider pointed out, given the close to 500 pages of paperwork provided, it would have been helpful for this to be highlighted. Because Individual #389's CDLP merely required community staff to be trained on the BSP, there was no requirement, for example, to ensure that community psychology staff collaborated with Facility psychology staff prior to the individual being transferred. Valuable information was not passed along as a result. Individual #389 was experiencing other behavioral issues about which pre-transfer coordination might have been helpful, including refusal to eat anything unless it had peanut butter on it, and refusal to get off the van, which resulted in his breaking a van mirror, and his not being allowed back on the school bus. He also was refusing to have his blood pressure taken, resulting in required daily blood pressures not being taken. His CDLP merely required 24-hour awake staff with no definition of what level of supervision he needed. Fortunately, based on his needs, the community provider was offering him one-to-one supervision, with 30-minute checks when he was alone in his room. Because this level of staffing/protection was not written into the CDLP, it was not something that the post-move monitoring process could help to ensure was in place. One concern noted with regard to the documentation from this review was that Individual #389's CDLP included an essential support for his blood pressure to be taken twice a day. As noted above, the community provider staff said he was not allowing this	

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		to happen, and asked for suggestions about how to complete this task. The post-move monitoring form for the visit indicated that this essential support was in place. The seven-day monitoring had documented it as complete as well. This is an issue that requires additional follow-up.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no	While on site, the reviewer asked about alternative discharges and was only provided the name of one individual, specifically, Individual #380. Based on a review of the discharge summary completed for Individual #380, it appeared to meet the CMS requirements as it included a summary of the individual's developmental, behavioral, social, health, and nutritional status. It was unclear, however, why it was considered an alternate discharge because it did not meet any of the criteria listed in the SA. Individual #380's family had pursued another placement without the knowledge of ABSSLC staff. The transition was to a private facility in Texas. Although ABSSLC was not involved in the identification of the new provider, it is not clear why attempts were not made to involve the family and provider in a full transition process as required by the SA. If such attempts were made, documentation to this effect was not provided. It also should be noted that in response to the document request for a list of individuals for whom alternate discharges were completed, ABSSLC submitted three PSPs, including PSPs for Individual #124, Individual #189, and Individual #349. All were in different stages of the community living options process. Individual #349 was pursuing	

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	commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	community visits to assist in his decision-making; Individual #189's team did not believe a community referral was appropriate; and Individual #124's 11/5/09 PSP indicated she was being referred for community placement, and would attend pre-placement visits. Individual #124 was on the referral list. It did not appear, however, that any of these individuals met the criteria for an alternate discharge. It is unclear, therefore, why this information was provided in response to this document request. It likely was a misunderstanding of the documents requested. The Monitoring Team did not identify this issue while on site, so did not clarify this.	

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

1. The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
2. Consideration should be given to beginning the process of developing the CLDP much sooner in the process to ensure that a comprehensive plan is developed, and that there is time to implement an adequate transition process.
3. Essential and non-essential supports need to be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process needs to be better defined. As nuances, such as provider variability with regard to the locking of medication cabinets, are learned with regard to the community system, individuals' CLDPs should include essential supports to address the need for such specific protections, as appropriate.
4. Teams should be provided with additional competency-based training on the identification of obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. Such obstacles should be defined in terms of protections, services, and supports that currently are lacking or not available in the community. Obstacles also should be defined with sufficient detail to allow the State to identify and address issues related to the current community system. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, the timeliness with which services can be accessed in the community (e.g., certain types of medical services) may be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes.
5. Likewise when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the State.
6. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be

competency-based.

7. With regard to Post-Move Monitoring, clear expectations should be established with regard to the process that needs to be used for monitoring, and the documentation that needs to be maintained.
8. Post-Move Monitoring Checklists should include: 1) a description of the monitoring methodology (e.g., documents reviewed, people interviewed, observations made); and 2) information to substantiate conclusions that essential and non-essential supports are in place, and/or steps being taken by the provider agency to ensure that such supports and services are provided.
9. Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.
10. Only alternate discharges that meet the definitions in the SA should be addressed using the truncated CMS-mandated format. With any transition that does not meet the definitions set forth in Section T.4 of the SA, the transition/discharge process required by the SA should be used. If an individual or LAR refuses to participate in the required CDLP process, then this should be documented.
11. Additional follow-up should be conducted with regard to Individual #389's refusal to have his blood pressure taken, and the community provider's request for assistance to ensure provision of this essential support.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 592. Rights of Persons with Mental Retardation, Subchapter A. General Provisions, Section 592.054. Duties of Superintendent or Director; o ABSSLC Facility Human Rights Committee Policy, revised 1/8/10; o ABSSLC Guardianship Policy, revised 1/8/10; o List of individuals served for whom some had been assigned a priority score, undated; o ABSSLC Comprehensive Functional Assessment, dated 1/30/08; o ABSSLC Rights Assessment, revised June 2007; o ABSSLC Guardianship Priority Tool, undated; o Summary of interest by current guardians of individuals at ABSSLC becoming guardians for other individuals; o Minutes from Guardianship Assistance Program, dated 1/27/10; o Letters sent 2/18/10 to current guardians who have expressed interest in obtaining guardianship for another person; o Physician's Report of Medical Exam form; and o PSPs and related assessments for Individual #27, Individual #69, Individual #83; Individual #117, Individual #189, Individual #199, Individual #268, Individual #277, Individual #341, Individual #357, Individual #358, Individual #380, Individual #381, Individual #389, Individual #404, Individual #408; Individual #421, Individual #429; Individual #452; Individual #456, Individual #475; Individual #496, Individual # 504; and Individual #514 ▪ **Interviews with**: o Jill Antilley, Acting Ombudsman
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

	Summary of Monitor's Assessment: At the time of the review, DADS Central Office was still in the process of developing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. The ABSSLC policy on guardianship, dated 1/18/10, did not address the need to develop a prioritized list of individuals who lack capacity to make informed decisions and who do not have a guardian. ABSSLC had developed a tool, however, to assist teams in determining an individual's priority level with regard to guardianship. With some modifications, this tool appeared to be a positive step in providing an objective methodology for prioritizing the list of individuals who needed guardians. Reportedly, the Facility was close to finalizing a prioritized list. Concerns related to the process used by PSTs included the following: 1) the process used to determine an individual's ability to provide informed consent was vague and did not appear to be directly related to specific and adequate assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship. ABSSLC had taken some steps to identify potential guardians for individuals who needed them. Specifically, staff had approached guardians of individuals currently living at ABSSL to determine their interest in becoming guardians for others. Some interest was expressed. To address concerns about funding for the guardianship process, staff approached the Guardianship Committee that had some funds available for this purpose. An application process was made available to current guardians to request funds to pay the fees associated with filing for guardianship for individuals on the priority list.

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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	Staff indicated that DADS Central Office was still in the process of developing a policy on guardianship and consent that is expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. ABSSLC's policy on Guardianship, revised 1/8/10, did not address the process required by the SA of maintaining a prioritized list of individuals needing guardians. The Facility policy described guardianship and the types of guardianship available. It also had a section on the Facility's position on guardianship, and possible reasons to seek guardianship for an individual. Appropriately, the policy clearly stated that guardianship "is an extreme measure that involves removing a person's rights," and should only be used "when there are no other alternatives." Of concern, the section on reasons to seek guardianship did not mention an individual's lack of capacity to make informed decisions. Rather, it provided a list of situations that might dictate the need for	

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	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.	guardianship. Although some of the situations listed (e.g., use of restrictive practices, and life threatening conditions requiring treatment decisions) might assist teams in determining a priority level for obtaining guardianship, the underlying reason for pursuing guardianship should not be the situation, but always the individual's assessed inability to make informed decisions in particular areas. In addition, some of the items listed potentially were illustrative of perceived "bad" decision-making as opposed to an individual's inability to make an informed choice. For example, items on the list included: "A person served with a problematic placement history (leaving group homes to live in substandard conditions, associating with people of notoriously bad character, etc.) is once again referred for placement," and "A person served with a history of medication noncompliance or aftercare/followup (sic) noncompliance is referred for community placement." These are examples of decisions that staff may perceive as inappropriate, but are not automatically indicative of a lack of capacity to make informed decisions. Upon interview, staff reported that ABSSLC was in the final stages of prioritizing the list of individuals who needed guardians. A document, entitled "Guardianship Priority" was developed and provided to QMRPs to assist teams in determining an individual's priority need level for guardianship. This form appeared to be a helpful tool. The following comments are offered to assist the Facility in further refining the tool: 1) the medical issues section only provides two options, including routine care or 24-hour nursing supports. It would be helpful to provide teams with additional options related to the frequency of healthcare decisions that have to be made that require informed consent (e.g., invasive procedures, use of chemotherapy, surgery, use of restraint or sedation for the completion of medical appointments, etc.); 2) individuals who currently have DNR orders in place, but who do not have guardians should be considered to have a priority need for a guardian; 3) the financial section appeared to be weighted in the opposite direction of the other indicators. For example, a person with an abundance of income was weighted as a "1," and a person who has no income is weighted as a "3". When this was compared to the behavior section, a person who does not have a behavior plan is weighted as a "1", indicating a lower rather than higher need for a guardian; and 4) terms such as "abundance of money" should be further defined. As part of the annual individualized planning process, individual teams at ABSSLC were identifying whether an individual had a Legally Authorized Representative or not. According to documentation provided and an interview with the Acting Ombudsman, teams utilized the Rights Assessment that was completed prior to each individual's annual Personal Support Plan meeting, the ABSSLC Comprehensive Functional	

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		Assessment, and the individual's "psychiatric stability" to make a determination regarding whether an individual was able to make informed decisions. Some of the concerns related to the process used at the time of the review included the following: 1) the process that teams were using to determine an individual's ability to provide informed consent was vague, and did not appear to be directly related to specific and adequate assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship. Each of these concerns is discussed in further detail below: <u>Process Used to Determine Individuals' Capacity to Make Informed Decisions:</u> Section J of the "Rights Assessment" discusses the ability of the individual to give or withdraw informed consent. For each individual, "[b]ased on assessments and the annual review process, the PST [determines] that he/she in **unable** to give informed consent in the areas noted below." Areas that may be identified by the team include medical, programmatic, financial, restrictive/intrusive practices, media/photo, and release of records. At the time of the review, it was unclear how teams were using information from, for example, the ABSSLC Comprehensive Functional Assessment to reach conclusions regarding individuals' ability to provide informed consent in the various areas identified in the "Rights Assessment" document. Other assessments such as psychological, psychiatric or medical evaluations, that could have provided teams with insight into an individual's decision-making capacity, did not consistently comment on capacity to make decisions. Facility staff interviewed recognized guardianship as a restrictive procedure that, at times, was necessary to protect an individual who has limited ability to make informed decisions. Likewise, the Texas Guardianship Statute recognized guardianship as a restrictive procedure that requires due process. The statute also offered limited guardianship as a less restrictive option to full guardianship. Therefore, it is important for assessments of an individual's capacity to provide informed consent to detail the areas in which he/she is able to make informed decisions as well as those areas in which they cannot make such decisions. Although the "Rights Assessment" attempts to do this, it again was unclear how teams were objectively making decisions about what areas an individual was and was not able to provide informed consent. Further, it is important for such assessments to identify if there are supports or	

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		resources that could enable a person to make informed decisions, or increase their capacity to make such decisions. The following is an example that illustrates these concerns: ▪ Individual #452's 1/20/10's PSP did not include a service objective to assist her in identifying a guardian. Her 1/20/10 Rights Assessment indicated that she could not give or withdraw informed consent in any of the areas reviewed. It stated: "[Individual #452] is non-verbal and the team noted that when she was asked these questions, she did not give any type of response showing that she understood what was asked." It did not appear that any formal evaluation was completed or referenced by the team in making this determination. Of concern, Individual #452 has had a DNR order in place since 2003. This is discussed in further detail above in the section of this report related to Section L.1 of the SA. As noted above, it was unclear who approved the DNR as Individual #452's team had documented that she was unable to provide informed consent, and she had no guardian. Individual #452 was not included on the prioritized list of individuals requiring guardians provided by the Facility. <u>Recommendations to Increase Decision-Making Capacity or Pursue Guardianship</u>: Even when teams identified concerns with regard to an individual's ability to provide informed consent, this did not appear to result in a action plan within the PSP to either provide supports to increase the person's capacity, or to pursue guardianship as an alternative. Some individuals may be able to give or withdraw informed consent with additional education or when information is provided in alternative formats.	
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	ABSSLC had taken some actions to identify potential guardians. Specifically: ▪ The Facility sent a letter to the guardians of individuals currently residing at ABSSLC to ask if they would be interested in becoming the guardian for an individual who does not currently have one, but needs a guardian. Eight current guardians expressed interest. ▪ One of the concerns related to pursuing guardianship was the cost involved. The ABSSLC Guardianship Committee had received an $8,000 grant in years past to assist families interested in pursuing guardianship to pay these costs. In addition, a private donor made of gift of $10,000 for the same purpose. According to the minutes, at the 1/27/10 meeting of the Guardianship Assistance Program, the Committee discussed the issue of current guardians being interested in becoming guardians for individuals who need them, but needing assistance with the guardianship costs. It was decided that funds could	

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	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.	be used for this purpose. Interested guardians would need to submit an application for review by the Committee. Part of the consideration reportedly was whether the individual had funds that could be used for this purpose. On February 18, 2010, a letter was sent to the list of guardians who are interested explaining the application process. The Acting Ombudsman reported that another alternative that could be considered is the use of private guardianship organizations. This likely requires monthly payment by the individual for the guardianship services. The Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators may be appointed to assist the court in evaluating the need for guardianship as well as the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings included family members as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs and preferences, teams could potentially provide valuable information both in terms of written reports as well as verbal information regarding individuals who become the subject of guardianship proceedings. A meeting is being scheduled with the Monitoring Panel and the State to further discuss the guardianship process. However, at this juncture, it is unclear what, if any, role the State views Facility staff as having with regard to guardianship proceedings.	

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

1. The State should finalize the state policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);

c. A standard tool/process for identifying priority with regard to the need for guardianship. Individuals who currently have DNR orders in place, but who do not have guardians, should be given high priority on the list of individuals for whom guardians are being sought; and
d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court.

2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
3. Once the State policy is finalized, ABSSLC should modify its policy on guardianship to reflect the State policy. In modifying its current policy, ABSSLC should ensure that the need for guardianship is clearly linked to an individual's ability to make informed decisions as opposed to situations in which an individual may make an informed yet perceived "bad" decision.
4. Consideration should be given to further refining the ABSSLC form designed to help teams identify priority levels for individuals who need a guardian. Specifically: 1) the medical issues section should be expanded to include, for example, the frequency of healthcare decisions that have to be made that require informed consent (e.g., invasive procedures, use of chemotherapy, surgery, use of restraint or sedation for the completion of medical appointments, etc.); 2) individuals who currently have DNR orders in place, but who do not have guardians should be considered to have a priority need for a guardian; 3) the financial section should be weighted so that the numbering that represents the priority level is consistent with other sections; and 4) terms such as "abundance of money" should be further defined.
5. ABSSLC should complete the process of identifying individuals who need the support of a guardian, and prioritizing the list.
6. ABSSLC should continue its efforts to identify potential resources for guardians as well as funding for the guardianship process.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS policy #020 entitled "Recordkeeping", dated 9/28/09; o ABSSLC Recordkeeping Procedures, dated 9/17/08; o Index for ABSSLC Record System, revised 12/09; o ABSSLC Procedures for Routing of Medical Reports, dated 9/17/09 ▪ **Interviews with**: o Kalana Allen, Records Coordinator
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: At the time of the monitoring visit, the State was in the process of revising the Table of Contents for the unified record. The Records Management Department at ABSSLC anticipated the finalization of the new State requirements within a few weeks of the monitoring visit. The Records Coordinator described a detailed and thoughtful plan to convert all individuals' records to the new format within a two-week period of time. At the time of the review, no auditing of records was being completed. A Unified Records Coordinator had been hired, and one of this staff member's duties was to begin completing a records auditing process.

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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.	At the time of the monitoring visit, the State was in the process of revising the Table of Contents for the unified record, and had asked the Monitoring Panel for input regarding the new format before it was finalized. The Records Management Department at ABSSLC anticipated the finalization of the new State requirements within a few weeks of the monitoring visit. The Records Coordinator described a detailed and thoughtful plan to convert all individuals' records to the new format within a two-week period of time. The goal was to ensure that this process was as least disruptive to the delivery of supports and services as possible. The implementation of this plan was dependent on support staff at the unit level having the time to concentrate their efforts on the completion of the tasks involved, despite other responsibilities. The plan also included a process for training staff on the new record format. During future reviews, the Monitoring Team will review records that are in the new format.	

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V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development. At ABSSLC, the Records Management Department was overseeing the updating and revision of Facility policies. The Records Management Department had requested that each department review related policies, and submit changes by 2/28/10. The Records Management Department identified the need to ensure consistency in language as well as to reorganize policies within the manual for ease of use. It was unclear if any review and approval process was in place, for example, by executive staff and/or State office staff to ensure the adequacy of policies and their consistency with State policy.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	At the time of the review, no auditing of records was being completed. A Unified Records Coordinator had been hired, and one of this staff member's duties was to begin completing a records auditing process. The Monitoring Team will review this process during future reviews.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	During the review, it was noted that a number of documents had to be located since they were not timely filed in the medical records. This was a consistent problematic issue throughout the review process while on site. Both the Chief Nurse Executive and the QE Nurse verified that there were on-going problems with record keeping due to the lack of adequate staff assigned to file documents in the records. The Facility needs to ensure that documents are timely filed in the medical records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.	

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

1. Facility management should ensure that the Records Management Department has the support it needs to complete the conversion of records to the new format as expediently and accurately as possible so as to reduce the impact on the delivery of supports and services.
2. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures.
3. Monitoring tools and procedures should be finalized and implemented to allow regular review of records, analysis of data, and the development and implementation of action steps/plans to address individual as well as systemic issues as they are identified.
4. If one does not already exist, a procedure should be established for Facility policies to be reviewed and approved at the Facility-level and/or State-level. Such a review should be completed to ensure compliance with the Settlement Agreement as well as applicable laws and regulations.
5. The Facility should ensure that documents are timely filed in the medical records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.

Health Care Guidelines

SECTION I: Documentation
Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Individuals' medical records as noted in previous sections
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
Summary of Monitor's Assessment: A review of a number of individuals' medical records indicated that there were some problematic issues with the legibility of some of the nursing and physician notes rendering some of them impossible to read. Most progress notes reviewed included the complete date and time. However, there were several instances in which it was difficult to identify the professional title of the staff who wrote a progress note due to legibility issues. In addition, some signatures were difficult to decipher. Also, the format of the progress notes was inconsistent regarding the use of the SOAP (Subjective, Objective, Assessment and Plan), or DAP (Data, Assessment, and Plan) format. No inappropriate late entries were found in the records reviewed. Although there were a number of comprehensive and clear progress notes written by different disciplines, the communication between disciplines was not readily apparent from most of the notes reviewed.

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

1. The disciplines should ensure that all entries in the medical records are legible, accurate and clearly written to facilitate effective interdisciplinary communication, and to provide a means of assessing and evaluating individual care. The full signature and professional title of the writer also needs to be legible.
2. The disciplines should document communications with the interdisciplinary team members, including the content of discussions, and any health care decisions or recommendations that result.
3. The disciplines should consistently document the content of integrated progress notes concerning health problems in the appropriate format selected by the Facility (i.e., SOAP or DAP).

SECTION II: Seizure Management
Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Medical records for the following individuals: Individual #140, Individual #294, Individual #408, Individual #437, Individual #130, Individual #361, Individual #331, Individual #492, Individual #75, Individual #99, and Individual #148
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
Summary of Monitor's Assessment: A review of the medical records for 11 individuals with seizure disorders found that Seizure Records for all 11 individuals were incomplete. Several

dates were left off of the forms as well as the signatures of the staff that were completing the forms. In addition, a significant number of nursing assessments, and vital sign sections were left blank on the forms. In only a few cases was there a note directing the reader to see the progress notes for the vital signs and assessment. The Facility needs to determine where nurses' should document their assessments post-seizure activity so that there is not duplication or omissions. In addition, there was no place on the seizure record to record any precipitating factors or pre-ictal signs or symptoms as required by the Healthcare Guidelines. None of the individuals reviewed had status epilepticus.

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

1. A system should be developed and implemented to monitor the documentation requirements regarding seizure activity.
2. Documentation requirements should be reviewed regarding seizure activity to ensure that there is no need for duplication on the seizure record and in the integrated progress notes, and that the forms used are in alignment with the Healthcare Guidelines.

SECTION III: Psychotropics/Positive Behavior Support

Steps Taken to Assess Compliance: Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K).

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K) for information related to the use of psychotropic medication and Positive Behavioral Support Plans.

Recommendations: Please see the recommendations for Section J and Section K of the Settlement Agreement.

SECTION IV: Management of Acute Illness and Injury

Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.

Recommendations: No additional specific recommendations are offered at this time.

SECTION V: Prevention

Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.

Recommendations: No additional specific recommendations are offered at this time.

SECTION VI: Nutritional Management Planning	
Steps Taken to Assess Compliance: Please see sections above that address Section O of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Section O of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION VII: Management of Chronic Conditions

Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

- **Review of Following Documents**:
  - Individuals' Nursing Care Plans as noted in previous sections

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment:
A review of Nursing Care Plans for chronic conditions such as Hepatitis, Congestive Heart Failure, and issues with skin integrity found that there was a significant lack of interventions addressing the prevention of complications related to the chronic condition. In addition, assessments listed in the Nursing Care Plans were only focused on the signs and symptoms of the illness, not activities or interventions designed to relieve the particular symptoms of the chronic condition. In essence, the Nursing Care plans' focus was on illness rather than health promotion.

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

1. The Nursing Care Plans' focus should shift from assessing for only illness to health promotion and proactive, preventative healthcare.

SECTION VIII: Physical Management

Steps Taken to Assess Compliance: Please see sections above that address Sections O and P of the Settlement Agreement.

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Please see sections above that address Sections O and P of the Settlement Agreement.

Recommendations: No additional specific recommendations are offered at this time.

SECTION IX: Pain Management

Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

- **Review of Following Documents**:
  - Annual nursing care plans and quarterly assessments

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment:
The current practice regarding pain assessments at ABSSLC was to conduct an assessment every quarter on the Nursing Quarterly Assessments. However, in most cases, this assessment indicated that the individual was not experiencing pain at the time of the assessment. The Facility needs to develop and implement a system to track individuals who experience chronic and acute pain.

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

1. The Facility should consider developing and implementing a system to monitor and track individuals who experience both chronic and acute pain in order to assess clinical care and outcomes regarding pain management.

List of Acronyms

Acronym	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABSSLC	Abilene State Supported Living Center
ACP	Acute Care Plan
AED	Antiepileptic Drugs
AEM	Antiepileptic medication
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
BCBA	Board Certified Behavior Analyst
BID	Twice a Day
BM	Bowel Movement
BSP	Behavior Support Plan
CCC	Certificate of Clinical Competence
CDC	Centers for Disease Control
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CPR	Cardio Pulmonary Respiration
CRIPA	Civil Rights of Institutionalized Persons Act
DADS	Texas Department of Aging and Disability Services
DAP	Data, Assessment, and Plan
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DRR	Drug Regimen Reviews
DSHS	Department of State Health Services
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
E.coli	Escherichia coli
ECU	Environmental Control Unit
EEG	Electroencephalogram
EGDs	Esophagogaastroduodenoscopies
ENT	Ear, Nose and Throat

ER	Emergency Room
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
HST	Health Status Team
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facilities for Persons with Mental Retardation
IDEA	Individuals with Disabilities Education Act
IDT	Interdisciplinary Team
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IV	Intravenous
J-tube	Jejunostomy Tube
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
MH	Mental Health
MHMR	Mental Health Mental Retardation
MIVI	Multiply Impaired/Visually Impaired
MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Assistant
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
NM	Nutritional Management
NMT	Nutritional Management Team
NP	Nurse Practitioner
OCD	Obsessive Compulsive Disorder
OIG	Office of Inspector General
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Adaptive Living Skills

PBS	Positive Behavior Support
PBSP	Positive Behavior Support Plan
PEG	Percutaneous Endoscopic Gastrostomy
PFW	Personal Focus Worksheet
PLACHECK	Planned Activity Check
PMAB	Prevention and Management of Aggressive Behavior
PNMT	Physical Nutritional Management Team
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PO	By mouth
PP	Permanency Plan
PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)
PROM	Passive Range of Motion
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapist
PTA	Physical Therapist Aide
PTSD	Post Traumatic Stress Disorder
PFW	Personal Focus Worksheet
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
ROM	Range of Motion
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAO	Skill Acquisition Objective
SAMS	Self-Administration of Medications
SFBA	Structural and Functional Behavior Assessment
SGA	Second-generation Antipsychotic
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment and Plan
SPCI	Safety Plans for Crisis Intervention
SPD	Sensory Processing Disorder
SPO	Specific Program Objective

SSLC	State Supported Living Center
SSO	Staff Service Objective
STD	Sexually-transmitted disease
TID	Three times a day
TIMA	Texas Implementation of Medical Algorithms
TMAP	Texas Medical Algorithm Project
TST	Tuberculin Skin Test
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulators
VRI	Viral Respiratory Infection