United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

Dates of Review: October 4 through 8, 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 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 (SA), 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 were considered baseline reviews. Compliance reviews began in July 2010, and are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Austin State Supported Living Center.

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 a section of the report for which another team member had primary responsibility. For this review of Austin SSLC, the following Monitoring Team members had primary responsibility for

reviewing the following areas: Elizabeth Jones reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Edwin Mikkelsen reviewed psychiatric care and services; Wayne Zwick reviewed medical care, dental services, and pharmacy services; Victoria Lund reviewed nursing care, restraint, and safe medication practices; Susan Thibadeau reviewed psychological care and services, restraint, 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 might help the Facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and Facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the 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) **On-site review** – During the week of October 4 through 8, 2010, the Monitoring Team visited Austin 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 on-site 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 on-site 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 assurance 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. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their residences 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.

III. **Organization of Report –** The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report 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) **Facility's Self-Assessment:** No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(c) **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;
(d) **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;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for 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. However, it is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the 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

The Monitoring Team would like to thank the management team, all of the staff, and the individuals who live at AUSSLC for their assistance during the on-site monitoring visit, as well as in preparation before the visit, and the production of

many documents after the visit. Everyone with whom the Monitoring Team spent time during the on-site review was helpful in providing valuable information to assist the Monitoring Team in reviewing the Facility's status with regard to the Settlement Agreement.

At the outset, it is important to note that since the baseline review, a number of positive changes had occurred at the Facility, and these changes were beginning to have a positive impact on the protections, supports, and services provided to individuals who AUSSLC supported. Since the baseline review, a new Director had begun to work with the Austin team, and together they had been able to take a number of steps to begin the change processes necessary to ensure that individuals were protected from harm, and were provided with adequate treatment and habilitation. Although the Facility had many improvements still to make, it appeared that the groundwork was being laid for such modifications to be successful.

The new Director had an open door policy of which many staff had taken advantage. During the course of the review, it was clear that when issues were raised that required attention and support to allow staff to do their jobs, the new Director and the Assistant Directors were willing to work with members of the management team to obtain resources and ensure that staff had the necessary skills and competencies. This was evident, for example, with discussions regarding nursing, and physical and nutritional supports. The entire management team is encouraged to work in collaboration with the new Director and the Assistant Directors to effectuate meaningful changes for, most importantly, the individuals, but also staff working at the Facility.

It is important to specifically note that a number of significant concerns related to the ability of AUSSLC to protect individuals from harm were noted in the baseline report. Since that time, a number of initiatives had been put in place to address many of these concerns. Overall, AUSSLC had made a good faith effort to develop safeguards that would protect the individuals and staff from harm. As previously stated, many of these initiatives were in the early stages of implementation, some would take time to result in positive change, and still others needed to be developed and implemented. The following provides a summary of the concerns identified in the baseline review, actions that had been taken at the time of the most recent on-site visit, and areas of continuing concern:

- At the time of the baseline review, there were a number of staffing constraints at AUSSLC, making it difficult to consistently provide a safe environment. A number of important steps had been taken to correct these issues. For example, according to the Facility Director:
  - All direct support professional positions had been filled, allowing the Facility to discontinue the use of staffing agencies. In fact, the fill rate was 106 percent;
  - A "float pool" had been created to allow coverage when staff were on leave or reassigned;
  - The pay for direct support professionals had been increased by 10 percent in an effort to decrease turnover;

- "Employee of the Quarter," and "Employee of the Year" programs were being devised to provide incentive plans. Incentives included having a designated parking spot, receiving recognition through a certificate, and being awarded administrative leave;
- Other creative strategies for retaining staff were being considered and implemented;
- A new staffing configuration of four 10-hour days was being piloted in two residences;
- Staffing had been reconfigured, and a Home Supervisor was now assigned to each residence on campus. Previously, Home Supervisors had been responsible for up to three residences; and
- Beginning in July 2010, monthly Town Hall meetings had begun at which staff were encouraged to voice their concerns, in addition to suggestion boxes that had been placed around campus.
- Based on the Monitoring Team's interviews with direct support professionals, morale had begun to improve. They reported less mandated overtime, and less use of "pulled" staff.

These changes in staffing were impressive, but the full impact had not yet been seen. It would be expected that it would take some time for the full effects of improved staffing to be seen.

- The impact of inadequate staffing was evident during the baseline review. Specifically, in certain residential units, there were repeated observations of the failure to attend sufficiently to individuals with significant needs for support. For example, in some residences, there was a serious failure to monitor behavioral issues as required by behavioral support plans, physical and nutritional management plans, and other essential supports. As is discussed in further detail in Sections K and O, at the time of the most recent review, there were still concerns in these areas. Although there had been increases in numbers of staff, competency-based training of staff continued to be an area of significant need.
- A number of steps had been taken to reduce the dehumanizing practices observed during the baseline review, but work continued to need to be done. For example:
  - There had been an effort to personalize individual's haircuts. An additional hairdresser had been hired. In addition to asking individuals what type of haircut they wanted, pictures of various hairstyles were being shared with the individuals and their guardians. The campus barber had been provided guidance on appropriate haircuts;
  - To address grooming and clothing issues, the Active Treatment Team had developed and was implementing a checklist to monitor, and identify corrective actions that were needed;
  - The grates that had been on the windows in some of the residences had been removed;
  - During the baseline review, problems were noted with the general conditions at the Facility, such as residences lacking all but basic furniture, and others being in disrepair or poorly kept, and what appeared to be vacant buildings with broken windows. To address this, a Campus Beautification/Restoration Committee and an Extreme Makeover Committee been formed. Some of these efforts were beginning to show results. For example, one of the residences on campus had been newly painted, and decorations hung, and a second residence on campus was having a similar face-lift.

Additional furniture also was being purchased, but would be delivered over time. New management staff had been hired to address many of the physical plant issues on campus. It was very positive to see these changes beginning, but this was an area that continued to need significant effort.

As has been illustrated throughout the history of this field, it is essential that such practices continue to be corrected, or there is a high risk that staff will view individuals as less than human, and treat them as less than human, resulting in abuse, neglect, and other harm.

- At the time of the baseline review, there were some inappropriate groupings of individuals with very different, often unique, needs for support. Although some modifications had been made, the risk of abuse, neglect, and exploitation continued to be present in the living units.
  - The closing of living unit 772A appeared to have resulted in positive changes for the men who were relocated to other units.
  - It was reported that the Facility's census decreased by 12 individuals since the baseline visit, and that admissions were closed until staffing was stabilized.
  - Nonetheless, the number of individuals residing in each living unit continued to be seriously problematic. The most populated living unit had 20 individuals, the smallest had six, and the median was 15 individuals.
  - A number of the living areas, including, for example 772B, continued to provide poorly designed environments for safety, learning, and exercising skills. Facility Administration was in the process of reviewing options in an attempt to address some of the environments and these groupings.
  - There continued to be too many individuals, many with significant behavioral issues, living in the same residences. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. Although staffing had increased and was beginning to stabilize since the baseline visit, there remained a lack of sufficient individualized attention and active treatment. Staff were often noted to be distracted and unable to attend to each individual's needs for support. For example, in living unit 796, Individual #165 was noted to be biting her arm and hitting herself, but staff were occupied with other individuals and did not intervene to stop her. On the second shift, in living unit 793, individuals were pacing the room, and jumping up and down, but there were no meaningful activities underway and staff were otherwise engaged with other individuals.
  - The placement of adolescents/young adults with older adults violated acceptable practice and should be corrected without delay. For example, in living unit 778, Individual #98 was a minor and was placed with adults who required supervision due to their behavior.

These issues 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 might be used at a higher rate than it would in a setting with fewer individuals that afforded the individuals additional personal space. To adequately

protect individuals from harm, it will be necessary to continue to restructure the environments at AUSSLC, including a reconsideration of the number and active treatment needs of the individuals placed in each living unit.

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at Austin State Supported Living Center:

Quality Assurance

- AUSSLC continued to work carefully and conscientiously to strengthen its Quality Management strategies. The Trend Analysis reports contained useful information that could be applied to decision-making about the effectiveness of active treatment, the composition and structure of residential living units, and the implementation of adequate measures to ensure health and safety. The restructuring of the Program Improvement Council was in the process of being completed, and was a needed change. A broader focus on quality enhancement would be beneficial as the Facility strives to reach compliance with the Settlement Agreement. The Facility had begun to develop and implement some corrective action plans.

Integrated Protections, Services, Treatments and Supports

- The DADS policy on integrated protections, services, treatments, and supports was issued at the end of July. A number of AUSSLC staff had been certified as trainers, and all Qualified Mental Retardation Professionals (QMRPs) at the Facility had undergone the initial training. Training also had begun to be provided to all other Personal Support Team (PST) members. The Facility had begun using the new process.

Psychiatric Care and Services

- The Psychiatry Department at AUSSLC had experienced a significant increase in professional resources in the last few years. Approximately three years ago, the Facility relied on seven hours per week of psychiatric consultation. At the time of the review, there were three full-time Psychiatrists (two of which had been added in the last year), as well as four hours per week of consultation time. The Facility also had recently added four full-time Psychiatric Nurses, in addition to the prior full-time Psychiatric Nurse. The Psychiatry Department also had added two full-time Psychiatric Assistants, who facilitated the work of the Department.
- A significant, positive undertaking had been the development of an initiative whose goal was to complete a thorough, comprehensive psychiatric assessment for individuals who had been prescribed psychotropic medication. Review of an initial sample of these assessments indicated that when this process is completed for all individuals receiving psychotropic medication, it should result in substantial progress toward meeting the provisions of the Settlement Agreement.

Psychological Care and Services

- Efforts to expand the number of psychology staff who were Board Certified Behavior Analysts (BCBAs) were commendable. Several staff had completed the certification requirements, with many others enrolled in classes. Ongoing supervision was provided on-site, enhancing timely completion of all requirements.
- Changes made to the Behavior Therapy Committee had resulted in improved internal peer review, and steps had been taken to develop an external peer review system. The Director of Behavioral Services had put effort into providing Facility-based support to improve the quality of services through the development of monitoring tools and on-site training. Expanded new employee orientation also had occurred.

Nursing Care

- Since the baseline review, AUSSLC had significantly reduced the number of nursing vacancies. At the time of the baseline review, AUSSLC had a total of 124 nursing positions with 25 vacancies. At the time of the most recent review, AUSSLC had 13 nursing vacancies. Although the number of vacancies had decreased, in order to meet the minimum staffing ratios, the Facility continued to use the services of six agencies.
- Since the baseline review, the Nursing Department had begun conducting quarterly medication observations. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube. However, competency will have to be confirmed for the auditors to ensure accurate data are generated from the observations. Also, the Facility was beginning to review its system regarding medication variances and ways to generate reliable data.

Pharmacy Services and Safe Medication Practices

- The Quarterly Drug Regimen Review (QDRR) has been redesigned, and, at the time of the review, was undergoing further change to streamline the process, provide important details, and address the various components of the SA. Attention to detail in completing the many parts of the QDRRs, as well as in monitoring DISCUS and MOSES evaluations, will lead to improved processes.

Physical and Nutritional Supports

- A number of positive training initiatives were underway with regard to physical and nutritional supports. The State Office had developed a set of training modules that were designed to provide Physical and Nutritional Management Team (PNMT) members with information about the expectations for the PNMT, as well as technical knowledge and skills. In addition, based on interview, the State Coordinator for Habilitation Therapies was planning to implement an educational case study process in which a PNMT would present an individual case to multiple PNMTs through a Webinar. The goal was to provide ongoing opportunities for peer review and clinical instruction through the observation of the assessment process of another PNMT.
- Using a matrix, the Habilitation Therapies Department had assigned individuals to the level of assistance they required during mealtimes. This was used to determine the appropriate staffing ratios for mealtimes. Based on interview, this analysis had been presented to Facility Administration for their review. The Habilitation Therapies Department was to be commended for completing this analysis designed to assist Facility

Administration in developing and implementing strategies to provide appropriate staffing ratios to support mealtime safety.

Dental Services

- The Dental Department was generally meeting the routine, preventive, restorative, and urgent care needs of the individuals who resided at AUSSLC. However, there had been issues with the timeliness of annual dental assessments, which the Dental Director was working to correct.

Communication

- The Speech Language Pathology (SLP) and Psychology Departments had agreed upon a process and procedures for SLPs and psychology staff to work together to integrate strategies to address individuals' communication needs with their behavioral needs. This had begun to happen for a few individuals.
- Since the baseline review, three videophones were in place. The videophones were located in the Augmentative Communication Lab, and Residences 772 and 501, where the individuals who used them lived.

Most Integrated Setting

- Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, they all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. Some concerns were noted with regard to the standards being used to monitor essential and non-essential supports, which was exacerbated by the lack of definition in the Community Living Discharge Plans.

Consent

- AUSSLC continued to use its valuable resources to assist them in identifying guardians for individuals. Since the baseline review, a total of eight individuals had obtained guardians. Four of these guardians were family members, and four were from Family Eldercare. AUSSLC continued to make referrals to a private, nonprofit guardianship agency called Family Eldercare. Since the baseline review, an additional five individuals were referred, with a total of 25 individuals on the waiting list for a guardian with this agency. In addition, the local Travis County Probate Court operated a Guardianship Assistance Program. This program allowed family members who wanted to petition the court for guardianship, to do so at no cost to the family member. Since the baseline review, an additional four individuals were referred to this program, with a total of 31 individuals in the referral process at the time of the review.

Recordkeeping and General Plan Implementation

- All of the active records at the Facility had been converted to the new Table of Contents required by the State Office. At the time of the review, all but two residences on campus had Individual Notebooks for each individual. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department.
- Since the baseline review, a process had been implemented requiring review of policies prior to their finalization. It required that policies be sent to the leadership group for review. The group reviewed any draft

policies to ensure adherence to State Office requirements, as well as Settlement Agreement, and regulatory requirements.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at Austin State Supported Living Center:

Restraints

- The lack of active treatment at AUSSLC continued to have an impact on behavior. Although vacancies had been filled and staffing had begun to be stabilized since the baseline visit, there continued to be a lack of consistent implementation of individualized programming. Improving the provision of active treatment is key to ensuring that restraint is not used in the absence of, or as an alternative to, treatment.
- Although the restraint checklist appeared to be used routinely, review indicated concerns with the timeliness and quality of monitoring by a nurse. In a couple of incidents, a restraint monitor was not present during the restraint, including one incident in which the monitor arrived one hour and fifty-five minutes after being notified of the initiation of the restraint.
- Debriefing forms were not attached to all of the checklists reviewed. When this form was included, it rarely noted that the restraint incident was reviewed at the unit meeting or at the Incident Management Review Team meeting. In addition, there did not appear to be much attention given to the environmental factors influencing the behavior of individuals who had been restrained.

Abuse, Neglect and Incident Management

- In interviews with the Facility Director and principal staff at AUSSLC, there was evidence of a serious commitment to prevent abuse, neglect, and exploitation of the individuals under their responsibility. However, there also was evidence of constraints impeding the timely investigation and resolution of serious incidents. For example, the workload of the two investigators had increased significantly due to the extended medical leave of the Incident Management Coordinator. Although there appeared to be a strong working relationship between the Human Rights Officer and the Assistant Independent Ombudsman, there was a lack of clarity regarding their respective roles and responsibilities. This lack of clarity resulted in unnecessary duplication of effort and confusion regarding the reporting and investigation of rights violations. In addition, the review of investigation reports provided during the monitoring visit noted deficiencies in timeliness and thoroughness of investigations.

Quality Assurance

- Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by AUSSLC. This is important for a few reasons, including providing the Facility with the ability to identify objectively individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively residences, day programs, and/or departments that require improvement, and to identify

a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place.

Integrated Protections, Services, Treatments and Supports

- As is noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning.
- Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen.
- The State and the Facility will need to ensure that person-centered concepts are incorporated to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

Integrated Clinical Services

- There had been success in some areas of integrated clinical services, such as the Pharmacy Department, in providing information so that it was available at the time of the quarterly psychiatric reviews. However, there were serious gaps in integration that will require improved communication and collaboration between departments, such as between nursing and pharmacy. The departments were beginning to identify approaches to provide integrated health services. However, the Facility's clinical departments were at the early stages of this development.

Minimum Common Elements of Clinical Care

- Although there was completion of annual medical assessments, individuals' needs were not being met for the long-term evaluation of serious recurrent processes. Many other assessments were not being completed in a comprehensive manner, or as individuals' status changed. Examples of this included nursing assessments, and assessments by the Physical and Nutritional Management Team, for individuals with complex needs.
- AUSSLC did not have an adequate Quality Assurance system that included clinical indicators. Development of such a system will require the identification of appropriate clinical indicators, as well as development and implementation of an adequate database. While a more comprehensive quality assurance system, including medical/clinical indicators is being developed and implemented, existing data should be utilized to begin to make changes that would positively affect outcomes for individuals.

At-Risk Individuals

- The Facility had developed its own risk assessment program, but there were concerns regarding the validity of the risk stratification. In the meantime, the State Office had been actively developing a risk assessment process to be used at all Facilities. At the time of the review, it had not been finalized.

Psychiatric Care and Services

- The current review identified deficits in the documentation of the symptoms that substantiate the psychiatric diagnosis, the periodic monitoring of individuals for side effects of the prescribed medications, and the empirical determination that the prescribed psychotropic medications had been established to be effective.
- Another issue was the degree to which the behaviors that were identified as targets of the psychotropic medication also were described in the Functional Analysis and Positive Behavior Support Plan as being related to environmental and behavioral factors.
- There were also concerns about the thoroughness of the evaluation process for assessing the risk versus benefit related to the prescription of a specific psychotropic medication.

Psychological Care and Services

- The Structured and Functional Assessment Reports reviewed were well-written and comprehensive in scope. Valuable information was gained from these assessment efforts. Necessary steps should be put in place to ensure that this new information, particularly as it relates to preventative and antecedent management strategies, becomes part of the individual's Positive Behavior Support Plan in a timely fashion.
- An area that remained of great concern was the data collection system. Decisions continued to be made based on data that was questionable with regard to its accuracy.

Medical Care

- A major area that needed improvement was with regard to the critical thinking used by medical staff. For many of the individuals reviewed, numerous hospitalizations should have been followed by prompt aggressive evaluations and treatments until the hospitalizations were minimized. Unfortunately, for many of these individuals, serial hospitalizations were not followed by further evaluations and consultations once they returned to AUSSLC.
- Additionally, the Medical Director should take a leadership role and engage in ongoing communication and collaboration with the Facility's Administration in resolving a complex array of problems. Without such leadership and collaboration, a number of the problems noted in the Monitoring Team's review could continue to hinder the Facility's progress in reaching compliance with the SA. Issues that needed attention included timely filing of information in the medical record, review of physician caseloads, review of nonclinical physician duties, and providing respiratory therapy services.

Nursing Care

- Consistent with the findings from the baseline review, AUSSLC continued to have a significant number of problematic issues regarding the nursing documentation addressing timely, complete, and adequate nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when the individual began showing symptoms of a change in status, and of assessments prior to the transfer to an off-site medical center, as well as upon return to the Facility.

- Consistent with the baseline findings, there were significant problems found regarding the quality of the Nursing Assessments and Nursing Care Plans. Since the baseline review, the State Office had modified the Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. At the time of the review, the Facility had implemented the modified Comprehensive Assessment form, and the new Nursing Care Plan templates. However, adequate competency-based training was not provided prior to implementation. Consequently, there was no improvement found in the quality of the assessments or care plans.

Pharmacy Services and Safe Medication Practices

- Drug Utilization Evaluations (DUEs) had begun to be completed, but had not entered the implementation phase. Once issues were identified through the review process, action plans needed to be developed and implemented, and reevaluation needed to take place to ensure necessary changes had been made. In addition, more work needed to be done to ensure that appropriate drugs were selected for review, adequate sample sizes were reviewed, and the indicators selected for review were narrow enough to allow for a thorough review.
- There should be improved communication and collaboration with the Nursing Department in order to reduce the medication error rate, and the tracking system for errors/variances. Despite an inadequate tracking system, a number of issues had been identified. Some corrective actions had been taken, but not in a systematic way, leaving many areas in which improvements needed be made.
- The Pharmacy Department was unaware of some of the medications being administered across campus or the details of such administration, such as Botox in a psychiatry clinic, and intravenous sedation in the Dental Clinic. A system should be created to ensure all medications administered on campus are reviewed and tracked through the Pharmacy Department.

Physical and Nutritional Supports

- At the time of the review, the PNMT had some dedicated or core members as required by the SA, including a SLP, Occupational Therapist (OT), and Physical Therapist (PT). A nurse had not been assigned as core members of the PNMT. The reconstituted PNMT had conducted its first assessment in August 2010, as well as one other review.
- The implementation of competency-based individual-specific Physical and Nutritional Management Plan (PNMP) training for all staff in the Infirmary and Cardinal should be a high priority. During multiple observations by the Monitoring Team, staff were not following individuals' PNMPs, which placed individuals at risk of harm. PNMPs should be integrated into Nursing Care Plans to minimize identified risk factors for individuals. The consistent implementation of PNMPs is important to ensure the health and safety of these individual at highest risk.
- Habilitation Therapies staff were completing monitoring, but it did not appear that this was resulting in improved outcomes for the individuals AUSSLC served. Non-compliance findings with monitoring indicators within residences were not being analyzed, summarized, and/or addressed. Compliance with PNMPs and dining plans should be the joint responsibility of Habilitation Therapies and all staff responsible for the provision of

supports to individuals, including but not limited to residential staff, day program and vocational staff, nurses, the Dental Department, etc. Facility Administration, in collaboration with Habilitation Therapies staff and Quality Enhancement staff, should analyze monitoring results and implement strategies to support staff compliance with individuals' PNMPs.

- Seven individuals died within the time period from January to August 2010. Five of these individuals' deaths were attributed to acute respiratory failure, chronic respiratory failure, pneumonia, and aspiration pneumonia, which indicated these individuals had physical and nutritional support needs. ,Based on review of a sample of these individuals, the Nutritional Management Team (NMT) and Health Status Team (HST) had reviewed these individuals multiple times prior to their deaths, but as stated in the baseline report, the NMT reviews consisted of a chart review leading to recommendations that did not support an aggressive approach to minimize identified health risk indicators such as aspiration pneumonia.

<u>Physical and Occupational Therapy</u>

- The current caseloads for Occupational Therapists and Physical Therapists were not sufficient to enable the therapists to be active members of the individuals' Personal Support Teams (PSTs), and were presenting significant challenges in meeting the standards set forth in Section P of the SA. The Facility, in collaboration with the Interim Habilitation Therapy Director/staff, should revisit the therapy and dietitian staff-to-individual ratio to enable these professionals to function as active members of the PST for individuals on their caseloads.
- Although individuals had OT/PT Evaluation Updates, there had not been updates when there was a change in status such as a diagnosis of aspiration pneumonia, diet downgrade, Body Mass Index (BMI) in the super obesity range, unplanned weight loss, skin breakdown, and/or community transition. In addition, assessments did not lead to the development of direct or indirect treatment plans for individuals with identified needs.

<u>Dental Services</u>

- The high rate of restraint use, chemical and mechanical, was a challenge to the department. There was no oral health outreach program in the residences. Providing teaching and training by a dental hygienist in the residences would begin to prevent the need for dental procedures requiring chemical and mechanical restraints. Additionally, there should be rigorous desensitization plans that are implemented and followed, and revised as needed until successful. Although some desensitization plans existed, it was not clear that they were being implemented, reviewed, and revised. The dentist was unlikely to be successful in reducing restraint use without desensitization being a routine part of many individual's dental care. This will require oversight by the Psychology Department, and coordination with the Dental Department.

<u>Communication</u>

- Even though two additional SLPs had been hired, the caseloads for speech language pathologists remained inadequate to allow therapists to be active members of individuals' Personal Support Teams, and provide adequate functional communication supports to the individuals. While Speech Language Pathologists were completing evaluations, some of which identified the need for augmentative/alternative communication devices,

there were not sufficient resources to provide direct and/or indirect speech therapy supports for individuals with an identified need. Only two of 376 individuals (less than 1%) living at AUSSLC were receiving direct speech services.

- To the credit of the SLPs, there were multiple individuals with communication devices on campus (low tech and high tech), as well as many generic devices, but there was not a current framework within the PSP process to integrate these devices into formal, teachable moments, such as integration into skills acquisition programs.
- In addition to offering sign language classes, the Facility had been making an effort to hire staff with fluency in American Sign Language. This had had a positive impact for one individual, but issues remained with having an adequate number of fluent staff to ensure that all individuals on campus, who used sign language as their primary mode of communication, had staff available on a regular basis who could communicate with them. The Facility must continue to seek solutions to provide an environment that enables individuals, who are deaf and/or use sign language as their primary mode of communication, to communicate with staff, peers, and the community.

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

- Comprehensive assessment of an individual's preferences, strengths, and needs continued to be an area that required improvement. Only through assessment can individuals' PSTs identify skill deficits that will lead to the development of a comprehensive plan of habilitation.
- Training objectives remained compromised. Improved descriptions of skills to be learned, enhanced scheduling for training of these skills, and clearer instructions to staff in implementing teaching programs were all areas in need of improvement.
- Observations revealed a continued absence of interesting and age-appropriate materials designed to meet the needs and preferences of the individuals served at the AUSSLC. When tasks/activities were presented they were often nonfunctional, repetitive, and involved materials that were worn or damaged.

<u>Most Integrated Setting</u>

- At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations.
- Since the baseline review, when no obstacles to individuals' movement to the most integrated setting were identified in PSPs, improvements had occurred in that the newer plans included obstacles and plans to overcome them. However, the following issues were noted: 1) the obstacles often were listed as need areas for the individual, such as behavioral issues, medical concerns, etc., as opposed to identifying services or supports that either were unavailable or did not exist in the community; 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible or timeframes for completion; and 3) the strategies

often involved services to be provided to the individuals at the Facility, but did not include identifying support configurations in the community that would address individuals' needs.

- The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be 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.

Consent

- At the time of the review, DADS State Office was still in the process of finalizing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. AUSSLC did not have any instrument or process to determine functional capacity. It was anticipated that the State Office policy would provide guidance with regard to this issue.

Recordkeeping and General Plan Implementation

- Audits were being completed of records. No action plans had been developed yet to address issues related to records. As illustrated in this report, a number of issues negatively impacting the quality and availability of records needed to be addressed through the development and implementation of action plans.

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 AUSSLC Policy: Positive Behavior Support: Limitation of Restraint as a Crisis Intervention, dated 11/24/09; o Do Not Restrain Lists; o DADS Policy #001: Use of Restraint, dated 8/31/09; o Restraint checklists and Debriefing Forms for Individual #167, Individual #83, Individual #77, and Individual #406; o Restraint documentation for the following 13 individuals: Individual #421, Individual #74, Individual #139, Individual #350, Individual #156, Individual #395, Individual #175, Individual #217, Individual #210, Individual #283, Individual #276, Individual #344, and Individual #360, from May through August 2010; o Human Rights Committee (HRC) minutes, from 4/1/10 through 9/23/10; o Restraint analysis for 5/10 and 6/10; o Restraint Trend Report for 2nd and 3rd Quarters 2010; o Crisis Intervention Restraint Summaries (CIRS) from 1/10 through 7/10; o Department of Psychology report tracking restrictive procedures, from 1/10 through 8/10; o AUSSLC Corrective Action Plan, Section C, dated September 1, 2010; o AUSSLC Supplemental Plan of Implementation (POI), Section C; o Table entitled "Most Frequently Restrained;" o List of chemical restraints, between January and August 2010; o Restraint Analysis, for May and June 2010; o Restraint Trend Report, Second and Third Quarters, FY2010; o Restraint Trend Report, July, 2010; o Crisis Intervention Restraint Summary (CIRS) Summary, January to July, 2010; o Routing for restraint checklists and debriefing reports, dated September 2010; o Restraint Documentation Work Group meeting notes, dated September 2, 2010; o Process for routing chemical restraint consultation forms, dated August, 2010; o Restraint Checklists for the following individuals: Individual #175, Individual #406, Individual #276, Individual #283, Individual #395, Individual #77, Individual #350, Individual #83, Individual #74, Individual #360, Individual #425, and Individual #139; o Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint for the following individuals: Individual #175, Individual #406, Individual #276, Individual #283, Individual #395, Individual #77, Individual #350, Individual #83, Individual #74, Individual #360, Individual #425, and Individual #139; o Structural and Functional Assessment Report (SFAR) for the following individuals: Individual #210, Individual #276, Individual #16, Individual #350, and Individual #83;

	○ Functional Analysis Report for: Individual #139; ○ Positive Behavior Support Plan (PBSP) for the following individuals: Individual #406, Individual #276, Individual #283, Individual #395, Individual #77, Individual #350, Individual #83, Individual #74, Individual #360, Individual #425, and Individual #139; ○ Safety Plan for Crisis Intervention (SPCI) for the following individuals: Individual #210, Individual #276, Individual #283, Individual #267, Individual #395, Individual #350, Individual #83, and Individual #74; ○ Staff training curriculum on the use of restraint; and ○ Restraint report, from March through August 2010. ▪ **Interviews with**: ○ Jose Levy, Director of Behavioral Services; ○ Tammy Snyder, Director of Quality Management; and ○ Bruce Weinheimer, State Coordinator for Psychological Services; ▪ **Observations of**: ○ Human Rights Committee Meeting, on 10/7/10; ○ Program Improvement Council Meeting, on 10/6/10; ○ Incident Management Review Team (IMRT) Meetings, from 10/4/10 through 10/6/10; ○ Behavior Therapy Committee meeting, on 10/5/10; and ○ Site visits to all living units and day program areas. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees, as well as some of the individuals. Particular emphasis was given to the residence at 772 B Main Street.
	Facility Self-Assessment: In its Plan of Improvement, dated 5/17/10, AUSSLC assessed its compliance with the provisions of the Settlement Agreement and found Substantial Compliance for C.3, the development of Facility policies/procedures governing the use of restraints. All other areas of this Section of the Settlement Agreement were determined still to be in noncompliance. The Monitoring Team concurs with the Facility's judgment regarding compliance with the Settlement Agreement requirements in this section.
	Summary of Monitor's Assessment: The Director of Behavioral Services appeared to be working diligently to comply with the provisions of the Settlement Agreement with regard to restraint, and to reduce the overall use of restraint. This included efforts to improve behavioral supports provided to individuals. For example, an agreement had been established with Lubbock State Supported Living Center to share external peer review responsibilities. In other words, each Facility would conduct peer review of the other Facility. This was a promising development. It is recommended that this collaboration include site visits to the respective Facilities in addition to the exchange of documents. Although the restraint checklist appeared to be used routinely, review indicated concerns with the timeliness and quality of monitoring by a nurse. In a couple of incidents, a restraint monitor was not

	present, including one incident in which the monitor arrived one hour and fifty-five minutes after being notified of the initiation of the restraint. Debriefing forms were not attached to all of the checklists reviewed. When this form was included, it rarely noted that the restraint incident was reviewed at the unit meeting or at the Incident Management Review Team meeting. Observations of the Incident Management Review Team meetings during the monitoring visit indicated that restraint episodes were reviewed. However, there did not appear to be much attention given to the environmental factors influencing the behavior of individuals who had been restrained. In particular, there was no consistent evidence of discussion of how the census and/or groupings in the larger residential units impacted behavior, whether consideration needed to be given to community placement for individuals for whom crowded environments and/or noise exacerbated their behavior, or if more integrated social/programmatic opportunities needed to be offered as alternatives to reduce the number of behavioral crises leading to restraint. The lack of active treatment at AUSSLC also continued to have an impact on behavior. Although vacancies had been filled and staffing had begun to stabilize since the baseline visit, there continued to be a lack of consistent implementation of individualized programming. As reported by the Director of Behavioral Services in his 2nd Quarter, FY 10 "Restraint Trend Report," behavioral outbursts may be triggered by "setting events." The report stated that in general, "setting events include having task demands made, having requests denied or delayed, and most prominently, preventative steps within the behavior plans and programmed activities not being implemented consistently. The barrier to this has been inconsistent staffing… Although the unit is relatively dense with psychology staff, there continues problems (sic) with direct care staff implementing programs as designed." Although the report was discussing one unit, as is discussed in greater detail with regard to Section S of the SA, the Monitoring Team's findings were that there was a failure to provide adequate active treatment throughout the Facility. Improving the provision of active treatment is key to ensuring that restraint is not used in the absence of, or as an alternative to, treatment. It should be noted that informal conversations with employees indicated greatly improved staff morale. The reduction in tension about mandated overtime and overtime compensation was a critical change that should impact favorably on staff performance.

#	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	The Facility's policy governing the use of restraint prohibited the use of prone restraint and physical restraints where the individual was supine. When queried, the Director of Behavioral Services stated that he was confident that prone restraint was not used at AUSSLC. He cited the training provided to staff; the use of restraint monitors; the historical prohibition on prone restraint; and the independent observations of staff, such as maintenance workers, not approved to implement restraint but trained to report on its use.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Based on a review of 147 restraint records involving 13 individuals, from the documentation found on the restraint checklists, there was no indication of prone restraint. There also was no evidence of restraint being used for the convenience of staff or as punishment. The above-referenced policy required that the use of restraint be limited to "…1) acute emergencies that place the individual or others at serious threat of violence or injury and only after less restrictive measures have been determined to be ineffective or not feasible…or 2) as a medical restraint." The policy also emphasized AUSSLC's commitment to reducing restraint use. It recognized that: "restraints are restrictive and potentially traumatizing or re-traumatizing experiences for our residents; damages (sic) the relationship between staff members and residents; and lessens (sic) the quality of life for the residents." The policy enumerated a list of less restrictive and less intrusive measures that were to be attempted prior to any use of restraint. The policy prohibited the use of restraint for disciplinary purposes (i.e., retaliation or retribution), for the convenience of staff or other individuals, or as a substitute for effective treatment or habilitation. It required that restraint only be used if an individual posed an immediate and serious risk of harm to him/herself or others, and after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner (e.g., verbal redirection, redirection toward a calm environment, eliminating the source of an individual's distress, etc.). At times, it appeared that environmental factors and institutional placement precipitated the use of restraint. Individuals were restrained because they became angry and frustrated when required to comply with the Facility's schedule or demands. For example, Individual #83 was restrained after he "had behaviors" because he did not get his money on time. Individual #167 was placed in restraint after she requested referral to a community placement on 8/3/10, but her guardian refused to grant approval. The relationship between her disruptive behavior and her expressed desire for an alternative placement was not explored in any of the documentation reviewed or in any of the discussions about this individual. The lack of active treatment at AUSSLC also had an impact on behavior. Although vacancies had been filled and staffing had begun to stabilize since the baseline visit, there continued to be a lack of consistent implementation of individualized programming. As reported by the Director of Behavioral Services in his 2nd Quarter, FY 10 "Restraint Trend Report," behavioral outbursts may be triggered by "setting events." The report stated that in general, "setting events include having task demands made, having requests denied or delayed, and most prominently, preventative steps within the behavior plans	

#	Provision	Assessment of Status	Compliance
		and programmed activities not being implemented consistently. The barrier to this has been inconsistent staffing… Although the unit is relatively dense with psychology staff, there continues problems (sic) with direct care staff implementing programs as designed." Although the report was discussing one unit, as is discussed in greater detail with regard to Section S of the SA, the Monitoring Team's findings were that there was a failure to provide adequate active treatment throughout the Facility. The Settlement Agreement requires that restraint not be used in the absence of or as an alternative to treatment. As the Facility has identified in its restraint trend report, there is a need to ensure that behavior programs are implemented consistently, and that individuals are provided with adequate treatment. Moreover, as is discussed in further detail below with regard to Section C.7, the individuals who had been restrained more than three times in a 30-day period had PBSPs. However, some issues were noted with regard to the quality of these plans. Again to ensure that restraint is not used in the absence of adequate programming, necessary improvements to PBSPs need to be made.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Following the baseline visit, the restraint checklist revised by the State Office was adopted at AUSSLC. This form provided a release code (L) that specified that an individual should be released immediately when he/she was no longer an immediate and serious risk of harm to self/others. This code was added to ensure that restraint was as brief as possible, and that the previous measure for release, namely that the individual was calm, was replaced by the assessment of the risk of harm. Nineteen restraint checklists for four individuals were reviewed. The restraint checklists showed inconsistency in applying and/or documenting the standard for release. For example, there were three incidents when the individual was released because he/she was no longer a danger to self or others; four instances when the individual was described as calm; and four incidents where the individual was described as "calm and no longer a danger to self and others." The other nine incidents lacked release codes, or the individual was released due to injury, distress, or because staff could not maintain the hold properly. Reviews of restraint episodes should include review of the release criteria. An analysis should be completed to determine if individuals are being released when they are no longer a danger to self or others. If so, then staff need to be trained to properly document this. If not, then actions need to be taken to ensure that staff understand and implement the correct criteria for release.	Noncompliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within	The DADS Policy "Use of Restraint," dated 8/31/09, complied with the requirements of Section C3. As discussed above, AUSSLC implemented a policy, dated 11/24/09, to govern the use of	Noncompliance

#	Provision	Assessment of Status	Compliance
	one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	restraints. The policy enumerated the less restrictive interventions that must be applied prior to the use of restraint. If there was a Safety Plan for Crisis Intervention (SPCI) for the individual, the provisions of that SPCI must be attempted in order to de-escalate a situation. If a SPCI was not prescribed, then the policy stipulated a graduated range of interventions that must be attempted to stop the behavior or reduce its intensity so that it was no longer dangerous. Each of the restraint checklists reviewed documented attempts to use less intrusive alternatives to restraint. When interviewed, the Director of Behavioral Services listed the restraints that were permissible and those that were not allowed under this policy. Permissible mechanical restraints included helmets, mittens, splints, gloves, and approved protective devices. Prohibited restraints included cages, restraint chairs, restraint boards, ankle cuffs, and restraining sheets. The most common form of restraint documented at AUSSLC was physical restraint. In the 3rd Quarter for FY 10, there were 215 restraints implemented in relation to a behavioral crisis. This was a 10 percent increase from the last quarter. There were 130 physical restraints, 35 chemical restraints, 26 emergency physical restraints, and 22 mechanical restraints. According to the Trend Analysis Report for the 4th Quarter, there were a total of 156 restraints implemented for crisis intervention in relation to behavioral crisis. This was reported as a 27% decrease from the previous quarter. Throughout the course of the 4th Quarter, the overall restraint trend was reported as downward. This trend was especially significant for physical restraints. There was a slight increase in the use of chemical restraints. Emergency restraints also trended upward. It appeared that the Facility was striving to reduce the use of restraint through several means, including the review of restraint at the Incident Management Meeting, the development of addenda to the individual's PSP, the enrichment of programming, and the expansion of community-based activities. During orientation and annually thereafter, AUSSLC staff were required to complete competency-based training on the requirements of this policy, prevention and de-escalation techniques, and the use of approved restraints. However, the Director of Behavioral Services stated that the availability of time to train staff was problematic, resulting in staff not being consistently adequately trained. Documentation was provided by the Facility that listed all staff who had attended the training module "Restraint: Prevention and Rules for Use at MR Facilities." This documentation included the names of 836 staff. The Director of Behavioral Services reported that, as of 9/8/10, the Facility was 96% compliant in PMAB training.	

#	Provision	Assessment of Status	Compliance
		In response to the Monitoring Team's request, the Facility provided a copy of the curriculum used to train staff in the use of restraint. This training material, "Restraint: Ordering, Assessing, and Evaluating" was copyrighted in 2004, and also dated 6/28/06. It contained information that conflicted with that obtained in an interview with the Director of Behavioral Services. Specifically, the training material stated that chair restraint and restraining nets were approved devices. The Director of Behavioral Services said they were not permitted at AUSSLC. In its response to the Monitoring Team's draft report, the State/Facility indicated that the curriculum provided was one that is used by multiple state agencies, and that Facility staff are not trained on the use of the these devices. For the next review, the Facility should provide the Monitoring Team with a copy of the curriculum that is actually used with Facility staff. If modifications are made to this standard curriculum, then these should be identified clearly in the written documentation provided.	
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.	As discussed above, AUSSLC policy required that all restraints, other than medical restraints, be limited to crisis intervention. No restraints were to be used if contraindicated by the individual's medical condition. The review of 19 restraint checklists indicated that alternatives to restraint had been attempted in each episode and that the restraint was determined to be necessary to avoid harm to the individual or to others. However, as noted above in C.1, environmental and other factors may have negatively influenced the individuals' behavior. These factors were not addressed consistently. The Facility also continued to use programmed restraint. In conducting a review of 12 Individuals, programmed restraint was not indicated for five (42%). The summaries for the remaining seven individuals included a description of restraint (58%). Only four of these seven (57%) had a Safety Plan for Crisis Intervention, however, even in these cases the reader of the summary was not directed to review the safety plan. These plans are discussed in further detail with regard to Section K.9 of the SA. Programmed restraint should no longer be a part of any individual's behavior support plan. AUSSLC provided a Do Not Restrain Under Any Circumstances list with the names of 30 individuals. The primary reason for inclusion on the list was osteoporosis or osteopenia. A second list with 13 names permitted the use of restraint, with caution, only if necessary. As is discussed in greater detail below with regard to Sections J.4 and Q.2 of the SA, desensitization plans had been developed for a number of individuals requiring restraint for dental care. However, there was no evidence provided that these plans were being routinely implemented, reviewed, and revised, as appropriate. According to the Dental Director, there had been no success in terms of improved outcomes for individuals.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As is reported below with regard to Section Q.2 of the SA, the Dental Department provided information concerning mechanical restraint use. The Human Rights Committee counted 177 mechanical restraints in Rights Assessments from 9/09 to 8/10. Based on a census of 376, it was estimated that 47% of the population residing at AUSSLC used mechanical restraints for dental procedures. This does not represent an unduplicated count. In 2009, three types of mechanical restraints were documented: wristlets, seatbelts, and papoose restraints. August 2009 was the last month in which papoose use was recorded. Wristlets and seatbelt remained as the documented types of restraints. For the last year, the restraint use was documented as the following: ▪ September 2009 - 21 visits requiring restraints; ▪ October 2009 - 14 visits requiring restraints; ▪ November 2009 - 13 visits requiring restraints; ▪ December 2009 - 19 visits requiring restraints; ▪ January 2010 - 13 visits requiring restraints; ▪ February 2010 - 23 visits requiring restraints; ▪ March 2010 - 31 visits requiring restraints; ▪ April 2010 - 20 visits requiring restraints; ▪ May 2010 - 15 visits requiring restraints; ▪ June 2010 - 14 visits requiring restraints; ▪ July 2010 - 7 visits requiring restraints; and ▪ August 2010 - 4 visits requiring restraints. There was a range of restraint use from four to 31 per month. Some individuals required more than one type of restraint. The few restraints being used in August might in part be due to the Dental Director going on leave, and there being fewer dental appointments as a result.	
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	In accordance with AUSSLC policy, Restraint Monitors received additional training. They were required to conduct and document a face-to-face assessment of the restrained individual as soon as possible, but no later than 15 minutes, from the start of the restraint. Face-to-face assessment by a trained monitor occurred in 16 of the 19 instances reviewed (84%), but did not occur in three. Furthermore, in one incident, the Restraint Monitor did not arrive until nearly two hours after the restraint was initiated. In this instance, the monitor still completed the Debriefing form despite the lack of presence during the episode. In another instance, the Restraint Monitor arrived 18 minutes after the individual was released. In one, the restraint monitor was called, but another signed the restraint checklist. In another instance, the Restraint Monitor was notified and arrived in a timely manner, but did not sign the restraint checklist until days later.	Noncompliance

#	Provision	Assessment of Status	Compliance
	professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Similar problems were noted with the timely presence of a licensed health care professional. In 14 of the 19 episodes of restraint (74%), a licensed health care professional arrived within 30 minutes of the initiation of the restraint. However, in four instances, the nurse was not present for up to three hours and 35 minutes after the restraint began. In one episode, the licensed health professional was not notified, and did not arrive to monitor the individual. An additional review was conducted of 147 episodes of physical restraints for 13 individuals (Individual #421, Individual #74, Individual #139, Individual #350, Individual #156, Individual #395, Individual #175, Individual #217, Individual #210, Individual #283, Individual #276, Individual #344, and Individual #360). Consistent with the findings of the baseline review, this review found that there continued to be significant problematic issues regarding the required documentation completed by nursing staff. More specifically: ▪ In only 50 of the 147 episodes (34%) were the vital signs taken, or attempts made to take them every 30 minutes from the start of the restraint. ▪ Of the 147 episodes, the vital signs were taken timely in 72 episodes (49%). In 22 episodes (15%), the vital sign section on the Restraint Checklist was blank. In two of the episodes of restraint, the time the vital signs were taken, however, the time they were taken was not documented. ▪ In only 88 episodes (60%) was there an appropriate mental status documented. In 27 episodes, the Restraint Checklists indicated that the individual "refused" the mental status assessment, which is not appropriate since cooperation is not warranted to assess an observation of mental status. In 15 episodes, the documentation indicated that the individual was "usual self," "A&O x 3" (alert and oriented to person, place and time), or "baseline" which does not provide an adequate description of the individual's mental status. For 17 episodes, the mental status section was left blank. In addition, Debriefing and Review forms were provided for only 106 of the 147 episodes of restraint (72%). From the review of the 106 the Debriefing and Review forms provided, AUSSLC's data indicated that all restraint episodes had the injury, vital signs, and mental status completed by the nurse. These findings did not comport with the Monitoring Teams' findings, as noted above. A review of the Debriefing and Review form found that it did not include a review of the timeliness and frequency of the vital signs as required by the SA, or the criteria for appropriate documentation by nursing for mental status and injury assessments. In fact, these items were scored as being in compliance even when these sections were left blank. The Facility should ensure that it is auditing the nursing sections of restraint forms in alignment with generally accepted standards of practice as defined in the SA.	

#	Provision	Assessment of Status	Compliance
		According to the documentation reviewed for the sample of 19 checklists, there were no restraints applied outside of the Facility.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	The restraint checklists followed the format in Appendix A of the SA. Eighteen (18) of the 19 checklists (95%) indicated that one-to-one supervision was provided. Although the AUSSLC policy required that every individual in restraint receive an opportunity to exercise restrained limbs, to eat as near mealtimes as possible, to drink fluids and to use a toilet/bedpan, the restraint checklists reviewed did not indicate that those opportunities were offered in any restraint episode (0%). Although most restraints were brief and did not utilize mechanical restraints, there were eight episodes that lasted more than 10 minutes. One episode was 23 minutes in duration. In these episodes, the offer of fluids or the use of the bathroom might have been important to the comfort of the restrained individual. In addition, the documentation for only 100 of the sample of 147 restraint episodes (68%) demonstrated an adequate assessment of injury after the restraint episode. In 24 episodes, the injury section was left blank. In 21 episodes, the nurse documented that the individual refused an assessment, however, issues such as gait, pain behaviors, activity level and functioning should be assessed and documented until the individual allows a more comprehensive assessment. Also, in two episodes, the documentation of bruises/scratches did not include the appropriate descriptions and locations of the injuries.	Noncompliance
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:	The Director of Behavioral Services provided a list of individuals who had been placed in restraint most often during the first eight months of 2010. Per the information provided, 11 of these 14 individuals (79%) had Functional Behavior Assessments, all (100%) had a Positive Behavior Support Plan, and 13 of 14 (93%) had a Safety Plan for Crisis Intervention. Immediate action should be taken to complete a structural and functional assessment with Individual #344 who was placed in restraint four times in August. Assessment priority also should be given to Individual #406, Individual #421, and Individual #395. Lastly, although Individual #139 had a functional behavior assessment completed, this should be updated, because it was over three years old.	Noncompliance
	(a) review the individual's	Addenda to individuals' PBSPs and/or PSPs were reviewed for the following: Individual	Noncompliance

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	adaptive skills and biological, medical, psychosocial factors;	#175, Individual #424, Individual #406, Individual #421, Individual #276, Individual #77, Individual #350, Individual #389, Individual #344, Individual #425, and Individual #139. Each of these individuals had been restrained (physical, mechanical, and/or chemical) more than three times in a rolling 30-day period in the previous eight months. A review of the frequent use of restraints was addressed in the addenda for six of these eleven individuals (55%). Specifically: ▪ The Team for Individual #406 reviewed several variables that could have been responsible for problem behavior that had resulted in restraint. He had undergone several medication changes, he had suffered a boil on his leg that resulted in a trip to the emergency room, and he had awakened several times at night. ▪ During a Personal Support Team meeting held on 8/18/10 for Individual #276, a review was conducted of his adaptive, biological, medical, and psychosocial factors as these related to his problem behaviors. ▪ The Team for Individual #389 reviewed the need for a life vest and mittens to prevent this person from pulling out his G-tube. The vest could only be worn during waking hours when not in bed, and was to be removed/loosened for meals and change in clothing. The mittens were placed on when the Individual was in bed. Further discussion related to conducting a trial with a smaller vest to increase the individual's level of comfort. ▪ The Team for Individual #344 reviewed communicative behavior that was exhibited prior to behavior that necessitated restraint. Changes to the prevention section of the PBSP were recommended. The Team also discussed changes in medication. ▪ During one meeting of the Team, problems with constipation and corresponding discomfort were discussed for Individual #425. ▪ A meeting was held on 10/5/10, during which the Team for Individual #139 met to review adaptive, biological, medical, and psychosocial factors that were possibly related to the need for restraint. A review of medication was scheduled to occur the following month.	
	(b) review possibly contributing environmental conditions;	As noted above, a review of the frequent use of restraints was addressed in the addenda for only six of eleven individuals (55%) reviewed. Of the six individuals whose addenda clearly addressed restraint, potential contributing environmental factors were addressed in four cases (67%). Specifically: ▪ On 9/7/10, 9/17/10, and 9/21/10, the Personal Support Team met regarding Individual #406. Recommendations were made to: a) introduce items to help prevent agitation following night awakenings; b) remind staff to follow the individual's picture schedule; c) purchase clothing that was loose fitting and possibly more comfortable; and d) re-train staff regarding the individual's PBSP. Additionally, the individual had been provided his own bedroom. It appeared	Noncompliance

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		that environmental conditions had been taken into consideration regarding his clothing, and need for his own bedroom. ▪ The Personal Support Team for Individual #276 met 17 times between 1/11/10 and 10/7/10. On 12 of these occasions, restraint was reviewed. Actions taken included: a) a review of his Structural and Functional Behavior Report, his PBSP, and his Safety Plan; b) referral for counseling; c) teaching of safety skills related to bike riding; and d) privilege restriction. The Team had advised that the individual was to be banned from the computer lab for two weeks and he would not be allowed to ride a bike for 30 days. Consideration for a more timely, but perhaps gradual, reintroduction of privileges is recommended. Clearly consideration had been given to potentially contributing environmental conditions. ▪ The Personal Support Team for Individual #344 met three times between 5/10/10 and 8/3/10. Recommendations were made to intervene when the individual displayed agitation prior to aggression to try to promote appropriate communication, to revise his augmentative communication systems, and to preserve uneaten meals so he can access the food at a later time. Here, too, it was apparent that the Team had considered environmental factors that might have contributed to the frequent use of restraint. ▪ The Team for Individual #139 identified loud and congested environments, transitions, competition for staff attention, and the presence of new staff as contributing factors to problem behavior. Staff should ensure that steps to address these variables are contained in her behavior support plan.	
	(c) review or perform structural assessments of the behavior provoking restraints;	Structural and Functional Assessment Reports were completed since the beginning of the year for at least four individuals who had been placed in restraint frequently (Individual #276, Individual #16, Individual #350, and Individual #83). As noted by the Director of Behavioral Services, the focus was to be on completing assessments for those individuals who were frequently restrained. As noted above, of the 14 individuals who had been restrained more than three times in a rolling 30-day period during the eight months prior to the review, 11 out of the 14 (79%) had had Structural and Functional Assessment Reports completed. It is unclear, however, whether the completion of these assessments always resulted in an update to the Positive Behavior Support Plan. For example, in the case of Individual #83, the assessment was completed on 8/25/10, but the behavior support plan provided was dated 12/10/09. The Facility should take steps to ensure that support plans are revised in a timely manner following the completion of an assessment.	Noncompliance
	(d) review or perform functional assessments of the behavior	This is discussed above with regard to Section C.7.c of the SA.	Noncompliance

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	provoking restraints;		
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	As noted above, PBSPs existed for all individuals on the Director of Behavioral Services' list of individuals who most frequently were placed in restraint (including the individual restrained more than three times in August). A request was made for 11 plans, but the plan for Individual #74 was incomplete, and is not included in the analysis that follows. The following summarizes the analysis of these PBSPs: ▪ These plans provided operational definitions of the target behaviors, information regarding the hypothesized function of the problem behaviors, a review of preventative strategies, and clear descriptions of interventions to follow when problem behaviors occurred. ▪ All, but one, for Individual #350, or nine out of 10 (90%) included appropriate replacement behaviors based upon the hypothesized function of the problem behaviors. In the case of Individual #283, the definition and subsequent teaching guidelines for the development of the replacement behaviors were particularly clear. ▪ Only one plan, for Individual #139, (10%) included a complete description of reinforcement that was sufficient for strengthening desired behavior. Some plans included a schedule of reinforcement that was very lean. For example, Individual #406 could earn a token once per shift. The plan did not indicate what behavior resulted in the awarding of a token, although later in the plan there was a review of what was said to the individual when he did not earn a token. Frequent praise was recommended following compliance, but praise was not identified as a potential reinforcer. Individual #83 was also to earn a token at the end of each day shift as long as he did not display problem behaviors. A schedule for token exchange was not included. Other plans mentioned token economies, contracts, incentive programs, or "behavior money," but there were not clear guidelines provided to implement these contingencies (e.g., Individual #276, Individual #350, Individual #77, and Individual #83). One plan that was very well written and comprehensive in its scope (Individual #283) included terminology [i.e., VR (variable ratio) and FI (fixed interval) schedules of reinforcement, DRO (differential reinforcement of other behavior) contingencies] that might not be understood by all readers. A clear description of how to implement a schedule of reinforcement or differential reinforcement contingency would likely contribute to the degree to which the plan is implemented with integrity. ▪ Eight of the plans (80%) included guidelines for collecting data. More than three restraints in a rolling 30-day period for Individual #267 prompted the development and review of a Safety Plan for Crisis Intervention at the Behavior Therapy Committee meeting held on 10/5/10.	Noncompliance

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	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	As the time of the monitoring visit, there was no plan in place for assessment of treatment integrity.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Individual #350 and Individual #83 had Structural and Functional Behavior Reports completed four and eight months, respectively, after the development of the PBSP. Both contained valuable information regarding preventative strategies and antecedent management that should be added to the PBSP. Their Positive Behavior Support Plans that were provided to the Monitoring Team predated these assessments. As noted above, a review of the frequent use of restraints was addressed in the addenda for only six of eleven individuals (55%). Given that any changes to PBSPs would need to be reviewed and approved by the PST, it did not appear that even though recommendations had been made in some cases for changes to be made that teams had consistently modified these plans.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	Debriefing forms were not attached to all of the checklists reviewed. As noted above with regard to Section C.6 of the SA, Debriefing and Review forms were provided for only 106 of the 147 episodes of restraint (72%). When this form was included, it rarely noted that the restraint incident was reviewed at the unit meeting or at the Incident Management Review Team meeting. As noted below, it appeared that the Incident Management Review Team was reviewing restraints, but this discussion needed to be documented. According to policy, the Incident Management Review Team was expected to review each use of restraint. The meetings attended during the monitoring visit indicated that AUSSLC staff was concerned about the use of restraint. Discussions focused on the antecedents to restraint use on an individual-by-individual basis. However, there did not appear to be much attention given to the environmental factors influencing the behavior of individuals who had been restrained. In particular, there was no consistent evidence of discussion of how the census and/or groupings in the larger residential units impacted behavior, whether consideration needed to be given to community placement for individuals for whom crowded environments and/or noise exacerbated their behavior, or if more integrated social/programmatic opportunities needed to be offered as alternatives to reduce the number of behavioral crises leading to restraint.	Noncompliance

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		In addition, the Director of Behavioral Services had articulated the constraints with regard to staffing and programming at AUSSLC that interfered with acceptable behavior. It would be important to discuss his findings in depth at either an Incident Management Review Team meeting, or at a meeting of the restructured Program Improvement Council. As is discussed above with regard to Section C.7, teams of individuals who experienced more than three restraints in a rolling 30-day period did not consistently meet to review the need for changes to be made to the PBSP or the PSP.	

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

1. Reviews of restraint episodes should include review of the release criteria. An analysis should be completed to determine if individuals are being released when they are no longer a danger to self or others. If so, then staff need to be trained to properly document this. If not, then actions need to be taken to ensure that staff understand and implement the correct criteria for release.
2. As is recommended below with regard to Section Q.2, the Dental Department should develop a plan to reduce the use of mechanical restraints from the estimated current 47% of individuals served.
3. The Dental Director should meet with the Psychology Department to review the current desensitization plans and implementation process, as well as other strategies to reduce the need for restraint. The experience that the Dental Director has with the current plans should be shared.
4. The Facility should audit thoroughly and accurately the nursing sections of restraint checklists to ensure they are in alignment with generally accepted standards of practice as defined in the SA.
5. The efforts to reduce restraint at AUSSLC should continue. Every effort should be made to support the reduction of restraint use through individualized active treatment strategies, well-trained staff, and stringent monitoring. The observations of the Director of Behavioral Services regarding the impact of a lack of adequate programming should be the focus of discussion so that alternatives to restraint can be implemented.
6. In conducting its reviews, the Incident Management Review Team should address potential environmental factors influencing the behavior of individuals who have been restrained. In particular, consideration should be given to how the census or groupings in the larger residential units impact behavior, whether consideration needs to be given to community placement for individuals for whom crowded environments and/or noise exacerbate their behavior, and/or whether more integrated social/programmatic opportunities need to be offered as alternatives to reduce the number of behavioral crises leading to restraint.
7. The training curriculum, "Restraint: Ordering, Assessing and Evaluating," should be reviewed for its appropriateness and accuracy.
8. A timeline should be developed for completion of Structural and Functional Assessment Reports for those individuals who frequently are placed in restraint. This information should be updated at least annually for those individuals who continue to present with highly challenging behavior.
9. Upon completion of Structural and Functional Assessment Reports, the Team should meet to revise the Individual's Positive Behavior Support Plan. Such revision should take place within one week, with staff training occurring thereafter.

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 Investigator's Manual; o DADS Policy #002.2, Incident Management, dated 6/18/10; o DADS Policy, #021, Protection from Harm: Abuse, Neglect and Exploitation, dated 6/18/10; o DADS Policy #042.1: Video Surveillance, dated 4/2/10; o DADS Draft Policy #00.1: Death of an Individual, dated 8/24/10; o DADS Draft Policy #006: At Risk Individuals, undated; o Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation forms, for all employees hired between 6/1/10 and 10/1/10; o Booklet entitled "Your Rights in a State Supported Living Center," dated 2009; o AUSSLC issued Pamphlet entitled "Stopping Abuse is Everyone's Responsibility," undated; o Presentation slides from the 6/3/10 conference call with DADS and the Department of Family and Protective Services (DFPS) regarding Adult Protective Services (APS) compliance with the Settlement Agreement; o Interagency Memorandum of Understanding Regarding Investigations of Abuse and Neglect in State Supported Living Centers, dated 5/28/10; o Senate Bill No. 643; o Human Rights Committee Minutes for April through September 2010; o Rights Poster; o Incident Management Meeting Minutes, from 7/10 through 9/10; o Trend Analysis Reports for 3rd and 4th Quarters, FY 10; o Listing of Peer-Caused Injuries; o List of employees reassigned following allegations of abuse and neglect; o Administrative Death Reviews for Individual #164, Individual #44, Individual #27, Individual #136, and Individual #252; o Injury reports for Individual #299, Individual #175, Individual #292, Individual #448, Individual #416, Individual #108, Individual #192, and Individual #49; o Investigation reports for 30 individuals as provided by the Facility in response to the Monitoring Team's initial document request; and o Additional investigation reports, including investigation report for Individual #305; investigation report for Individual #77 and Individual #177; investigation report for the individuals residing in 781 N. Meadow Circle. ▪ **Interviews with**: o Vira Benson, Facility Director; o JoAnn Villasana, Human Rights Officer; o Jessica White, Assistant Independent Ombudsman;

	o Tammy Snyder, Director of Quality Management; o Fred C. Bibus, MD, Medical Director; o Aubrey Johnson, Facility Investigator; and o Adrian Watson, Facility Investigator. **Observations of**: o Incident Management Meetings, from 10/4 through 10/7/10; o Program Improvement Council Meeting, on 10/6/10; o Human Rights Committee Meeting, on 10/7/10; o Home Supervisors' Meeting, on 10/7/10; o Site visits to all living units and day program areas. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees, as well as some of the individuals.
	Facility Self-Assessment: In its POI, dated 5/17/10, AUSSLC determined that it was in substantial compliance with the provisions that there be a stated commitment that abuse and neglect would not be tolerated; alleged perpetrators were removed from direct contact with individuals until the investigation was complete; training regarding abuse, neglect and exploitation was competency-based and occurred annually; the training curriculum addressed recognizing and reporting potential signs/symptoms of abuse, neglect and exploitation; and documentation of training completion was maintained for all staff. Additionally, AUSSLC assessed that it was in substantial compliance with the requirements contained in Section D.2.d. Namely, that new employee orientation included curricula on reporting abuse, neglect and exploitation; all new employees received this training at orientation; all staff were retrained annually; documentation of all such training existed; and there was documentation that all staff who were considered mandatory reporters had a signed statement on file evidencing their recognition of this responsibility. AUSSLC also determined that it was in substantial compliance with the requirement that the individuals' Legally Appointed Representatives and Primary Correspondents receive education/support on identifying and reporting unusual incidents, including abuse, neglect and exploitation. AUSSLC's self assessment indicated substantial compliance with reporting, through DFPS as appropriate, allegations of abuse, neglect and exploitation to law enforcement agencies, and with coordinating with law enforcement agencies in applicable investigations. It also reported substantial compliance with preventing retaliation for reporting abuse, neglect and exploitation, and taking appropriate personnel action should it occur. In accordance with Section D.2.i, AUSSLC stated it was in compliance with the provision to report all significant injuries. AUSSLC also reported compliance regarding the provisions of Section D.3.a, requiring Facility investigators to have training in investigation, training in working with people with a developmental disability, and not being in direct line of supervision of the alleged perpetrator. Furthermore, as required by Section D.3.e, AUSSLC assessed it was in compliance with initiating the investigation of serious incidents within 24 hours of reporting; completing a written report for all investigations of serious incidents, including a summary of the investigation, its findings, and, as appropriate, recommendations for corrective action. AUSSLC also self-assessed that it was in substantial compliance with the requirements of Section D.3.f. stipulating the contents of each investigation report. AUSSLC stated that it was in compliance with the requirement that

	all investigation reports be maintained in such a manner that permitted investigators and other appropriate personnel easy access. Also, AUSSLC reported compliance with the provisions of Section D.5. regarding the background checks of staff and volunteers. All remaining provisions of Section D were assessed by AUSSLC to be in non-compliance at this time. There were significant differences between the Facility's and the Monitoring Team's findings regarding compliance with certain provisions of Section D. The bases for the Facility's findings were not always clear. For example, although AUSSLC determined that there was compliance with requirements regarding the reporting and investigation of abuse, neglect and exploitation, the review of investigation reports provided during the monitoring visit noted significant deficiencies in timeliness and thoroughness of investigations. The Facility determined that the training for investigators was completed. However, documentation provided to the Monitoring Team did not support this finding. According to the Supplemental Plan of Improvement, as of 9/10, the Facility had not completed a local policy regarding the training of investigators.
	Summary of Monitor's Assessment: In interviews with the Facility Director and principal staff at AUSSLC, there was evidence of a serious commitment to prevent abuse, neglect and exploitation of the individuals under their responsibility. However, there also was evidence of constraints impeding the timely investigation and resolution of serious incidents. For example, the workload of the two investigators had increased significantly due to the extended medical leave of the Incident Management Coordinator. Although there appeared to be a strong working relationship between the Human Rights Officer and the Assistant Independent Ombudsman, there was a lack of clarity regarding their respective roles and responsibilities. This lack of clarity resulted in unnecessary duplication of effort and confusion regarding the reporting and investigation of rights violations. In addition, the review of investigation reports provided during the monitoring visit noted deficiencies in timeliness and thoroughness of investigations. During the baseline visit, from an incident prevention perspective, there were a number of practices identified that had the potential to place individuals AUSSLC served at risk for abuse, neglect, serious injury, or other harm. A number of very positive changes had been made with regard to these issues. However, a number of concerns remained. The following provides a summary of the concerns identified in the baseline review, actions that had been taken at the time of the most recent on-site visit, and areas of continuing concern: ▪ At the time of the baseline review, there were a number of staffing constraints at AUSSLC, making it difficult to consistently provide a safe environment. A number of important steps had been taken to correct these issues. For example, according to the Facility Director: o All direct support professional positions had been filled, allowing the Facility to discontinue the use of staffing agencies. In fact, the fill rate was 106 percent; o A "float pool" had been created to allow coverage when staff were on leave or reassigned; o The pay for direct support professionals had been increased by 10 percent in an effort to decrease turnover; o An "Employee of the Quarter," and "Employee of the Year" program was being devised to provide an incentive program. Incentives included having a designated parking spot,

	receiving recognition through a certificate, and being awarded administrative leave; o Other creative strategies for retaining staff were being considered and implemented by the Facility Director; o A new staffing configuration of four 10-hour days was being piloted in two residences; o Staffing had been reconfigured, and a Home Supervisor was now assigned to each residence on campus. Previously, Home Supervisors had been responsible for up to three residences; and o Beginning in July 2010, monthly town hall meetings had begun at which staff were encouraged to voice their concerns, in addition to suggestion boxes that had been placed around campus. o Based on the Monitoring Team's interviews with direct support professionals, morale had begun to improve. They reported less mandated overtime, and less use of "pulled" staff. These changes in staffing were impressive, but the full impact had not yet been seen during the most recent review. It would be expected that it would take some time for the full effects of improved staffing to be seen. ▪ The impact of inadequate staffing was evident during the baseline review. Specifically, in certain residential units, there were repeated observations of the failure to attend sufficiently to individuals with significant needs for support. For example, in some residences, there was a serious failure to monitor behavioral issues as required by behavioral support plans, physical and nutritional management plans, and other essential supports. As is discussed in further detail in Sections K and O, at the time of the most recent review, there were still concerns in these areas. Although there had been increases in numbers of staffing, competency-based training of staff continued to be an area of significant need. ▪ A number of steps had been taken to reducing the dehumanizing practices observed during the baseline review, but work continued to need to be done. For example: o There had been an effort to individualize people's haircuts. An additional hairdresser had been hired. In addition to asking individuals what type of haircut they wanted, pictures of various hairstyles were being shared with the individuals and their guardians. The campus barber had been provided guidance on appropriate haircuts; o To address grooming and clothing issues, the Active Treatment Team had developed and was implementing a checklist to monitor this, and to identify corrective actions that were needed; o The grates that had been on the windows in some of the residences had been removed; o During the baseline review, problems were noted with the general conditions at the Facility such as residences lacking all but basic furniture, and others being in disrepair or poorly kept, and what appeared to be vacant buildings with broken windows. To address this, a Campus Beautification/Restoration Committee and an Extreme Makeover Committee been formed. Some of these efforts were beginning to show results. For example, one of the residences on campus had been newly painted, and decorations hung, and a second residence on campus was having a similar face-lift. Additional furniture also was being purchased, but would be delivered over time. New management staff had been hired to address many of the physical plant issues on campus. It was very positive to see

these changes beginning, but this was an area that continued to need significant effort. As has been illustrated throughout the history of this field, it is essential that such practices continue to be corrected, or there is a high risk that staff will view individuals as less than human, and treat them as less than human, resulting in abuse, neglect, and other harm.

- At the time of the baseline review, there were some inappropriate groupings of individuals with very different, often unique, needs for support. Although some modifications had been made, the risk of abuse, neglect and exploitation continued to be present on the living units.
  - The closing of living unit 772A appeared to have resulted in positive changes for the men who were relocated to other units.
  - It was reported that the Facility's census decreased by 12 individuals since the baseline visit, and that admissions were closed until staffing was stabilized.
  - Nonetheless, the number of individuals residing in each living unit continued to be seriously problematic. The most populated living unit had 20 individuals, the smallest had six, and the median was 15 individuals.
  - A number of the living areas, including, for example 772B, continued to provide poorly designed environments for safety, learning, and exercising skills. Facility Administration was in the process of reviewing options to attempt to address some of the environments and these groupings.
  - There continued to be too many individuals, many with significant behavioral issues, living in the same residences. The opportunity for conflict was high, as was the possibility that one individual's behaviors would exacerbate his/her peer's behaviors. Although staffing had increased and was beginning to stabilize since the baseline visit, there remained a lack of sufficient individualized attention and active treatment. Staff was often noted to be distracted and unable to attend to each individual's needs for support. For example, in living unit 796, Individual #165 was noted to be biting her arm and hitting herself, but staff were occupied with other individuals and did not intervene to stop her. On the second shift, in living unit 793, individuals were pacing the room and jumping up and down, but there were no meaningful activities underway and staff was otherwise engaged with other individuals.
  - The placement of adolescents/young adults with older adults violated acceptable practice and should be corrected without delay. For example, in living unit 778, Individual #98 was 15 years old and was placed with adults who required supervision due to their behavior.

These issues 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 might be used at a higher rate than it would in a setting with fewer individuals that afforded individuals additional personal space. To adequately protect individuals from harm, it will be necessary to continue to restructure the environments at AUSSLC, including a reconsideration of the number and active treatment needs of the individuals placed in each living unit.

In order to protect individuals from harm and in order to comply with the Settlement Agreement, the

	positive initiative that already had been taken to address the staffing issues and improve the quality of life issues at AUSSLC will need to be continued, and monitored to ensure they are having the desired effects.

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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.	On 6/18/10, DADS issued its policies "Protection from Harm-Abuse, Neglect and Exploitation," and "Incident Management." These policies clearly stated that there was zero tolerance for abuse, neglect and exploitation of individuals under the responsibility of the State Supported Living Centers. The policies mandated that all employees, agents, contractors and volunteers who suspected, had knowledge of, or who were involved in an unusual incident that might include an allegation of abuse, neglect, or exploitation immediately, within one hour, report the allegation to the Department of Family Protective Services.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	According to information received after the Monitoring team's visit was concluded, the Facility had adopted the State Office's policy on Incident Management. As a result, the Settlement Agreement provisions discussed below relied on the State policy's requirements.	
	(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	According to the State policy that the Facility had adopted, employees were required to report serious incidents within one hour. Reporting of abuse and neglect could be made directly to the toll free line answered by intake workers from Adult Protective Services. The intake worker was responsible for notifying the Facility Director or her designee in a timely manner. The intake worker also notified law enforcement agencies and the Office of the Inspector General, as appropriate. It was difficult to determine from the investigation documents whether reporting occurred in a timely manner. Information was lacking about the actual time of the incident in most of the investigations reviewed. However, there was documentation that indicated delays in reporting in at least four incidents. Specifically: ▪ Individual #398 was found to have a fractured hip. The bruised hip was discovered at 7:00 a.m. on 8/11/10. The fracture was determined to be a week to two weeks old. The injury was reported to the Facility Director at 9:55 a.m. that same day. (Case #100812.) ▪ On 8/6/10, it was alleged that a staff person treated Individual #127 roughly and pushed her. The incident was reported to DFPS on 8/12/10 at 2:38 p.m. The Facility Director was notified the same day at 3:10 p.m. (Case # 100814.)	Noncompliance

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	standardized reporting.	▪ In an investigation involving Individual #108, the incident occurred at 2:30 p.m. and was reported at 10:30 p.m. (Case # 100801.) ▪ For Individual #360, the incident occurred on 9/17/10 at 8:15 a.m. and was reported to DFPS on 9/19/10, just after midnight. (Case # 110917.)	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	In compliance with the State's policy, AUSSLC's reassigned alleged perpetrators from direct contact with any individuals until the investigation is completed. This practice was confirmed in each of the investigation reports where the alleged perpetrator was known. Letters of reassignment were included in some, not all, of the investigation files. A list documenting the reassignment of alleged perpetrators was provided during the monitoring visit. In the review of investigation reports, there were examples of other measures taken to protect the individual from further harm including: increased levels of supervision and the provision of in-service training to staff. These interventions were planned and implemented under the guidance of the Personal Support Team (PST). In the Incident Management Meetings, these types of measures also were discussed. However, evidence was not provided to document that any proposed recommendations were implemented in every individual case.	Noncompliance
	(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.	Competency-based training on recognizing and reporting potential signs and symptoms of abuse, neglect and exploitation was required during the orientation phase and at least yearly for all staff. In order to confirm that employees completed annual training in recognizing and reporting potential signs and symptoms of abuse, neglect and exploitation, a random sample of 26 employees was selected. AUSSLC provided documentation of the training completed for all of the employees. With the exception of a single employee who was last trained in 4/09, all employees updated their training in 2010. In addition, periodic quizzes were conducted of employees throughout AUSSLC to ensure that they could respond to questions about the reporting process.	Substantial Compliance
	(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	Copies of the "Acknowledgment of Responsibility for Reporting Abuse, Neglect and Exploitation" forms were requested for all employees hired from 6/1/10 through 10/1/10. The signed forms for hires in 6/10 were checked against the Employee Alpha Roster dated 10/4/10. Forms were provided for 68 of the 69 employees hired during 6/10	Substantial Compliance

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	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.	(99%). The signed forms for 9/10 were then compared with the Employee Alpha Roster. Forms were provided for each of the 30 employees recorded as hired during that month (100%). During unannounced visits to each living unit and day program area, staff were asked whether they understood the obligation to report abuse, neglect or exploitation. Each staff person affirmed that they had been instructed about this reporting obligation, and had signed a statement of acknowledgement at the time of employment and annually thereafter.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	Copies of the pamphlet issued by AUSSLC, "Stopping Abuse is Everyone's Responsibility," and the booklet, "Your Rights in a State Supported Living Center," were provided during the monitoring visit. This material was given to individuals residing at AUSSLC, their primary correspondent and their Legally Appointed Representatives (LAR) in order to educate them about the signs and symptoms of abuse, the telephone number for reporting an allegation of abuse or neglect, and the process for filing a complaint. Examples of letters sent to primary correspondents and guardians about the reporting of abuse and neglect also were provided. The letters were dated 12/29/09 and 3/29/10. More recent correspondence was not included in the documents received after the monitoring visit. Rights issues were to be discussed with the individual and the guardian at the annual meeting held to discuss the Personal Support Plan. The Human Rights Officer stated that it was the Unit Director's responsibility to provide educational materials to the individual and to his/her guardian or LAR. There were posters reminding individuals, staff and visitors to report abuse and neglect posted throughout the Facility, often on the same bulletin board as the rights poster. The Human Rights Officer had initiated a monthly training module designed to inform individuals of their rights. To date, the right to be free from abuse had been featured in the training materials. Although this information had been used in some residential units, there was a lack of uniform attention to the training module as is discussed further below with regard to D.2.f that relates to the rights posters required by the Settlement Agreement. Notification to the guardian of any allegation of abuse, neglect, or exploitation and/or of any injury or unusual incident was required. The Unusual Incident Report form documented whether such notification took place. Appropriate notification was made, or at least attempted, in each of the investigations reviewed.	Substantial Compliance

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	(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.	Site visits were made to each living unit and day program area to determine whether a "rights poster" was visible, and whether staff used the poster to educate individuals about their rights. Posters were appropriately placed in these living units: 730, 732E, 772, 779H, 779R, 781, 782, 783, 784, 785, 789, 791, 793, 794, 795, 796 and 797. Posters also were present in day program areas 527, 775 and in certain areas of 544. The posters were visible, at an appropriate eye level, and were not obscured by other informational material. In the following living units, the posters were present, but were placed too high to be read by the individuals residing there: 729 (located next to the ceiling instead of under plastic for protection from individuals who eat paper); 788 (placed well above the towel and soap dispensers in the dining room); 732 D, 779 F, and 732M (placed too high for individuals who use a wheelchair, and the poster in 732 D was partially obscured.) In living unit 501, the poster was in a glass case and not readily noticeable by the young women who lived there. When the Monitoring Team pointed out the poster, one individual became very interested and began to ask questions about her rights. Posters were missing in living units 792, 727 C (this poster was brought out from the nurses' office and placed on the bulletin board in response to the Monitoring Team's question), and in two areas of Building 554. In living units 786 and 787, the posters were placed in the staff offices, and were not easily accessible to the individuals who lived there. Knowledge about individual rights, and interest in teaching individuals about them varied among the residential staff encountered during the monitoring visit. Although the poster was missing, the staff person in 792 could explain how she taught about rights issues. In 772, 730 and 782, the poster was used to explain rights and rights restrictions. In residential areas 789, 791, 794 and 795, staff reported that the rights poster was not used. In 791, a staff person stated that they did not need to teach about rights because it was the day program's responsibility to do so. In order to enhance the understanding of rights, the Human Rights Officer had initiated a monthly program to teach about individuals' rights. The lessons, filed in a notebook on each living unit, were to be used as teaching aids by direct support professionals. Awareness of these materials was sporadic across the living units. The Human Rights Officer also supported a Self-Advocacy Group with approximately 20 members. Participation in this group varied across the residential areas, but was highly commended by the staff and individuals who were involved in its activities. Although there was a need for role clarification, the Human Rights Officer and the	Noncompliance

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		Assistant Independent Ombudsman appeared to work well together in investigating rights violations and in addressing complaints from individuals and staff. At the time of the review, there were discussions occurring regarding individuals moving to different residences on campus, as well as potentially closing some buildings and relocating individuals to more suitable locations. Because of their general knowledge of Facility issues as well as the specific concerns of certain individuals, it is recommended that the Human Rights Officer and Assistant Ombudsman be involved in these discussions.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The Memorandum of Understanding (MOU) regarding Investigations of Abuse and Neglect in State Supported Living Centers, dated 5/28/10, mandated that the Department of Family and Protective Services notify, within one hour, the local law enforcement agency, if there was cause to believe that criminal activity occurred. The Office of the Inspector General (OIG) must be notified, within one hour, of any allegation of abuse, neglect, or exploitation that may constitute criminal conduct. There was evidence in the documentation reviewed that law enforcement agencies and the Office of the Inspector General were notified as appropriate. In the conference call held on 6/3/10, it was stated that the OIG would send a copy of its report to the General Counsel for DADS, while the Facility was supposed to receive a summary of the report. However, there were no reports from either DADS or the OIG included in the investigation files. At most, an email from the OIG to the Facility would summarize the findings of an investigation. It should be noted that the OIG investigators were not required to comply with a specific timeframe for completing their work, and could take as long as they needed. The OIG was involved in the investigation involving the abuse of Individual #305. The Office of the Inspector General promptly assumed responsibility for and conducted the investigation. Reportedly, there was full cooperation between the agencies. As a result, criminal charges against the alleged perpetrators were to be filed with the Grand Jury.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for	During interviews with staff, there were no reports of retaliation for reporting allegations of abuse or neglect. There was no evidence of retaliation for reporting in any of the investigations reviewed during this monitoring visit. There was a single incident where a staff person reported mistreatment of an individual in retaliation for a problem with a personal relationship. The Facility investigator stated that, if retaliation were suspected, the Office of the Inspector General would be contacted. The Facility Director emphasized that there was zero tolerance of retaliation. Reportedly, in situations in which it was known which	Substantial Compliance

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	appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	employee made an allegation, the employee who reported an allegation was given the option of a new assignment rather than returning to the work site where the alleged activity occurred.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Trend Analysis Reports for the 3rd and 4th Quarters, FY 2010, provided useful descriptions of unusual incidents; allegations of abuse, neglect and exploitation; the use of restraints; and the occurrence of injuries. The reports described the probable causes for specific injuries and referenced those that were referred for investigation by DFPS. Additionally, according to the Quality Enhancement Manual provided during the monitoring visit, information was compiled for the monthly Client Injury Report System (CIRS) reports for the State Office.	Substantial Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	As referenced above, the State had developed and mandated implementation of 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. DADS Policy #002.2: Incident Management, dated 6/18/10, governed investigation of abuse, neglect, exploitation, theft, serious injury and other serious incidents. DADS Policy #021: Protection from Harm - Abuse, Neglect and Exploitation, dated 6/18/10, established procedures for the identification, reporting, trending, analysis, and prevention of abuse, neglect, and exploitation for the State Supported Living Centers. A draft policy, #00.1, dated 8/24/10, was in the process of being finalized, and would direct the actions to be taken upon the death of any individual served at a State Supported Living Center. In order to meet the requirements that were put into place with the passage of Senate Bill 643, an independent organization had been awarded a contract to report data regarding deaths at the State Supported Living Centers. In	Noncompliance

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		addition, DADS was re-examining the internal procedures for the investigation and other reviews that were conducted of deaths. DADS Policy Number 002.2 specified "a trained and authorized investigator will investigate all unusual incidents within 24 hours or sooner." The policy stated that all Facility investigators must complete the courses "Comprehensive Investigator Training," and "People with Mental Retardation" within one month of assignment. The course Fundamentals of Investigation, and a class in Root Cause Analysis must be completed within six months. As discussed in the conference call with DADS and DFPS, the investigators under the supervision of the Department of Family and Protective Services (DFPS) had mandatory training that included modules regarding working with people with developmental disabilities. However, there was no documentation provided to substantiate that such training had occurred for all DFPS investigators. According to the training transcripts, five out of 10 (50%) of the DFPS investigators received the requisite training, ILSD and Advanced ILSD. Of the remaining five investigators, one had attended the ILSD training only; three investigators had attended a four-hour course entitled "MH & MR Overview-APS Investigator Role." One investigator's transcript showed no evidence at all of training about people with a developmental disability. The two Facility investigators at AUSSLC were experienced in working with individuals with a developmental disability, including mental retardation. One investigator was a direct support professional, and then a unit supervisor; and the other investigator had worked at AUSSLC as an investigator for DFPS. Training records indicated that both had completed courses in Root Cause Analysis. One investigator had completed the course "Fundamentals of Investigation." However, no documentation was provided to verify completion of this training requirement by the second investigator. Also, there was no documentation that either investigator had completed the "Comprehensive Investigator Training," or the class regarding "People with Mental Retardation." DADS Policy 002.2 required that the investigator not be in the direct line of supervision of the alleged perpetrator. All of the investigations reviewed confirmed that the investigators from DFPS were outside of the line of supervision of the alleged perpetrator.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	As noted above, the Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the	Substantial Compliance

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		Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." In interviews at AUSSLC, it was reported that a cooperative working relationship existed between the law enforcement agency, the Office of the Inspector General, and the Facility. Based on a review of 32 investigations, including a small number in which law enforcement or the OIG was involved, it appeared that Facility staff cooperated with the outside entities conducting such investigations. This was clearly the case with the investigation concerning Individual # 305.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Interagency Memorandum of Understanding delineated the respective agency roles and responsibilities relating to the investigation of a report of alleged abuse, neglect, or exploitation in the SSLCs and the ICF/MR component of the Rio Grande Center. In any investigation concerning abuse, neglect, or exploitation, the lead was to be taken by DFPS, the Office of the Inspector General, or a law enforcement agency. As noted previously, in the recent investigation involving Individual #305, the Office of the Inspector General promptly took the lead in the investigation. Reportedly, there was full cooperation between the agencies. As a result, criminal charges against the alleged perpetrators were to be filed with the Grand Jury.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	Procedures for the safeguarding of evidence were contained in DADS Policy #002.2, Exhibit B. These guidelines referenced the collection, identification, and storage of physical evidence that might be essential to the investigation and disposition of an allegation. DADS Policy #042.1: Video Surveillance outlined procedures for documenting an observation of a suspected act of abuse, neglect and/or exploitation or an incident of alleged criminal activity. Safeguarding of physical evidence was not applicable in the investigations reviewed for this report. It should be noted that medical personnel at AUSSLC examined any injuries. Photographs were taken in certain cases to document bruises, and other possible signs of abuse or neglect. Video cameras were to be installed soon at AUSSLC.	Substantial Compliance
	(e) Require that each investigation	The DADS policy governing the investigation of serious incidents required that each	Noncompliance

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	of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	investigation commence within 24 hours or sooner, if necessary, of the incident being reported. In addition, the Settlement Agreement required that the investigation be completed within 10 days unless a written extension was granted for good cause. Each investigation report was to result in a written report that included a summary of the investigation, its findings and, as appropriate, recommendations for corrective action. AUSSLC provided a total of 89 investigations, dated since the baseline monitoring, for review. The majority of these reports (75) focused on a single individual. Although most individuals had only one investigation report, there were five individuals with two or more investigations of abuse or neglect. A sample of 30 investigation reports, representing 30 individuals, was selected for review from this group. (Case #s: 110917, 110923, 110909, 110925, 110914, 110918, 110916, 110923, 110908, 110921, 110905, 110919, 100812, 100817, 100815, 110901, 110911, 110902, 100808, 100824, 100818, 1008SER04, 100813, 100823, 110903, 100805, 100806, 100822, 1008SER03, 1008SER02.) In addition to the investigations described above, AUSSLC submitted 10 investigation reports involving two or more individuals. The most recent of these reports was selected for review for this report (Case #110924). There were four investigation reports focused on an entire living unit. Living unit 779H had two investigations, and living units 727 and 781 each had one investigation report. The most recent investigation report was chosen for review, which concerned 781 (Case #110906). Given the nature of the incident, DFPS was responsible for investigating 20 allegations. These allegations involved physical, verbal and emotional abuse, neglect, and an allegation of sexual abuse. All of the alleged incidents occurred in August or September 2010. For eight of the 20 allegations (40%), there was documentation provided to indicate that DFPS actually conducted the investigation. For the remaining 12, an Unusual Incident Report and the narrative of the intake call were included in the file, a DFPS investigator was assigned, and documents from the individual's record were attached. These were cases that should have been investigated by APS, including Incidents #110917, alleged physical abuse; #110923, alleged neglect; #110915, alleged verbal abuse; #110909, alleged physical abuse; #110925, alleged emotional abuse; #110914, alleged physical abuse; #110924, alleged verbal abuse; #110916, alleged verbal abuse; and #110905, alleged neglect. All of these investigations should have been completed by the time of the monitoring visit. It is unclear whether the investigation report was not included through error, or if the investigation was delayed or incomplete.	

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		There were records for eight investigations provided that DFPS actually completed. The following summarizes the findings with regard to these investigations: ▪ The investigation was initiated within 24 hours in four of the eight of the cases (50%). ▪ In seven of the eight cases (88%), the investigation was completed within the 10 days required by the Settlement Agreement, or a request for an extension was approved. ▪ Each investigation (100%) resulted in a written report that summarized the findings and recommended remedial action, as appropriate. The Facility was responsible for investigating 12 cases. DFPS sent four Information and Referrals, DFPS also referred two "streamlined" investigations, two cases submitted were for peer review, and there were four incidents involving serious injuries, including lacerations and a fractured hip. The following summarizes the findings with regard to these investigations: ▪ Three of the 12 of the investigations completed by the Facility (25%) were initiated within 24 hours. Two cases were referred for peer review and no other information was available. Two cases (17%) were not initiated within the requisite timeframe. Five (42%) could not be determined due to a lack of detail. ▪ Of the non-peer review cases, four of the 10 (40%) of the investigations were completed within 10 days, and six were late. ▪ As with the DFPS investigations, a standardized format was followed for the written reports. The format included a summary of the findings and recommendations, as appropriate. In addition, the Facility provided a list of all abuse, neglect, exploitation investigations that were begun since 1/1/10. At the time of the monitoring visit, 38 investigations commenced between 9/7/10 through 9/13/10 were described as "open." Given the 10-day timeline required by the Settlement Agreement, these investigations should have been completed by the time of the monitoring visit. It should be noted that although the history of the alleged victim was reviewed in each investigation, there was no evidence in any of the 30 cases (0%) that the background or history of the alleged perpetrator was examined.	
	(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	There was a standardized reporting format that included all of the requirements listed in this provision of the Settlement Agreement. As noted previously, in the 32 investigation files selected for review, DFPS was responsible for 20 of them. However, only eight of the 20 files provided to the Monitoring Team for which DFPS was responsible for the investigation included completed investigations. The Facility was responsible for 12, but	Noncompliance

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	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.	only 10 of these included investigation reports, and the remaining two were for "peer review," and included no final investigation report. With regard to the two cases referred for Peer Review, both cases alleged neglect: neglect due to insufficient staffing in the Infirmary, and neglect due to a serious medication error. The findings from the peer reviews were unknown. Review of the remaining 20 investigations, eight conducted by DFPS and 12 by the Facility investigators, indicated: ▪ Each investigation report (100%) contained the type of serious incident or allegation of wrongdoing; the names of all witnesses; the names of alleged victims and perpetrators; the names of all persons interviewed during the investigation; a summary of each interview; and all documents reviewed during the investigation. ▪ In general, these documents included excerpts from the alleged victim's individual record, including any Behavior Support Plan and relevant observation notes. ▪ Previous investigations involving the alleged victim were documented in each of the written reports. However, this information was not analyzed. ▪ None of the investigations (0%) provided a comprehensive summary of the topics discussed during each of the interviews. Rather, the statements were transcribed as presented during the interview. Specifically with regard to the Facility investigations, as noted above, two of the 12 files contained no final investigation report. The following summarizes information regarding the remaining 10 investigations: ▪ There were two unfounded reports made by Individual #175 and Individual #167 (Case #s 100822, 100817). Both investigations were "streamlined' investigations referred by DFPS. However, the Facility Investigator noted correctly that Individual #167 technically should not be included on this list, because her Behavior Support Plan did not include "unfounded" reports as a problematic behavior. There were no findings of abuse or neglect in either case. The Investigator's finding was supported by the facts as described. ▪ One investigation focused on the entire living unit 781 (Case #110906). Neither abuse nor neglect was suspected. These findings were supported by the facts. Appropriate recommendations were provided for in-service training. ▪ Four investigations reviewed serious injuries, including a fractured hip (unknown alleged perpetrator), and lacerations (Case #s 100812,1008SER02, 1008SER03, and 1008SER04). There were no findings of abuse or neglect. These findings were supported by the facts. Appropriate recommendations were offered in each of the cases.	

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		▪ The remaining three investigations (Case #s 100806, 100801, and 100805, respectively) concerned an allegation of neglect (Individual #189 refused to walk further on a trip to the zoo, and a bystander made a report); mistreatment (Individual #108 was alleged to have been treated rudely); and an alleged violation of an individual's rights (chair was placed in front of Individual #2's door to prevent him from leaving the bedroom at night.) Each of these allegations was investigated. The findings were supported by the facts. Appropriate recommendations were included for each incident. A total of eight DFPS investigations were reviewed. The following summarizes this review: ▪ Of these, three investigations were unfounded (Case #s 100808, 100815, and 110903). ▪ One allegation of verbal abuse was reviewed by DFPS and returned to the Facility for further investigation, because, according to DFPS, "yelling" and "raising one's voice" did not constitute verbal abuse under Chapter 711 (Case #110903). Chapter 711 defined "emotional or verbal abuse" as "Any act or use of verbal or other communication, including gestures, to curse, vilify, or degrade a person served or threaten a person served with physical or emotional harm. The act or communication must result in observable distress or harm to the person served, or be of such a nature that a reasonable person would consider it harmful or causing distress." Since Individual #380 was described in the call narrative as "feeling sad and taken aback" by the yelling, it would appear that distress was evident and that verbal or emotional abuse could have occurred during this incident. The Facility Investigator later found the allegation to be "unfounded" based on staff reports. The individual was not interviewed, although his Physical/Nutritional Management Plan stated that he speaks in single words and uses gestures/motions to lead people to what he wants. ▪ There were four DFPS investigations that were "unconfirmed" (Case #s 100902, 100814, 110911, and 110901). These investigations concerned allegations of neglect (1) and physical abuse (3). In one investigation, the statements of interviewed staff members were found believable, while the statement of Individual #77 was not found credible. Individual #77 reported that a staff member had slapped Individual #374. Individual #77 had a history of unfounded calls. Since the names of reporters were not included in the investigation reports, it was unclear whether Individual #77 made the allegation (Case #110911). ▪ The final DFPS investigation concerned an allegation of neglect and was determined to be "inconclusive" (Case #100824). The Investigator could not determine whether there was neglect in the supervision of Individual #350 (who requires one-to-one staffing) and Individual #401. During an unsupervised	

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		period, Individual #350 kissed Individual #401. The Investigator found serious gaps in the documentation of one-to-one supervision, but found both alleged perpetrators to lack credibility with regard to who was responsible for Individual #350 at the time. According to Chapter 711, "neglect" includes, but is not limited to, "the failure to establish or carry out an appropriate individual program plan or treatment plan for a person served, if such failure results in a specific incident or allegation involving a person served." The Investigator did not think that there was sufficient evidence to determine neglect. However, the investigation report confirmed that the two individuals were left unsupervised for five minutes, despite a requirement for one-to-one staff for one of the individuals, during which time an incident did occur. A more reasonable finding, therefore, might confirm neglect, but state that blame could not be assigned to a specific staff person due to credibility concerns. There also would have been implications with regard to the system for staffing assignments if it could not be determined who was responsible for a particular individual at a particular time. None of the 32 investigation files included evidence that the recommended follow-up actions occurred. Inclusion of this information in the investigation file would be helpful.	
	(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.	According to the interagency conference call held on 6/3/10, the supervision of DFPS investigations were to be documented electronically and, therefore, could not be verified for this report. As was discussed during this meeting, a process needs to be devised to allow the Monitoring Teams to assess this component of the SA. This element will not be in substantial compliance until DFPS is able to provide evidence that the supervision of the DFPS investigations is occurring. The supervisory review of the investigation reports completed by the Facility was not documented consistently.	Noncompliance
	(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 were contained in each of the 32 investigation report files reviewed. However, the Unusual Incident Reports included in the 12 incomplete DFPS investigation report files did not contain an analysis of findings, the proximate cause, or any signatures in the review/approval section. Two of the investigations reviewed were returned to AUSSLC for peer review. Unusual Incident Reports were included in each of these investigation report files. There was an analysis of each incident, but the sections regarding proximate cause and review/approval were pending the peer review.	Noncompliance

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		The Unusual Incident Reports included in the remaining 18 completed investigation reports were completed as required by the Settlement Agreement. Twelve (12) Unusual Incident Reports were completed by the Facility. These reports were clearly written; provided a coherent summary of the facts related to each incident; and provided recommendations for in-service training and other appropriate follow-up actions. The findings from these Unusual Incident Reports are discussed in (f) above.	
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The Facility submitted evidence that it implemented disciplinary action as the result of 22 investigations. However, the documentation was not current. For example, the disciplinary action described for the alleged perpetrator in Case #100712 was described as "reassigned out of coverage," when, in fact, she was to be dismissed. In more than one case, the disciplinary action was questionable. As a follow-up to Case #100513, the alleged perpetrator was transferred to another SSLC despite the fact that he failed to cooperate in an ongoing investigation and was to be disciplined for that failure. In Case #100611, the alleged perpetrator was reportedly dismissed but the personnel documentation indicated that the type of separation was retirement or voluntary separation. As discussed above, although recommendations were made by the Facility and DFPS Investigators, no evidence of any follow-up actions was included in the investigation files submitted for review.	Noncompliance
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The Facility Investigator reported that every investigation record was easily accessible. His statements were confirmed through observation and in an interview with the Administrative Assistant responsible for the maintenance of all records. Four years of investigation records were maintained on-site. Investigation records from 2006 through 2010 were secured in locked file cabinets in the offices of the Incident Management Coordinator. Under a state contract, all records prior to 2006 were stored with Iron Mountain. A database was maintained of all investigations conducted since 2000.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation	The Trend Analysis Reports had begun to capture this information. However, since the reports lacked sufficient detail in certain areas, it was not possible to determine the specific corrective action taken to address underlying concerns about the environment, individualized treatment approaches, staff training or staff performance. For example, the Reports referenced disciplinary action, but no information was provided as to the nature of the discipline or its correlation to the gravity of the offense. The Reports did	Noncompliance

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	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.	not reference or track environmental constraints that might lead to abuse or neglect. There was evidence that the Facility had begun its trending and tracking of unusual incidents and investigation results. During the most recent monitoring visit, Trend Analysis Reports were reviewed for the Third and Fourth Quarters of FY2010. The reports detailed the total number of incidents by type; the staff alleged to have caused the incident; the individuals involved in the incidents; the probable causes; and the locations and times during which the incidents occurred. These reports did not summarize the status or outcomes of any investigations. As noted above, there was evidence that not all serious incidents had been investigated fully by either DFPS or the Facility. In addition, although there were graphs trending the use of restraints in these Trend Analysis Reports, such trending was not present for the information regarding incidents. The Facility had begun to track the investigation reports for abuse and neglect; and the outcome of each investigation was specified. This information was included in a report entitled "Allegations of Abuse/Neglect." Based on an interview with the QE Director, the Facility was in the process of refining the tracking and trending process, and the resulting reports and follow-up activities. The members of the Program Improvement Council were working to identify and implement corrective actions based on the information received from monitoring reports. The restructuring of the Program Improvement Council was anticipated to be a potentially beneficial change. There was evidence that information obtained from the analysis of incidents and investigations led to the closing of living unit 772A. Despite their shortcomings, the Trend Analysis Reports provided a useful starting point for understanding the causes of abuse and neglect so that appropriate corrective action plans could be developed and implemented.	
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	In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 27 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas	Substantial Compliance

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	factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. Portions of the above background checks were completed annually for all employees. Background checks were conducted on new employees prior to orientation. Current employees of AUSSLC were subject to annual fingerprint checks during the month of October. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees are mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that an employee charged with assault was terminated. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of AUSSLC.	

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

1. In order to continue to address the protection from harm issues, the State and Facility should continue to address the many factors that could be contributing to this issue, including but not limited to:
    a. Develop and implement a plan to decrease the numbers of individuals with intense behavioral issues living together in various residences, including providing these individuals with additional personal space;
    b. Continue to stabilize staffing at the Facility, including decreasing the turnover rated, as well as the use of overtime, and "pulled" staff;
    c. Until there is further stabilization of staff, continue to keep admissions closed;
    d. Decisive action should be taken to improve the quality of life in certain residential units, including, for example 772B;
    e. As soon as possible, eliminate the practice of placing adolescents/young adults in the same residences with older adults;
    f. Continue to increase the State Office's involvement in quality assurance/enhancement activities, as well as follow-up with regard to serious incidents and allegations.
2. Posters that explain individuals' rights should be placed in areas in the residences and day programs that are clearly visible to individuals. For example, they should not be placed on crowded bulletin boards or behind other materials.
3. AUSSLC should develop and implement an auditing system to ensure that serious injuries are being appropriately referred for investigation.
4. When peer review of a clinical issue is recommended as a result of a DFPS investigation, the documentation of the findings of the peer review should be included as part of the final investigation file.
5. Based on the information provided and/or the lack thereof, DFPS should conduct timely and thorough investigations of abuse and neglect for

the allegations made with regard to individuals residing at AUSSLC.

6. The Facility is encouraged to continue to expand its efforts with regard to the tracking, trending, and analysis of information related to incidents, allegations, and recommendations related to investigations. As issues are identified, action plans should continue to be developed and implemented to address underlying causes.
7. In order to avoid confusion, there needs to be further clarification of the respective roles of the Human Rights Officer and the Assistant Independent Ombudsman. In particular, the responsibility for responding to individual complaints or grievances should be clarified so that individuals and staff are better informed about these valuable resources.

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

1. The notable improvement in staff morale at AUSSLC should continue to be supported by incentives and increased opportunities for career development.
2. At the time of the review, there were discussions occurring regarding individuals moving to different residences on campus, as well as potentially closing some buildings and relocating individuals to more suitable locations. Because of their general knowledge of Facility issues as well as the specific concerns of certain individuals, it is recommended that the Human Rights Officer and Assistant Ombudsman be involved in these discussions.
3. The staffing and other supports currently provided to the Self-Advocacy group should continue to be provided.
4. Concerted efforts should be made to assist individuals in learning about their rights, and about how to exercise them. Such efforts could take many forms, including, for example, learning objectives related to the exercise of rights; regular house meetings in which individuals are not only taught about their rights, but encouraged to exercise rights such as choice making about foods or activities; posting in residences or day programs about a "right of the month" with ongoing discussion with individuals about that right and how they could exercise it. Efforts to educate individuals about their rights should be individualized, as appropriate.

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 Trend Analysis Reports for the 3rd and 4th Quarters, FY 10; o Draft Quality Enhancement Manual; o Presentation Book E; o Plans of Improvement for each of the Sections of the Settlement Agreement; o Program Improvement Council meeting notes from 10/6/10; o Documentation of peer caused injuries; o Results from Abuse Neglect Procedures Quizzes, for 4/10, 5/10 and 9/10; o Results from Notification and Response Quizzes, for 5/10, 6/10, and 9/10; o Results from BSP Quizzes, for 4/10, 7/10, and 8/10; o Restraint analysis, for 5/10 and 6/10; and o List of all restraints that have been utilized, including the date, time, type of restraint applied, duration of restraint and if an injury occurred for 3/10 through 7/10. ▪ **Interviews with**: o Vira Benson, Facility Director; o Tammy Snyder, Director of Quality Management; o Jo Ann Villasana, Human Rights Officer; o Jessica White, Assistant Independent Ombudsman; and o Individual #213. ▪ **Observations of**: o Program Improvement Council meeting, on 10/6/10; o Home Supervisors' meeting, on 10/7/10; o Human Rights Committee meeting, on 10/7/10; o Incident Management meetings, on 10/4/10 through 10/7/10; and o Site visits to all living units and day program areas. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees, as well as some of the individuals.
	Facility Self-Assessment: In its most recent Plan of Improvement, dated 5/17/10, AUSSLC did not indicate it was in compliance with any of the requirements of Section E. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: AUSSLC continued to work carefully and conscientiously to strengthen its Quality Management strategies. The Trend Analysis reports contained useful information that could be applied to decision-making about the effectiveness of active treatment, the composition and structure of residential living units, and the implementation of adequate measures to ensure health and

	safety. The restructuring of the Program Improvement Council was in the process of being completed, and was a needed change. A broader focus on quality enhancement would be beneficial as the Facility strives to reach compliance with the Settlement Agreement. The Facility's efforts to evaluate staff knowledge and performance competencies through such strategies as unit-based quizzes indicated a creative approach to issues of ongoing importance. Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by AUSSLC. This is important for a few reasons, including providing the Facility with the ability to identify objectively individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively residences, day programs, and/or departments that require improvement, and to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. AUSSLC was in the beginning stages of developing corrective action plans, and had developed one for each of the sections of the Settlement Agreement. The corrective action plans submitted by AUSSLC were reviewed and were found to be reflective of the deficiencies addressed. The strategies proposed for corrective actions were appropriate and, in certain instances, had been implemented by the time of the monitoring visit.

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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.	As reported in the baseline monitoring report, data collection was occurring for some indicators. In the documentation provided to the Monitoring Team and based on an interview with the Director of Quality Management, it was clear that data was being collected regularly through consultation with the Unit Directors and clinical professional staff, through observation of such activities as meal times, and through unannounced quizzes conducted in the residential units. Incident reports and reports documenting the use of restraint were being reviewed and summarized. The Trend Analysis reports prepared by the Quality Management staff were useful and provided a foundation for continued efforts to track data. At this time, however, the trending and tracking did not reflect sufficient detail or analysis. In order for the Facility to be in compliance with this component of the Settlement Agreement, a tracking system needs to be in place to allow identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only the review of monitoring data, but also collection and analysis of key indicators or outcome measures. Although AUSSLC had collected some data related to incidents and allegations and the data required for	Noncompliance

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		submission to the State Office, it had not yet developed a set of key indicators. Without these key indicators, it was more difficult for the Facility to identify objectively the individuals who required additional attention to ensure safety and active treatment. This was especially critical for the living units for individuals with behavioral challenges or who had medical complexities. For example, the Director of Quality Management acknowledged that falls and head injuries were major issues now at AUSSLC, and that she was not certain that she was receiving all relevant data. As noted above, monitoring tools had been adopted based on the tools used by the Settlement Agreement Monitoring Teams. At the time of the review, they were being field-tested. It was positive that the Facility was making use of the tools developed by the Monitoring Teams. However, while on site, the Monitoring Team discussed with Facility staff some of the modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to: ▪ The monitoring tools did not currently include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools were using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; o Provide adequate guidance to reviewers who did not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of Monitoring Team members with substantial subject-matter knowledge. If they were going to be used by, for example, QE staff, who had more limited subject-matter expertise, it would be essential that specific, written guidance was available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts; and o Ensure that quality is being measured, and not just the presence or absence of an item. ▪ The items on the tools had not been weighted, but would need to be if they were going to be used to generate cumulative scores. ▪ Some of the indicators on the tool were specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Particularly if the Quality Enhancement Department was going to use these tools, such indicators would need to be modified, and more specific methodologies identified to evaluate such indicators. ▪ At times, it might be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitated this process because they tracked very closely the requirements of the Settlement Agreement that calls for, for example,	

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		policy development, as well as policy implementation. As a result, they were not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process. ▪ Methodologies for monitoring needed to be developed carefully. For example, different samples might need to be drawn to answer all of the questions on one tool. So, for example, a sample of individuals who still lived at the Facility and a different sample of individuals who had transitioned would need to be pulled to answer all of the questions for Section T of the SA. It might be beneficial in these situations to separate the questions for these two groups onto different review tools. The monitoring techniques (e.g., interviews, record reviews, and/or observations) that an auditor would be expected to use also should be defined. Sample sizes also would need to be defined.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Corrective Action Plans submitted included the actions to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person responsible; and the time frame in which each action step is to occur. Although data analysis had begun and Corrective Action Plans were developed, not all proposed actions were completed at the time of the monitoring visit. For example, the new risk policy was not yet completed and all high-risk living situations had not been assessed and addressed thoroughly. The Facility acknowledged the work to be done in this area. Certain actions had been taken, however, in response to the baseline monitoring report and improvements were noted as a result. For example, actions were taken to stabilize the Facility's leadership, reduce the need for mandatory overtime, and retain qualified staff. Restraint use was being examined. Although the Program Improvement Council met regularly, it needed to focus more directly on quality assurance as a whole at AUSSLC and not only on the compliance with the Settlement Agreement. The restructuring of the Program Improvement Council and the finalization of monitoring tools will be important next steps. The Facility was waiting for further guidance about the monitoring tool from the State Office. Restructuring of the Program Improvement Council was slated to begin in November 2010.	Noncompliance
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Corrective Action Plans have been developed but have not been fully implemented, as written. The Plans were being reviewed as the major part of the agenda for the Program Improvement Council. Each Department Head was to report on any accomplishments for the last three months; the challenges being experienced in implementing the Corrective Action Plans; plans for overcoming these challenges; as well as the supports needed and/or requested. In addition, the Department Head was to review the use of any monitoring tools; the presence and use of any databases; the status of policy/procedure review, revision and implementation; and the priorities for the next quarter.	Noncompliance

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		In discussions with key staff, frustration about the above process was cited. There was a perceived lack of clarity and a growing concern about the time required to accomplish these tasks. Furthermore, there was an absence of a holistic approach that linked these activities to improvement in health, safety and active treatment at the Facility. For example, an appropriate role of a Quality Assurance/Improvement Committee would be to include discussions of broader topics, such as the implementation of positive behavioral supports, and to then specify the compliance issues that affect this programmatic goal. Such discussion could involve, for example, analysis of factors that influence the implementation of positive behavioral supports, such as an adequate number of trained staff, age-appropriate materials and resources, properly designed environments, opportunities to exercise independence and choice, and access to community-based options. Staff from each discipline should be involved in this broader discussion. Once the analysis is completed and corrective actions are identified, the criteria for determining progress and the evaluation methodology should be specified. This approach would replace, or at least supplement, the point-by-point review of the monitoring tool by one staff member with little or no involvement of others.	
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.	As discussed above, the Program Improvement Council met regularly to review the progress in implementing corrective action plans. The Facility acknowledged that work was ongoing for this requirement of the Settlement Agreement. A new Quality Management Manual had been drafted. It assigned responsibility for monitoring the corrective action plans to the Quality Management monitoring staff. There were five monitors assigned at the time of the interview. One monitor was assigned to each Unit and one monitor had overlapping responsibilities.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	As noted above, the Facility was in the beginning stages of developing and implementing comprehensive corrective action plans. This issue was identified as a priority for the Facility leadership and the Quality Management Director and her staff. The restructuring of the Program Improvement Council with a focus on the Facility as a whole rather than on the requirements of the Settlement Agreement should benefit this critical area of responsibility.	Noncompliance

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

1. As is detailed above with regard to Section E.1 of the SA, the SA monitoring tools should continue to be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the development of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, development of scoring sheets, as appropriate, and the definition of the methodologies to be utilized (e.g., definition of samples to be drawn,

sample size, and the use of various monitoring techniques, such as interviews, record reviews, etc.).

2. The Facility should continue its useful efforts to analyze trends. It is critical that such analysis result in improved conditions in the living units, including the provision of active treatment and the reduction of the risk of harm.
3. In order to assist with this goal, the Facility should develop and implement a tracking system that allows identification of issues across the many components of protections, supports, and services provided to the individuals residing at the Facility. This will require not only the finalization of monitoring tools and the comprehensive review of monitoring data, but also collection and analysis of key indicators or outcome measures.
4. The valuable information already being collected should be used more rigorously to actually reduce and eliminate risk still evident for the individuals under the responsibility of AUSSLC. The information gathered by the Quality Management staff should be analyzed more consistently and thoroughly to identify problematic trends and/or individual issues. Action plans should be formulated to address such identified concerns. These action plans should continue to include actions, person(s) responsible, timeframes for completion, and definition of the desired outcomes.
5. Once these action plans are finalized, they need to be monitored to ensure their completion and their effectiveness in remedying the problems identified. If the actions plans are not effective, they should be modified appropriately.
6. It is highly recommended that there be a more holistic view of the challenges currently present at AUSSLC. The process of reviewing each Department and Unit separately should culminate in a review of the Facility as a whole.
7. The Facility should prioritize where changes will be made based on the level of risk and potential harm existing in a specific residential unit.
8. The Facility should explore ways in which the Self-Advocacy group can participate in its Quality Management efforts.

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 Personal Support Plan Process Policy #004, dated 7/30/10; o Personal Support Plans (developed under new policy/process) for the following individuals: Individual #355, Individual #432, Individual #445, and Individual #291; o PSPs and related assessments for the following individuals: Individual #285, Individual #177, Individual #280, Individual #72, Individual #354, Individual #208, Individual #144, Individual #18, Individual #183, and Individual #320; o QMRP information, updated 10/7/10; o Supporting Visions Tier 1 Training Schedule; o Lesson Plan and Content for four-hour Facility sessions, dated 7/10; o Supporting Visions: Personal Support Planning Workbook, dated 7/10; o Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 7/10; o AUSSLC Competency-Based Training Roster, blank form, undated; o Supporting Visions: Personal Support Planning Assessment, undated; o AUSSLC Corrective Action Plan; o Qualified Mental Retardation Professional (QMRP) Meeting Agendas, dated 9/1/10; 9/21/10, and 10/5/10; o Staffing Dates 2010 as of 9/10/10; o AUSSLC Corrective Action Plans, Section F, undated; and o Completed Personal Support Plan Meeting/Documentation Monitoring Checklists for 10 PSP meetings held between 9/2/10 and 10/6/10. ▪ **Interviews with**: o Tom Cochran, Coordinator of QMRP Services, and Sarah Knowles, Director of Active Treatment, on 10/4/10; ▪ **Observations of**: o PSP annual review meeting for Individual #68; and o PSP annual review meeting for Individual #26.
	Facility Self-Assessment: The Facility recognized in the POI that is was not in compliance with any of the components of the SA. This was consistent with the Monitoring Team's assessment. As noted below, a number of positive steps had been taken to implement the new planning process, which showed promise for improving the integration of protections, supports, and services.
	Summary of Monitor's Assessment: While this Section of the Settlement Agreement is complex and will continue to require the collaboration of all disciplines, there had been progress since the baseline review was conducted. Specifically: ▪ The DADS policy on integrated protections, services, treatments, and supports was issued at the

	end of July; and ▪ A number of AUSSLC staff had been certified as trainers, and all QMRPs at the Facility had undergone the initial training. Training also had begun to be provided to all other PST members. The Facility had begun using the new process. Some areas that required attention included: ▪ As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning; ▪ Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen; and ▪ The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

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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 was issued on 7/30/10. AUSSLC had not issued a companion policy as of the monitoring visit.	Noncompliance
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.	DADS Policy #004 at II.C.1.b indicated that the QMRP would plan and facilitate the PSP meeting. The Facility had not developed a companion policy. The QMRP Coordinator confirmed that QMRPs facilitated the teams, including team meetings. During the on-site review, at both the annual planning meetings for Individual #68 and the PFA meeting for Individual #26, the QMRP facilitated the meeting. It was a positive development that the new DADS policy was in place, and that key Facility staff had completed initial training. Specifically, all QMRPs at AUSSLC had undergone the initial training on the new PSP process and format. This policy clearly identified QMRPs as responsible for facilitating the teams. However, based on review of PSPs as well as during observation of two meetings held the week of the on-site review, facilitation of team meetings was not consistently resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. This is a key requirement to achieve compliance with this component of the Settlement Agreement.	Noncompliance

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		It was positive that the monitoring system that was beginning to be implemented was beginning to identify some of the issues with regard to individual planning. One component of the monitoring system was to have QMRPs sit in on PSP meetings, and using the Personal Support Plan Meeting/Documentation Monitoring Checklist monitor the meeting. Two QMRPs monitored the meeting for Individual #68, and a member of the Monitoring Team observed this meeting as well. In discussing the meeting after it ended, the QMRPs articulated a number of positive aspects of the meeting, as well as concerns about the meeting that were consistent with the Monitoring Team's findings. This was confirmed in their documentation of their observations. For example: ▪ The QMRP did a good job of ensuring that team members engaged in conversations, and did not only read directly from assessments. ▪ Some of the PST members were very actively involved in the conversations, and contributed to a number of the strategies discussed. ▪ Generally, the focus remained on speaking to the individual and/or guardian in a way that was easily understood and respectful. ▪ There was some good integration of supports and services, such as psychology, nursing, and speech contributing to discussions and problem-solving regarding overcoming the individual's medication refusals, helping him to transition from one activity to another, and reducing behavioral issues by providing him with a way to communicate the concept of "no," or that he needed a break. ▪ A list of preferences was developed. Some of these were incorporated into action plans, and/or strategies to address needs. For example, an action plan was developed to buy him a new rocker recliner because his broke, and he likes to rock. Likewise, action plan was developed to purchase a radio for his room because he likes music. However, when the team discussed his refusals to participate in day program activities, the team did not use his preferences with regard to music and/or movement to identify creative options to increase his participation in day/vocational activities. ▪ A prioritized set of needs was not established based on assessment information. ▪ No action plans specifically for skill acquisition goals were established with the input of all team members. In fact, very few action plans were discussed. No action plans were developed or discussed to integrate the various treatment plans into the PSP (e.g., nursing, speech, PBSP, etc.). Although health risks were identified at the beginning of the meeting, no action plans were developed to address these risks. ▪ Specific integration of any of the individual's goals or objectives into community settings and/or their functionality in such settings was not discussed. The State and the Facility should ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Person-centered planning is	

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		not a reason for not having plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc. An important change was related to QMRP staffing. At the time of the baseline review, it was reported that there were 16 QMRPs. There were 28 residential sites on campus. QMRP caseloads ranged from 22 to 32 individuals. Since then, 10 QMRPs had been hired, increasing the number to 26. The QMRP Coordinator reported that the goal was to have one QMRP per residence. This should assist QMRPs in being able to complete the many requirements of their job, including the adequate facilitation of PSP meetings. The supervision for QMRPs had been shifted from the Unit Directors to the QMRP Coordinator. Monthly meetings also had begun to be held with the QMRPs. This appeared to offer QMRPs the opportunity for additional training, as well as to share best practices with one another.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Policy #004 described the Personal Support Team as including the individual, the LAR, if any, the QMRP, direct support professionals, and persons identified in the Personal Focus Meeting as appropriate, as well as professionals dictated by the individual's strengths, needs, and preferences. Individuals' teams did not consistently include all of the staff necessary as dictated by the individuals' needs. For example: ▪ Individual #413's PSP, dated 9/11/09, stated: "continue PNMP and current assistive equipment issued by physical and occupational therapy." The PSP signature sheet did not document the attendance of an OT, PT and SLP to discuss the rationale for the PNMP strategies, and ensure the integration of these strategies across multiple disciplines. ▪ At her annual PSP meeting on 9/8/10, Individual #72's team did not include a Physical Therapist, a Speech Language Pathologist, or a physician, despite a long list of physical and nutritional support needs. ▪ Generally, other than nurses, other medical staff were not identified as being present at individuals' PSP meetings. As is discussed with regard to Sections J and K, the challenges of having adequate input from medical staff into individuals' plans while balancing their clinical responsibilities had not been adequately addressed. It also was difficult to determine who should be a member of each individual's team. For example, sign-in sheets were provided for many of the PSPs reviewed, but because team membership was not defined clearly, it often could not be determined who should have	Noncompliance

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		been present. The discussion and documentation of this in the PFWs should assist in ensuring teams are duly constituted based on the individuals' needs.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences, and needs, as well as recommendations to achieve their goals, and overcome obstacles to community integration. As is discussed in further detail with regard to Section S.1 of the SA, the revised Personal Support Plan Process Policy #004, dated 7/30/10, provided many appropriate and commendable standards, including, but not limited to: a) the use of assessment to determine an individual's current level of need; b) the opportunity for individuals to live, work, and recreate in integrated settings; c) competency-based staff training; d) skill acquisition training in all environments; e) clearly written behavioral objectives for all skill acquisition programs; and f) training objectives that address a range of areas, including personal hygiene, social skills, communication, domestic activities, leisure skills, community skills, and employment. Further, on page 14, the policy noted: "If training objectives are not able to be conducted in a community setting, justification must be documented." Lastly, the policy indicated that members of the Personal Support Team would review all assessments in preparation for the annual meeting. However, a review of even the plans completed using the new format and procedures did not consistently result in individuals having the benefit of a comprehensive assessment of their strengths, preferences, and needs, particularly with regard to their adaptive living skills. Without such comprehensive assessments, teams were stymied in their efforts to develop a plan to assist individuals as being as independent as possible. A number of specific examples are provided of this with regard to Section S.1 of the SA. Most of the PSPs reviewed contained assessments of health, behavior including psychological evaluations, speech, OT/PT, nutrition, self-administration of medication, audiological screening, dental, community living options, vocational or day evaluations, and other assessments based on specific needs. However, the quality of these assessments was of concern. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. This is discussed in further detail throughout this report with regard to the sections of the Settlement Agreement that address psychiatric services (Section J), psychology (Section K), medical services (Section L), nursing services (Section M), physical and nutritional supports and OT/PT (Sections O and P), communication (Section R), and habilitation, vocational, and skill acquisition (Section S). 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.	Noncompliance

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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 appeared to be two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a PSP that outlined the protections, services, and supports provided to the individual. These were: 1) there was a lack of consistent interdisciplinary discussion and coordination in the development of PSPs. This limited teams' ability to utilize assessment information to develop integrated protections, supports, and services; and 2) as is noted in other sections of this report, many of the assessments and evaluations being conducted were inadequate. Examples of this include inadequate nursing assessments, vocational assessments, psychiatric assessments, and assessments of individuals' physical and nutritional management support needs. The Facility needs to address these two issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the SA. The following provide examples of were incorporation of the results of assessments into individuals' plans was problematic: ▪ As noted with regard to Section S.2 of the SA, the Monitoring Team attended the Personal Support Plan meeting for Individual #26. The individual was present along with staff from a range of disciplines. There was an in-depth discussion regarding his preferences and needs. Towards the end of the meeting, one participant noted that, "… as a Team, we need to come up with objectives." Staff then began to suggest different activities that could become part of the individual's plan. There was no reference to an assessment that identified the individual's strengths or skill deficits. Suggestions for training objectives were presented randomly without clear recognition of the individual's learning needs. ▪ Likewise, as is illustrated in the example provided of Individual #68's plan with regard to Section F.1.a, similar concerns were noted in the meeting a member of the Monitoring Team attended.	Noncompliance
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.	Noncompliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and		

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	procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004 at II.D.4 indicated that Action Plans should be based on prioritized preferences, strengths, and needs. The use of the Personal Focus Worksheet appeared to be helping teams better understand the preferences and strengths of individuals. However, clear prioritization of the individuals' needs or careful delineation of barriers to addressing needs generally was not found. The integration of individuals' preferences to address needs or barriers also was not consistently seen. It was not consistently clear whether or how the goals and objectives were related to individuals' preferences, or were designed to overcome barriers to living in the most integrated setting. For example: ▪ As was mentioned above with regard to the planning meeting that the Monitoring Team attended for Individual #68 and Individual #28, there was no discussion of the priority of his needs. ▪ As is discussed below with regard to Section S, it was difficult to determine how skill acquisition goals were decided upon or prioritized based on the various needs of individuals as identified in their assessments. In Section S.1, an analysis is provided with regard to the sample of plans reviewed using the new PSP format and process. As is illustrated there, the newer plans did not clearly identify the individuals' prioritized needs. As indicated in the baseline report, another area where all plans reviewed could have benefitted from additional attention was with regard to "community participation." While some 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. Most simply stated that the individual would "have the opportunity to participate in off campus activities at least" for a stated number of times per month. Goals that easily could have been implemented in community settings and probably would have been more meaningful if they had been did not specifically state that they would be implemented in the community. For example: ▪ Individual #183 only had one objective that involved community involvement. It read: "[Individual # 183] will attend an off campus activities (sic) at least two	Noncompliance

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		times a month, to be documented on a service objective tracking sheet…" He had a goal to put money in a vending machine. It was unclear if his team had considered having him make purchases in the community, or using a vending machine in a community location. ▪ Likewise, Individual #354's plan identified general opportunities for him to participate in community activities. However, no specific skill acquisition goals were targeted for implementation in the community.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	As is discussed in other sections of this report, nursing plans, psychiatric treatment plans, and physical and nutritional support plans were not fully integrated into the PSP. They were generally stand-alone documents that might 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 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 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 included: ▪ Individual #432's PSP included an objective to "maintain the best possible health as evidenced by no injuries related to seizure activity for the next 12 months." Nursing was identified as responsible. It was unclear what measurable strategies would be utilized to attain this overall goal. ▪ Individual #72's PSP did not include measurable objectives regarding her physical and nutritional management plan. Her PNMP was merely referenced in narrative portions of the PSP. In addition, although her nursing care plan was repeated in the action plan section, the objectives were inadequate, and did not include steps either nursing or direct support professionals to address proactively Individual #72's healthcare needs. For example, an objective read: "[Individual #72] will maintain the best possible health as evidenced by 5 or fewer episodes of constipation during each quarter in the next 12 months." No measurable strategies were defined to assist the individual to achieve this outcome. ▪ Individual #285's PSP, dated 1/6/10, included no measurable objectives regarding either his nursing care plan or PNMT. In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. In summary, the Facility is at the very initial stages of complying with this component of the SA.	Noncompliance
	3. Integrates all protections,	None of the plans reviewed included a comprehensive set of measurable goals,	Noncompliance

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	services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	objectives, treatments, and strategies to be employed to fully support the individual. As noted in other sections of this report, PSPs did not integrate all of the protections, services, and supports, treatment plans, clinical care plans, and other interventions provided for individuals. For example: ▪ In reviewing Section O of the SA, 21 individuals' records were reviewed, and in none (0%) of the PSPs reviewed was evidence found that the PNMPs were actually reviewed at the PSP meetings, particularly for those individuals for whom habilitation therapies staff were not present to meaningfully review the PNMPs. Without such review, they were not adequately integrated across disciplines, and recommendations from other assessments and/or team members were not incorporated into the plans. The following provides a specific example of this: o As noted below with regard to Section O.3 of the SA, Individual #251's PNMP, revised 6/24/10, discontinued "assisting on her right side and walking with two staff holding gait belt if she lifts her right leg or use transport wheelchair." Offering her six ounces of liquids at meals, snacks, and in the evening was discontinued. Additions to her PNMP were "use of a recliner, stand pivot transfer with one staff holding gait belt, moves freely in bed and stop feeding her if she falls asleep." Her PSP did not discuss the rationale for these changes, nor were these changes integrated into her PSP. ▪ Similar concerns were found with regard to the integration of individuals' communication devices into their PSPs. o Individual #355's PNMP, revised 9/17/10, listed his assistive equipment as a picture communication book and picture schedule. His PSP, dated 9/17/10, did not document the participation of a SLP, nor were these devices integrated into his PSP training and/or service objectives. o Individual #284's Speech Language (SL) Evaluation, dated 12/11/09, documented the use of a "portable picture communication schedule, which she should continue to use everyday according to the instructions provided in her PNMP and posted on or near the equipment itself." Her PSP, dated 5/26/10, did not integrate the use of her picture schedule into training and/or service objectives. o Individual #228's Speech Language Evaluation Update Equipment Review, dated 4/8/10, documented the continued use of her communication book, picture board, and use of speech generating device with vibrating option on pictures, so that she could be aware when auditory messages were being delivered. Her PSP, dated 4/12/10, did not integrate the use of her communication devices into her action plan objectives, nor was a SLP in attendance at the annual PSP.	

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		▪ As is discussed below with regard to Section J.9 of the SA, a significant deficiency in this process of integration between psychiatry and psychology was identified. It related to the degree to which behaviors that were identified as being targets of a psychotropic medication were also identified in the Functional Analysis and the Positive Behavior Support Plan as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavior factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis, suggested that the medications were being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the Psychological Behavioral Treatment Plans were developed through parallel processes that were not fully integrated.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	DADS Policy # 004.II.D.4.d included the required elements. 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.	Noncompliance
	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	As is identified in other sections of this report, not all of the interventions, strategies, and supports offered to individuals at AUSSLC effectively addressed individuals' needs, and not all were practical and functional at the Facility and/or in community settings. These are discussed in the sections of this report related to the need to improve the plans that address conditions that place individuals at-risk, psychiatric treatment plans, Nursing Care Plans, PNMPs, OT/PT treatment plans, and Behavior Support Plans. The following provide some examples: ▪ Individual #177's PSP, dated 3/5/10, included some objectives that appeared to meet her needs, were functional and practical both at the Facility and in the community, such as objectives to learn to call preferred staff to make an appointment to meet with them (e.g., psychologist, Infirmary staff, etc.), floss her teeth, write a letter to friends or family members, and punch her medication out of a blister pack. However, there were a number of needs that either were not addressed at all, or were addressed inadequately due to the absence of practical and functional objectives. For example, Individual #177's nutritional evaluation, dated 3/5/10, indicated that her weight was "72 lbs [pounds] over her EDWR [Estimated Desired Weight Range]… Her nutritional status is not acceptable as evidenced by a BMI [Body Mass Index] of 35.2, indicating that she is obese." The only objectives that appeared in any way to address this need were: 1) for Individual #177 to walk four times a week for 10 minutes; 2) for Individual	Noncompliance

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		#177 to walk to appointments at the Infirmary; and 3) for staff to encourage her to purchase healthy snacks. There were no objectives designed to assist Individual #177 in understanding more about her nutritional status and/or steps that she could take to improve her status. In a community setting, Individual #177 likely would be expected to assist in planning menus, grocery shopping, and preparing meals. Based on her PSP, she was not being provided the opportunity to learn or refine any of these functional skills. It also should be noted that although individual had a dining plan that included a prescribed diet, it was not integrated into the PSP, because no measurable, functional objectives related to this plan were included in the PSP. On 4/20/10, a PSP Addendum meeting was held to discuss Individual #177's high risk due to her overweight status. No objectives were added to the PSP. There were two recommendations for follow-up, including looking into the possibility of healthier options in vending machines on campus, and an issue related to direct support professionals providing individuals with food outside of their prescribed diets. No details were provided in the notes regarding the latter issue, specifically as it related to Individual #177. Although it did not result in a formal recommendation, the team also discussed a possible referral to the Active Treatment Coordinator for an exercise program. Based on the documentation provided, the team had not met again to discuss resolution of the issues identified. Another need not adequately addressed in her PSP related to Individual #177's vocational needs. Although the vocational assessment described her as "doing very well at work… She is a very high producing employee… Overall, she is a very good worker and shows that she likes to make money," her PSP included no objectives or action plans to assist Individual #177 in identifying and obtaining a more competitive or integrated job. In addition, the objectives that were included related to her vocational training were not adequate. For example, one objective addressed Individual #177 "not leaving her work area." A more functional, practical objective would have been for Individual #177 to learn to identify reasons that were appropriate for leaving her work area (e.g., a bathroom break) and/or asking her supervisor for permission to leave the work area. ▪ Individual #320's PSP dated 5/12/10 also included some objectives that were functional and others that were not. For example, Individual #320 had objectives to take the public bus to the library at least once a month, and another to check out a library book and return it in good condition at least once a month. These were not only functional, but were good examples of objectives that assisted an individual in learning how to use community resources. Individual #320 also had objectives to fold laundry, and add up what she had spent on a	

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		weekly transaction log. These also were functional objectives that should assist Individual #320 in being more independent, and should be easily transferable to a community setting. Her PSP included some functional work skills, including signing in to work, and learning to use a calendar to identify when she would be paid. Although the overall goal read: "Through the increase (sic) development of coping skills, [Individual #320] would like to work at least 20 hours in a supported employment setting," none of the objectives related to this action plan appeared to be directly related to developing "coping skills." In addition, there were no service objectives included to assist Individual #320 in obtaining a supported employment position, or other more competitive or integrated work. Examples of objectives included in Individual #320's PSP that were not functional included the following that were assigned to nursing: "Ineffective airway clearance and breathing pattern," "Altered nutrition more than body requirements related to increase in calorie consumption," and "Knowledge deficit related to medication regiment (sic)." These were written as problems, not objectives. Likewise, the objectives included in the PSP from the BSP included descriptions of target behaviors to be reduced, but included no objectives related to the increase of functionally equivalent replacement behaviors. Also, a group of objectives were included related to the completion of physical therapy exercises. For example, an objective read: "With no more than 2 verbal prompts [Individual #320] will do OT/PT recommended exercise for 10 minutes 6 of 10 assessment trials for 4 consecutive months." Although it is positive that the PSP incorporated the OT/PT exercises, these objectives were not written in functional terms. Review of the Occupational and Physical Therapy Update, which appeared to have been completed four days after the PSP annual meeting, the function of the exercises appeared to be to reduce pain. Without definition of the expected measurable, functional outcome of the exercises (e.g., decrease in complaints of pain, and/or even more functional, an increase in the individual's ability to participate in certain types of activities), it was not clear how the team expected to measure the efficacy of the exercises. It also should be noted that other components of her PNMP were not incorporated into the PSP, including, for example, the use of her shoe lift, knee braces, postural support brace, etc. In addition, as was discussed in the baseline report, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Although many of the residences on campus had kitchens, food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Likewise, because	

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		pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at AUSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. For example, while the Monitoring Team was on campus, they witnessed a number of individuals walking about or riding their bikes independently, without much regard for typical pedestrian or biking rules or safety. Although it is positive that individuals have this level of independence, the different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. For example: ▪ Individual #146 was listed as an individual who had requested community placement, but for whom a referral had not been made. The explanation provided was that because he liked to walk around campus on his own and this would not be safe in a community setting, a community setting would be more restrictive. It was unclear whether or not training objectives had been developed to teach Individual #146 appropriate safety skills in community settings. This is a good example of an individual who clearly had the potential of being more independent becoming "institutionalized," because the system had not been adequate to teach him important independent living skills.	
	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.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. Consistent with the baseline review, for the goals and objectives included in PSPs, generally, the PSPs specified data to be collected and/or documentation to be maintained, and specified a frequency for data collection. It was not always clear who was responsible for reviewing the data, and what that review meant in terms of making changes when there was little or no progress. As is discussed above with regard to Section F.2.a.2, the overarching concern was that many goals and objectives were not specified in individuals' PSPs, or other treatment plans that should have been integrated into the PSP (e.g., Nursing Care Plans, PNMPs, psychiatric treatment plans, etc.). As is discussed below with regard to Sections K and S of the Settlement Agreement, processes were not yet in place to determine the reliability of the data. There were some indications that the data being collected was not reliable.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and	As noted in the baseline review, and based on the current review of PSPs, this was an area that required 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 dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to	Noncompliance

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	treatments are coordinated in the ISP.	individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach. As it noted above, it was encouraging to see the coordination and integration of some supports during Individual #68's PSP. Hopefully, as the new format and process are rolled out, the integration of protections, supports, and services will continue to grow.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.II.D.m required the PSP to be accessible and comprehensible to staff who must implement it. Copies of the PSP were being maintained in the Active Records in the residences to which staff working with the individuals had access. However, the content of the plans was not written in a manner that facilitated direct support professionals' understanding. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that PSPs and all of their various components are comprehensible, while still containing the necessary clinical requirements.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004 at III addressed personal support plan monitoring including the requirements of the SA. Quarterly/monthly reviews were requested for a sample of individuals. None were submitted. This was consistent with the baseline review at which time, the Director of Quality Enhancement, reported that few monthly and/or quarterly reviews were being conducted by individuals' teams. Moreover, examples are provided in various sections of this report of individual experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to medical and nursing care. In addition, as noted below with regard to Section O.3, there were times when a team member(s) identified a need for a change, but individuals' PSPs were not consistently modified to reflect such changes. Specific examples included: ▪ Individual #452's PNMP, revised 3/5/10, discontinued the use of his abdominal binder and added: "use of any position in wheelchair for feedings, medications and tooth brushing." These changes were not integrated into his PSP, nor were the changes integrated in Nursing Care Plans. It should be noted that his positioning in his wheelchair for these activities should have been better defined, and the team should have discussed this. ▪ Individual #159's PNMP, reviewed 8/5/10, added the use of a good grip coated youth spoon, angled to the right, and thicken liquids to honey consistency. Her PSP, dated 12/8/09, did not incorporate her PNMP, nor were there PSP Addendums to provide the rationale for these changes and integration of her	Noncompliance

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		revised PNMP into her PSP.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	DADS Policy #004.IV addressed staff training on the PSP process that comports with the SA requirements. A number of staff from AUSSLC had been certified as trainers on the new PSP policy, including the Director of QE and the QMRP Coordinator. It was reported that all QMRPs completed the training designed for them. One of the requirements for QMRPs was that they had to be able to provide training to other team members at the Facility. Members of the workgroup who developed the training observed the QMRPs training staff at AUSSLC. According to the QMRP Coordinator, all of them successfully completed this training requirement. In order to meet the Settlement Agreement requirements with regard to competency-based training, QMRPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. At the time of the review, it was reported that not all team members at AUSSLC had attended the initial training. For example, it was estimated that approximately 25 percent of the paraprofessionals had completed the training. In addition, staff consistently indicated the need for ongoing training and support in implementing this new, but exciting initiative. A number of staff described the training as a "whirlwind." A substantial amount of information was provided in a short period of time. Staff reported having questions as they began to implement the process, some of which had been answered and others not answered yet. Ongoing training should be provided to address gaps in knowledge regarding the new PSP process, as well as to enhance the various team members' skills.	Noncompliance
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	Based on a review of a list provided by the Facility of each individual and the dates of their 2009 and 2010 PSPs, it was found that of the 376 individuals supported by the Facility, 340 (90%) had had timely annual PSPs developed. Some of the individuals' PSP meetings were held within a few days of their anniversary date, while others were late by weeks or, in a few cases, months. The larger problem was related to the plans being available and in effect within 30 days. In many cases, a couple of months elapsed before the final document was prepared and filed. A sample of 50 individuals was reviewed. Of these 50, 28 PSPs (56%) had been filed within 30 days after the PSP meeting was held.	Noncompliance

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	preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	As noted in the baseline report, the PSP is the document that should drive the delivery of protections, supports, and services. It is essential that it be available for implementation within 30 days. As noted above, a number of changes had occurred since the baseline review with regard to QMRP staffing and supervision. The Facility should continue to monitor the timeliness in which PSP meetings are held, ensure that the documents are available for timely implementation, and make changes as needed.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	DADS Policy #004.V addressed quality assurance processes to ensure PSPs are developed and implemented consistent with the provisions of the SA. Monitoring tools had been adopted, and were being modified for Facility use as described in Section E of this report. This process was at the beginning stages. In addition, QMRPs were using the Personal Support Plan Meeting/Documentation Monitoring Checklist to monitor each other. As is discussed above, this appeared to be a valuable peer review tool that assisted QMRPs to learn both from being reviewed, and from being the reviewer. Some corrective action plans had been developed to address issues identified. For example, one was developed to improve specific components of the PSP process, for example by not pasting assessment into the PSP format to encourage group discussion, and creating action plans based on priority needs. The quality of this corrective action plan was questionable because it did not provide measurable action steps that went much beyond saying what not to do. For example, one action step read: "Do not paste assessments into new PSP shell – promote group discussion based on person's preferences." It was not clear what actions were going to be taken to facilitate QMRPs making this happen. For example, the corrective action plan did not identify additional training needed, or mentoring for QMRPs who had difficulty with this. The anticipated outcome was "Improved PSP process," but it was not clear how this would be measured. It appeared that two other corrective action plans were designed to address specific issues with particular individuals' plans. As the process for monitoring this Section of the SA is refined, additional action plans likely will need to be developed and implemented.	Noncompliance

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

1. Now that the State's policy with regard to interdisciplinary teams and integrated planning has been finalized, AUSSLC should review, and revise, as appropriate, its policies on these topics.
2. The State and the Facility should ensure that person-centered concepts are integrated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

3. As indicated in other sections of this report, focused efforts should be made to improve the quality and timeliness of assessments used in the development of individuals' PSPs.
4. Barriers, if any, to the inclusion and implementation of community-based skill acquisition programs, such as transportation, staffing, and funding, should continue to be investigated and addressed.
5. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the PSP, rather than stand-alone documents.
6. The Facility should be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking and realistic community safety skills, become a regular part of training programs for individuals served.
7. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that PSPs and all of their various components are comprehensible, while still containing the necessary clinical requirements.
8. QMRPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed.
9. Ongoing training should be provided to address gaps in knowledge regarding the new PSP process, as well as to enhance the various team members' skills.
10. The Facility should monitor to ensure PSPs are completed in a timely manner and prepared to allow implementation to begin within 30 days. Any issues identified should be addressed.
11. Corrective action plans should not merely state what needs to be changed, but should identify specific actions that are going to be taken to effectuate the change.

SECTION G: Integrated Clinical Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Consultation reports for the following individuals: Individual #168, ENT dated 7/8/10; Individual #151, Optometry Clinic, dated 8/18/10; Individual #287, Optometry Clinic, dated 8/18/10; Individual #190, Optometry Clinic, dated 8/18/10; Individual #45, Optometry Clinic, dated 8/18/10; Individual #213, Optometry Clinic, dated 8/18/10; Individual #347, Optometry Clinic, dated 8/18/10; Individual #22, Optometry Clinic, dated 8/18/10; Individual #102, Optometry Clinic, dated 8/18/10; Individual #381, Optometry Clinic, dated 8/18/10; Individual #100, Optometry Clinic, dated 8/18/10; Individual #422, Optometry Clinic, dated 8/18/10; Individual #405, Optometry Clinic, dated 8/18/10; Individual #212, Optometry Clinic, dated 8/18/10; Individual #51, Optometry Clinic, dated 8/18/10; Individual #62, Optometry Clinic, dated 8/18/10; Individual #18, Optometry Clinic, dated 8/18/10; Individual #456, Optometry Clinic, dated 8/18/10; Individual #239, Optometry Clinic, dated 8/18/10; Individual #299, Optometry Clinic, dated 8/18/10; Individual #366, Optometry Clinic, dated 8/18/10; Individual #390, Optometry Clinic, dated 8/18/10; Individual #416, Orthopedic consultation, dated 8/16/10; Individual #37, Optometry Clinic, dated 8/18/10; Individual #80, Optometry Clinic, dated 8/18/10; Individual #423, Physical Medicine Clinic, dated 8/3/10; Individual #8, Orthopedic consultation, dated 8/2/10; Individual #324, ENT, dated 7/8/10; Individual #189, ENT Clinic, dated 7/8/10; Individual #402, Surgery consultation, dated 7/26/10; Individual #396, Surgery consultation, dated 7/26/10; Individual #261, Neurology consultation, dated 8/23/10; Individual #190, Neurology consultation, dated 8/9/10; Individual #90 Gastrointestinal (GI) Clinic, dated 6/8/10; Individual #352, Optometry Clinic, dated 5/19/10; Individual #264, Eye Clinic, dated 6/11/10; Individual #278, Eye Clinic, dated 8/13/10; and Individual #440, Optometry Clinic, dated 5/19/10; o Pharmacy form: HRAT POLYRX-D1, entitled: Poly-Pharmacy – Health Risk Assessment Tool; o Poly-Pharmacy – Health Risk Assessment Tool for the following individuals: Individual #153, dated 9/29/10; Individual #243, dated 9/29/10; Individual #327, dated 9/29/10; Individual #442, dated 9/29/10; Individual #21, dated 9/29/10; Individual #382, dated 9/29/10; Individual #429, dated 9/29/10; Individual #298, dated 9/29/10; Individual #389, dated 9/29/10; Individual #215, dated 9/29/10; Individual #191, dated 9/29/10; Individual #51, dated 9/29/10; Individual #299, dated 9/29/10; Individual #168, dated 10/4/10; Individual #249, dated 10/4/10; Individual #340, dated 10/4/10; Individual #8, dated 10/4/10; Individual #84, dated 10/4/10; Individual #24, dated 10/4/10; Individual #113, dated 9/15/10; and Individual #454 dated 9/15/10; and o Austin SSLC monthly Psychiatry Poly-pharmacy Review Roster, dated 9/16/10.

	▪ **Interviews with**: o Fred Bibus, MD, Medical Director; o Kenda Pittman, Pharm D; o Rhonda Stokley, DDS, Dental Director; and o Donnie Lane, PharmD, Clinical Pharmacist. ▪ **Observations of**: o Individual #456; o Dental Clinic, on 10/7/10; and o Dr. L. Thompson, Dental anesthesiologist.
	Facility Self-Assessment: According to the Facility's POI, there was awareness of current noncompliance with this section of the SA. As the POI indicated, monitoring procedures needed to be put in place to assist the Facility in determining compliance or noncompliance, and identifying the specific areas requiring attention. As is noted below, there were some activities that were beginning to be implemented to achieve compliance. The Medical Director stated this SA would require the heads of the Facility's departments to collaborate. The POI indicated that the discipline heads had met, and agreed to form an Integrated Services Committee to develop strategies to address some of the outstanding issues with regard to integrated care.
	Summary of Monitor's Assessment: There had been success in some areas of integrated clinical services, such as the Pharmacy Department providing information so that it was available at the time of the quarterly psychiatric reviews. However, there were serious gaps in integration that will require improved communication and collaboration between departments, such as between nursing and pharmacy. The departments were beginning to identify approaches to provide integrated health services. However, the Facility's clinical departments were at the early stages of this development. There should be a system to document success in integrated services.

#	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	There were a number of examples of integrated clinical services currently being implemented at AUSSLC. For example: ▪ The monthly psychiatry poly-pharmacy review was an example of integration of psychiatry, pharmacy, and medicine. The committee met monthly to review definitions of poly-pharmacy, to review plans for medication reduction, and identify the number of individuals receiving psychiatric poly-pharmacy. ▪ The Pharmacy Department created a document entitled the "Poly-Pharmacy – Health Risk Assessment Tool." The form was brief, but provided the essential information needed by the Personal Support Team (PST) to discuss health care as related to poly-pharmacy, as well as the Health Status Team (HST) as they met to discuss risk. It provided brief entries on poly-pharmacy of both non-	Noncompliance

#	Provision	Assessment of Status	Compliance
	need.	psychotropic medication and psychotropic medication. The following Poly-Pharmacy – Health Risk Assessment Tools were reviewed for the following individuals: Individual #153, dated 9/29/10; Individual #243, dated 9/29/10; Individual #327, dated 9/29/10; Individual #442, dated 9/29/10; Individual #21, dated 9/29/10; Individual #382, dated 9/29/10; Individual #429, dated 9/29/10; Individual #298, dated 9/29/10; Individual #389, dated 9/29/10; Individual #215, dated 9/29/10; Individual #191, dated 9/29/10; Individual #51, dated 9/29/10; Individual #299, dated 9/29/10; Individual #168, dated 10/4/10; Individual #249, dated 10/4/10; Individual #340, dated 10/4/10; Individual #8, dated 10/4/10; Individual #84, dated 10/4/10; Individual #24, dated 10/4/10; Individual #113, dated 9/15/10; and Individual #454, dated 9/15/10. There were four questions asked on the Poly-Pharmacy – Health Risk Assessment Tool, which required a "yes," or "no" response, with room for comments. The form was clear, and it should provide PST and HST members a good understanding of this information. Based on the dates of the forms, this was a recent endeavor. However, it provided an example of information that was provided by one team member to allow all team members to integrate information into their department's assessment and recommended plan for the individual, and ultimately into the final PSP for the individual. ▪ While touring the Dental Department, the Monitoring Team observed integrated services between the Medical Department and the Dental Department. The Dental Anesthesiologist requested the PCP evaluate oral findings on Individual #456 that the dental anesthesiologist had identified. The PCP promptly arrived, and the two professionals examined the individual at the same time to develop a clinical conclusion. This was an excellent example of the medical staff's flexible approach with regard to their schedules and to accommodate the needs of another department in order to provide continuity of care efficiently and effectively. ▪ To assist the Psychiatry Department, for those individuals for whom a quarterly psychiatric review was scheduled, the Pharmacy Department completed the Quarterly Drug Regimen Reviews (QDRRs) just prior to the scheduled review. This provides valuable updated information that is immediately shared with the team during the quarterly meeting. This is an excellent example of integrated clinical care. The psychiatry services were integrated with psychology in that the psychologists played an integral role in the Psychiatric Clinic process. The Psychiatric Clinics were the primary forums for coordinating that aspect of medical care for the individuals who resided at the AUSSLC. The psychologists were responsible for providing the data that	

#	Provision	Assessment of Status	Compliance
		influenced and affected the decision-making of the psychiatrists. However, the review of the individual records described below with regard to Section J revealed that behaviors that were described in the Functional Analysis and Behavior Support Plan as being present on a behavioral basis, also frequently were described in the Psychiatric section as "targets" for the psychotropic medication. This would suggest that either the psychotropic medications were being used to suppress behaviors related to environmental and interpersonal factors or there was a lack of integration between the Psychiatry and Psychology Departments in the development of these plans. It is recommended that the Psychiatry Department begin an active collaboration with members of the Psychology Department to address these issues. The integration between psychiatry and medicine was primarily represented by the participation of the nursing staff in the Psychiatric Clinic process. The interaction with the Primary Care Practitioners was usually accomplished by written consultations between disciplines, as well as telephone contacts. Based on chart review of 15 individuals who had been hospitalized for acute illness, some due to aspiration pneumonia, and the medication administration observations and interviews with the nursing staff, there was little to no collaboration between nursing, medical, and the PNMT regarding the individuals who had recurrent pneumonias and aspiration pneumonias. From observations during medication administration, nurses were not assessing safe positioning for individuals when they administered medications orally or enterally. In addition, a number of the records reviewed indicated that many symptoms individuals had been experiencing had not been adequately assessed or re-assessed on a timely basis. The situations the Monitoring Team observed that are detailed with regard to Section M.6 of the SA clearly highlighted the need for interdisciplinary collaboration to ensure that individuals were not being place at risk of harm during medication administration and during other daily activities. There were a number of interdepartmental areas in need of better communication and integration. Examples included pharmacy and nursing, pharmacy and dental, pharmacy and habilitation services, dental and psychology, and the Medical Department and Facility Administration. Specifics are noted in below with regard to Sections L, N and Q of the SA.	
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-	Consultation reports were submitted and reviewed to determine whether there was documentation that the PCP had read and commented concerning the reports. The focus was on whether or not there was documentation that the PCP agreed with the recommendations, and if not, provided rationale for not completing the recommendation or had made a referral to the PST as a next step. The following consult reports indicated	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	the PCP initialed, dated and agreed with the report: Individual #168, ENT Clinic, dated 7/8/10; Individual #151, Optometry Clinic, dated 8/18/10; Individual #287, Optometry Clinic, dated 8/18/10; Individual #190, Optometry Clinic, dated 8/18/10; Individual #45, Optometry Clinic, dated 8/18/10; Individual #213, Optometry Clinic, dated 8/18/10; Individual #347, Optometry Clinic, dated 8/18/10; Individual #22, Optometry Clinic, dated 8/18/10; Individual #102, Optometry Clinic, dated 8/18/10; Individual #381, Optometry Clinic, dated 8/18/10; Individual #100, Optometry Clinic, dated 8/18/10; Individual #422, Optometry Clinic, dated 8/18/10; Individual #405, Optometry Clinic, dated 8/18/10; Individual #212, Optometry Clinic, dated 8/18/10; Individual #51, Optometry Clinic, dated 8/18/10; Individual #62, Optometry Clinic, dated 8/18/10; Individual #18, Optometry Clinic, dated 8/18/10; Individual #456, Optometry Clinic, dated 8/18/10; Individual #239, Optometry Clinic, dated 8/18/10; Individual #299, Optometry Clinic, dated 8/18/10; Individual #366, Optometry Clinic, dated 8/18/10; Individual #390, Optometry Clinic, dated 8/18/10; Individual #416, Orthopedic Clinic, dated 8/16/10; Individual #37, Optometry Clinic, dated 7/10/10; Individual #80, Optometry Clinic, dated 8/18/10; Individual #423, Physical Medicine Clinic, dated 8/3/10; and Individual #8, Orthopedic Clinic, dated 8/2/10. These 27 records were in compliance. However, for most records, there was little content other than that the PCP agreed with the findings, and not an actual response to each recommendation. It is recommended that the Medical Director meet with the medical staff to develop a standardized approach to documentation regarding the consultations. Documentation should provide proof that the PCP reviewed the report, and responded to each recommendation separately. A short form that is attached to or stamped on each consultation for completion might be adequate. A Quality Assurance program/system also should be created to track recommendations that are agreed upon by the PCPs to ensure completion. There were a number of consultation reports submitted that did not meet the basic requirements of the SA in this section. Consultation reports were reviewed for the following individuals: Individual #324, ENT Clinic, dated 7/8/09; Individual #189, ENT Clinic, dated 7/8/10; Individual #402, Surgery consultation, dated 7/26/10; Individual #396, Surgery consultation, dated 7/26/10; Individual #261, Neurology Clinic, dated 8/23/10; Individual #190, neurology consultation, dated 8/9/10; Individual #90, GI Clinic, dated 6/8/10; Individual #352, Optometry Clinic, dated 5/19/10; Individual #264, Eye Clinic, dated 6/11/10; Individual #278, Eye Clinic, dated 8/13/10; and Individual #440, Optometry Clinic, dated 5/19/10. Although the PCP initialed and dated these consultation reports, there was no indication of agreement or disagreement, or that recommendations were going to be completed. The initials and dates provided proof the consultation was acknowledged. The SA requires that there be notation or proof that the recommendation has been accepted and/or referred to the Interdisciplinary Team (IDT).	

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		If a recommendation is not accepted, justification should be provided. Based on this review, 27 out of 38 reports (71%) included documentation that the PCP had reviewed the consultation report, and indicated whether or not the PCP agreed with the recommendations. However, the SA also requires compliance with the HCG. The HCGs include detailed guidelines concerning consultation reports and recommendations. The HCGs state: "If recommendations are implemented, the PCP will include his/her signature and the date on the consultant report and dictate a corresponding integrated progress note entry." At the time of the review, AUSSLC did not have dictation services for the Medical Department, and it is recommended that this be obtained. However, the Monitoring Team requested not only submission of consultation reports, but also PCP notes written to agree or not on recommendations. There were no notes submitted to suggest entries into the Integrated Progress Notes (IPNs) for any of the 38 records reviewed, resulting in 0% compliance with this requirement within the HCGs. It is also important to note that the consultant reports should have a PCP signature, not initials. The only routine involvement between psychiatry and a non-facility physician would be with neurology. The Psychiatrist did not sign off the Neurology Consultation Notes, nor were they routinely referenced in the Psychiatric Progress Notes. However, the Psychiatry Department had begun an initiative to have the Psychiatrist attend the Neurology Consultations for the individuals on their caseloads. A recent example of this collaboration and the related documentation was found in this review, and is described below with regard to Section J.15 of the SA.	

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

1. The Medical Director should meet with the medical staff to develop a uniform approach to documenting review of the content of the reports and responding to any recommendations. Such documentation should provide proof the PCP reviewed the report, and responded to each recommendation separately.
2. A QA program/system also should be created to track recommendations that are agreed upon by the PCPs to ensure completion.
3. As required by the HCGs, PCPs should enter or dictate a corresponding Integrated Progress Note entry for each consultation reviewed.
4. The Psychiatry Department should begin an active collaboration with members of the Psychology Department to address issues related to behaviors that are described in the Functional Analysis and Behavior Support Plan as being present on a behavioral basis also frequently being described in the Psychiatric section as "targets" for the psychotropic medication.

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

1. The Medical Department should obtain transcription services, either by hiring additional or reassigning the duties of administrative staff, or through a contract service.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Austin State School Training Roster Course entitled: "ICD and DSM Diagnoses," dated 10/10; and o Documents reviewed in relation to Sections J, L, M, N, and Q of the SA. ▪ **Interviews with**: o Fred Bibus, MD, Medical Director; and o Staff interviewed in relation to Sections J, L, M, N, and Q of the SA.
	Facility Self-Assessment: The Facility's POI indicated noncompliance with regard to all indicators related to Section H. The responses in the comments section of the POI demonstrated the Facility's awareness of the need to assess progress with regard to compliance by collecting data. There is awareness that many areas have not been addressed, and that often the subsections build on the success of the prior step.
	Summary of Monitor's Assessment: Although there was completion of annual medical assessments, individuals' needs were not being met for the long-term evaluation of serious recurrent processes. Many other assessments were not being completed in a comprehensive manner, or as individuals status changed. Examples of this included nursing assessments, and assessments by the Physical and Nutritional Management Team for individuals with complex needs. AUSSLC did not have an adequate Quality Assurance system that included clinical indicators. Development of such a system will require the identification of appropriate clinical indicators, as well as development and implementation of an adequate database. As data becomes available, it will be essential for thorough analysis to be completed of the data, and plans of correction to be developed to address identified concerns on an individual, as well as on a systemic level. The Facility did not have a set of comprehensive facility-specific medical or dental policies, and was relying mainly on the Health Care Guidelines. There was a need for the development of a Medical Department policy and procedure manual, which incorporated the HCGs and any subsequent updates, as well as clinical guidelines and pathways. Likewise, formal dental policies needed to be finalized and implemented.

#	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	Completion of annual medical assessments had a compliance rate of 90 percent. Routine preventive testing and treatment had a more varied compliance rate. The compliance rate with the current, as well as HCG, recommendations for screening mammograms was 95 to 98 percent. Colonoscopy screening complied with national recommendations as well as the HCGs 45 percent of the time. A more in-depth review of these clinical areas is	Noncompliance

#	Provision	Assessment of Status	Compliance
	basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	provided below with regard to Section L.1 of the SA. More problematic was the long-term evaluation of serious recurrent problems. Although acute care needs were met, clinical acumen in searching out the reason for recurrent hospitalizations, for the same serious illness, before further problems and clinical compromise occurred, did not meet acceptable standards. This is discussed in greater detail with regard to Section L.1 of the SA. There was documentation that quarterly interdisciplinary reviews of psychotropic medication were being uniformly carried out, with more frequent reviews as required. However, the review of the individual records described below with regard to Section J of the SA indicated that the quality of the documentation contained in the Psychiatry Assessments and the Psychiatry Clinic Reviews did not meet the standards set forth in the Settlement Agreement. The Psychiatry Department had begun an initiative to complete thorough Comprehensive Psychiatric Assessments on all individuals who were receiving psychotropic medication. The initial review of a sample of these assessments indicated that they represented a significant improvement. As is discussed in detail with regard to Section O of the SA, individuals at risk due to their physical and nutritional support needs were not being provided with comprehensive assessments in a timely manner. The same was true for individuals who experienced a change in status. Likewise, nursing assessments were inadequate. This is discussed in greater detail below, with regard to Section M of the SA.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Physicians were expected to adhere to the International Classification of Diseases and Related Health Problems and the Diagnostic and Statistical Manual of Mental Disorders (DSM) in providing diagnoses that were consistent with clinical findings, and data results from laboratory, radiographic studies, and other diagnostic testing. The Medical Director indicated an in-service had been completed for this, and submitted a training roster for "ICD and DSM Diagnoses," dated October 2010. A description of the training stated: "Diagnoses given in assessments are consistent with the most recent DSM IV and/or ICD 9 classifications." Eight physicians and one physician extender signed off on this training roster. However, given this training occurred near the time of the Monitoring Team's visit, these expectations had been set forth just recently. As part of its quality assurance system, the Medical Department should monitor PCPs compliance regarding the use of DSM and ICD diagnoses. This should include the use of a database system that reflects diagnoses based on medical evaluations, and DSM and ICD nomenclature and classifications.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The psychiatric diagnoses utilized at the AUSSLC were consistent with the nomenclature utilized in the DSM-IV-TR. The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which sets forth the specific symptoms that the individual presented, in a manner that would support the validity of the psychiatric diagnosis. However, the aforementioned initiative to complete a thorough Comprehensive Psychiatric Assessment on every individual might address this deficiency, as the review of a sample of these documents indicated that they did meet the requirement of the Settlement Agreement. The Pharmacy Director indicated that 95 percent of psychotropic medications dispensed were linked to an appropriate DSM diagnosis, but it was estimated that only 50 percent of medications overall had a diagnosis identified at the time the order was written. This could mean the PCP did not write a diagnosis at the time of the order, or that the pharmacy staff did not capture the diagnosis at the time of data entry. It is recommended that pharmacy review the data entry system for all orders and provide in-service training to the pharmacy staff underscoring the importance of entering a diagnosis for each medication prescribed. As part of a Medical Department quality assurance program, there should be a system to track physician compliance with supplying an accurate diagnosis for each medication prescribed. Compliance with this section of the SA will require data indicating that all medications have an appropriate ICD or DSM diagnosis.	
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.	There was no standardization of treatment or standard timelines for intervening with further diagnostic evaluations and other medical or surgical treatments, when indicated. For example, there were three individuals hospitalized at the time of the Monitoring Team's visit. These three individuals had had repeated aspiration. When the Monitoring Team asked the Medical Director if these individuals had been provided a work-up for Gastrointestinal Reflux Disease (GERD), initially, there seemed to be the expectation that the acute problem was being treated and that was sufficient. When tests were completed, all three individuals were reported to have had significant GERD, which will lead to the next challenge of determining which options should be utilized to treat the GERD. However, a work-up should commence after a repeat hospitalization for the same reason, with the goal of preventing a third hospitalization for the same reason. Also, work-ups should not only occur when the individual is acutely ill and hospitalized, but should occur prior to that time, on an outpatient basis, while the individual is well. The quarterly Psychiatric Clinics and Assessments of the individuals were consistent with one of the requirements of this provision, in that they were performed in a "timely" manner. As noted above, and with regard to Section J of the SA, the deficiencies regarding this provision related to the requirement that these interventions are "clinically appropriate based upon assessments and diagnosis."	Noncompliance

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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 part of this standardization of treatment, the Medical Director should create and implement several clinical guidelines or pathways concerning the most common diagnoses and illnesses in the population, including, for example, aspiration pneumonia, GERD, chronic constipation, pica, and osteoporosis. These pathways should leave sufficient room for the PCPs to make appropriate choices, based on their training and experience, but be clear and detailed enough to provide guidance with the content of assessments and evaluation, as well as a step wise process of treatment, including follow-up, all within a timeline/timeframe agreed upon by the medical staff. Successful treatment should be defined by a number of parameters. For example, stabilization of the T-score in a DEXA scan, or 100 percent compliance with a vaccination schedule. Once the medical staff are in-serviced on these pathways, various parts of these pathways should be used as measurement tools to determine physician compliance with evaluation and treatment. The attainment of the goal can also be tabulated. The lack of sufficient documentation concerning the efficacy of the psychotropic medication was a significant deficiency in the utilization of these medications at the AUSSLC. This issue and the potential remedies are discussed in detail below with regard to Section J of the SA.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	AUSSLC had not developed a quality assurance program, in the medical department, which would include identification of clinical indicators to measure treatment efficacy. In creating new clinical pathways, there should be sufficient details within the guidelines to allow identification of one or more clinical indicators. For instance, if severe constipation is one of the clinical guidelines, then the guideline should outline the threshold for the next step to be taken. For instance, if a person requires more than three enemas in a month, then there may be an expected response, such as additional dosage of a medication given or a new medication added. A clinical indicator would be three or less enemas per month, which could be tabulated easily across the system to determine the attention and quality of care provided for this problem. One of the main tasks of the Medical Director would be to ensure the clinical pathways or guidelines were understood by the PCPs and followed. Many of the aspects of clinical pathways become practical and meaningful when they are used to demonstrate and measure quality care. The health care team gains a sense of accomplishment when they see measurable indicators have improved. The Medical Director also gains confidence that the health care needs are being met equally across all residences on the campus, and can readily determine if there is a residence needing further assistance. This will take considerable effort in creating and implementing a process, as well as development of an appropriate database for a variety of diagnoses. As mentioned below with regard to Section L of the SA, the databases currently available were significantly	Noncompliance

#	Provision	Assessment of Status	Compliance
		incomplete. The examples of osteoporosis and osteopenia are reviewed in detail below. The Medical Director should meet with those responsible for information technology on a routine basis, to create a user-friendly database, both for data entry, but also for producing reports of the data that provide the necessary information. The Medical Director should evaluate the current staffing of the Department, and if additional resources are needed to accomplish the necessary data entry, should work with Facility Administration to ensure that appropriate staffing is available. The psychiatric status of each individual receiving psychotropic medication was discussed on a quarterly basis in the format of the Psychiatric Clinics. These meetings also included a discussion by the nursing staff of any medical problems, as well as any apparent side effects of the medications. However, this information was not fully documented in the overall Facility health status assessment process.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	As already mentioned, the Facility had not developed and implemented clinical indicators from clinical guidelines that could be used as a measuring tool in identifying medical issues and providing interventions. This can be a valuable process for all levels of health care, from preventive, to routine maintenance, to acute care. Such clinical indicators can provide fresh insight into individuals' needs. For instance, episodes of wheezing may be an indicator that is targeted for intervention in attempts to reduce the episodes of bronchospasm. Although there is the understanding that allergies and asthma are causative factors for wheezing, another important cause of wheezing may be severe GERD with aspiration into the lung, setting off an episode of bronchospasm. The appropriate work-up may lead to a new treatment such as implementation of Proton Pump Inhibitors for those that develop wheezing, especially in those with known GERD. With less attacks of bronchospasm, there may be a reduced usage of PRN nebulizer treatments. The number of times PRN nebulizer treatment per week or month is used could be measured, and reviewed for trends to determine improvement. While this is a future goal, requiring database creation and management, it also will require developing clinical pathways that outline measurement tools and measureable clinical indicators for each diagnosis that is monitored. The "clinical indicators" that the psychiatrist responded to were primarily represented by the behavioral data presented by the Psychologist in the quarterly Psychiatric Clinics. As discussed above, and below with regard to Section J of the SA, a significant deficiency derived from the observation that the "target behaviors" of the psychotropic medication also frequently were described elsewhere in the record as being present on a behavioral basis.	Noncompliance

#	Provision	Assessment of Status	Compliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	At the time of the review, the Medical Department had few to no policies specific to AUSSLC. The HCGs and a few articles of updated information represented the majority of the policy and procedure guidance available. The Medical Director should create and implement a number of policies concerning medical care, including the clinical guidelines/pathways already mentioned. Additionally, updating the HCG will provide clarity and avoid confusion in some clinical areas that are rapidly changing. There should be standardization of care across the campus. The development and implementation of clinical pathways and monitoring of their implementation is one route for accomplishing this. However, unless the monitoring results are shared with the PCPs, there will not be information and/or motivation to change current practices. Analyzing the data collected and developing appropriate plans of correction will be an integral part of the Medical Director's role. Similarly, the Dental Director should finalize the current informal dental policy manual, including any new policies or guidance from the SO. Additionally, because there is intravenous (IV) anesthesia provided on site, there should be a series of policies and procedures governing this type of anesthesia, including pre, intra, and post anesthesia monitoring. The policies specific to the Psychiatry Department submitted for review consisted of a copy of those the DADS State office created and applied to all of the SSLCs. This policy is entitled "State Supported Living Centers Policy: Psychiatry Services" was dated 7/20/10. Although this document was very detailed, it did not contain any policies that were unique to AUSSLC as compared to the other SSLCs. Attached to this document as Exhibit A was an outline for "Psychiatric Evaluations/Assessments," which was meant to serve as a model for the assessments to be performed in all of the SSLCs, and was consistent with that included as an attachment to the SA. The samples of the new format of Comprehensive Psychiatric Assessments that were beginning to be completed for individuals at AUSSLC conformed to this outline.	Noncompliance

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

1. As part of its quality assurance system, the Medical Department should monitor PCPs compliance with use of DSM and ICD diagnoses. This should include the use of a database system that reflects diagnoses based on medical evaluations, and DSM and ICD nomenclature and classifications.
2. The pharmacy should review the data entry system for orders, and provide in-service training to the pharmacy staff underscoring the importance of entering a diagnosis for each medication prescribed.
3. As part of the Medical Department's quality assurance program, a system should be developed and implemented to track physician compliance with supplying an accurate diagnosis for each medication prescribed.
4. Evaluations that would assist in further diagnosis and treatment should commence after a repeat hospitalization for the same reason in order

to prevent a third hospitalization. Ideally, work-ups should occur on an outpatient basis while the individual is well, not when they are again hospitalized for a repeat event.

5. The Medical Director should create and implement several clinical guidelines or pathways concerning the most common diagnoses and illnesses in the population, including, for example, aspiration pneumonia, GERD, chronic constipation, pica, and osteoporosis. They should be sufficiently detailed to provide guidance with regard to the content and types of work ups to be completed, as well as step wise process of treatment and follow-up. Clinical pathways should be designed to ensure all available options are considered for each individual at the appropriate time in the clinical course. Timelines also should be included in the clinical guidelines to ensure all medical staff adhere to an appropriately aggressive approach to resolution of medical illness and diagnoses.
6. A number of parameters that are easily measurable should be defined to measure successful treatment.
7. Parts of the clinical pathways should be used as measurement tools to determine physician compliance with evaluation and treatment.
8. The Medical Director should meet with those responsible for information technology, on a routine basis, to create a user-friendly database, both for data entry, but also for producing reports of the data that provide the necessary information.
9. The Medical Director's role should include analysis of data regarding clinical outcomes, and development and implementation of plans of correction to address identified issues.
10. The Medical Director should evaluate the current staffing of the Department, and if additional resources are needed to accomplish the necessary data entry, should work with Facility Administration to ensure that appropriate staffing is available.
11. The Medical Director should create a Medical Department policy and procedure manual, which incorporates the HCGs and any subsequent updates, as well as the clinical guidelines and pathways.
12. The Dental Director should to transform the current informal dental policy manual into formal policies, and finalize it, including any new policies or updates from the State Office (SO).
13. Because there is intravenous anesthesia provided on site, there should be a series of policies and procedures governing this type of anesthesia, including pre, intra, and post anesthesia monitoring.

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 PSPs for the following individuals: Individual #51, dated 9/29/10; Individual #299, dated 9/29/10; Individual #191, dated 9/29/10; Individual #405, dated 9/8/10; Individual #121, dated 9/29/10; Individual #450, dated 9/29/10; and Individual #390, dated 9/8/10; o Health Risk Rating Tool for the following individuals: Individual #51, dated 9/29/10; Individual #299, dated 9/29/10; and Individual #191, dated 9/29/10; o Texas Department of Aging and Disability Services: SSLC policy: At Risk Individuals, Policy #006 Draft; o SSLC Risk Factor Definitions – DRAFT, dated 9/10; o SO Information sheet: Risk Assessment Questions/Comments; o Grid for risk scoring of all individuals; and o Medical Records for the following individual: Individual #136, and Individual #39.
	Facility Self-Assessment: According to the most recent POI, Facility's self-assessment indicated the Facility was not incompliance with this section of the SA. There had been an attempt by each Health Status Team (HST) to develop risk stratification that was accurate, but the results across the campus had been inconsistent and did not reflect the actual risk of many individuals. The State Office determined this to be a statewide issue, and had developed a draft proposal with additional risk factor definitions. Progress toward implementing a statewide policy is being made.
	Summary of Monitor's Assessment: The SO had taken the responsibility of standardizing "at risk" stratification, to ensure it is consistent across the state SSLC system. During the AUSSLC on-site review, a revised draft policy was reviewed, and the Monitoring Team provided additional comments. It will be piloted in the near future. It will require training of the HSTs, and continuous monitoring to ensure it is implemented correctly to ensure validity and reliability.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The Health Status Teams met quarterly in an attempt to determine risk levels for the various diagnoses of each individual. It did not appear that the assignment of risk level resulted in any changes with regard to the individual's treatment. This rendered the system meaningless. For example, the following individuals were assigned various risk levels, but the conclusion was regularly that no follow-up was necessary: ▪ The HST met on 9/29/10 to discuss risk stratification for Individual #51. The Family Nurse Practitioner (FNP) completed her Health Risk Rating Tool. The current health care plan was considered adequate and no changes were made based on the HST meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ The HST met on 9/29/10 to discuss risk stratification for Individual #299. She was considered high risk for osteoporosis, but no change in the health care plan was identified. ▪ The HST met on 9/29/10 to discuss risk stratification for Individual #191. She was considered high risk for GI concerns (pseudo-obstruction) and osteoporosis, but there was no change in the health care plan. ▪ Similarly, the health status reviews conducted at the same time as the quarterly PST meetings, indicated no follow up was needed for the following individuals: Individual #405, Individual #121, Individual #450, and Individual #390. ▪ The difficulties in developing a valid risk stratification system were evident in the assessment of Individual #136. She had urinary tract infections on 1/28/09, 2/24/09, 3/20/09, and 9/21/09, but the HST considered her to be low risk for urinary tract infections. ▪ Individual #39 was rated on 5/27/10 by the HST as having only a medium risk for aspiration. Yet she was hospitalized numerous times within a few months prior to the HST meeting for aspiration pneumonias (10/09, 11/09, 1/10, 2/10 through 3/10). As the individual units attempted to stratify risk for the individuals, the State Office realized the results were not producing the intended effect of prioritizing those most at risk for a variety of diagnoses. Further, despite the long meetings and good representation, as given by the examples above, the risk stratification did not impact the clinical care plan, even in those areas where individuals were determined to be at high risk. The SO developed a new SSLC policy: At risk individuals. It had remained in draft stage, but was to be piloted at one of the SSLCs. There were some additional concerns that were addressed with the SO regarding the draft policy. ▪ As State Office staff pointed out, the draft policy indicated that the PNMT would be a central point in addressing risk, but not all areas of risk fall under the expertise of the PNMT. There are other areas of risk that need to have a pathway through the HST or other designated entity. ▪ Further, many risk factor definitions were provided, but there was concern about the lack of levels of urgency that were incorporated into the descriptors to define when a health concern became a serious risk factor. The need for the team to address the urgent potential risk of pica ingestion, aspiration, rapid weight loss, severe constipation, and severe osteoporosis, for example, is different from that of poly-pharmacy and diabetes. ▪ Additionally, challenging behavior may need to be broadened into several important subcategories such as pica, suicidal ideation, elopement, and severe SIB threatening to cause permanent physical harm (for example, blindness).	

#	Provision	Assessment of Status	Compliance
		▪ There was also no process to monitor the use of the risk factor definitions to ensure that the interpretation of these was similar across a campus or across the state system. There may be reticence from a team to decide a high-risk level as it would mean more meetings and work for the team or members of the team. Monitoring would ensure that all individuals in the system undergo the same rigorous review and accurate assignment of risk. ▪ Lastly, the policy did not reflect how to take someone off of the risk level, or how to guide the team in down grading the risk once the condition had stabilized. It will be important to keep the team focused on those areas that are highest risk at any point in time. When finalizing the "at risk" policy, there should be an analysis to determine if it would have captured the recent hospital admissions, emergency room visits, and Infirmary admissions at AUSSLC. This would provide face validity that the risk system is prioritizing those individuals most at risk, and would be useful in guiding teams to develop and implement plans that would have the most impact on the health and safety of the individuals.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The State Office was continuing to refine the draft "at risk" policy at the time of the Monitoring Team's visit. A pilot site had been determined, but the policy had not been finalized. The draft policy did address this section of performing an interdisciplinary assessment once a risk had been identified. Implementation of the final policy will require considerable in-service training, as well as monitoring and mentoring to ensure its success. The Physical and Nutritional Management Team (PNMT) initiated their first comprehensive assessment for Individual #426 in August 2010. The PNMT was in the initial stages of implementing a full PNMT process that involved completing comprehensive assessments, developing and implementing action plans, training staff, as well as reviewing and monitoring the efficacy of these interventions for those individuals with complex physical and nutritional management needs as documented in detail below with regard to Section O of the SA.	Noncompliance
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	This is part of the draft policy, but the policy had not been finalized at the time of the Monitoring Team visit.	Noncompliance

#	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.		

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

1. The State Office should continue to finalize the At-Risk Individuals policy, and implement a pilot program at one Facility. In revising the draft policy, the following recommendations are offered:
    a. Not all areas of risk fall under the expertise of the PNMT, and there should be alternate pathways developed for those areas of need and potential risk.
    b. In reviewing the many risk factor definitions, there was concern with the lack of a descriptor discriminating between levels of urgency as part of the prioritization process.
    c. The challenging behavior category may need to be broadened to encompass several important areas of behavior, such as severe SIB, pica, elopement, suicidal ideation, etc.
    d. The policy should provide guidance on the steps necessary in taking an individual off of the high-risk level for a particular diagnosis or risk factor, and provide guidance to the team in downgrading to the next lower level.
2. Once implemented at a SSLC, and eventually across the state, there should be a process to monitor the interpretation of the risk factor definitions to ensure consistency and reproducibility.
3. Continued cross checking of the definitions used in defining the level of risk with face validity is recommended. For example, the question should be asked to determine if those individuals who are hospitalized, or go to the ER, or are admitted to the Infirmary, are the ones categorized as highest risk. If they are, then the definitions and the system are accurately measuring risk. If these individual do not rise to the highest risk level, then the system should be reviewed and revised.

Staff of the SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Psychiatric Caseload distribution; o Emergency medication list; o Emergency chemical restraint procedures; o Minutes of monthly psychiatric poly-pharmacy meetings and attachments, from May 2010 through September 2010; o List of individuals seen in neurology clinic from June 2010 through September 2010, correlated with individuals receiving psychotropic medications; o For the following individuals (random 20% sample) who were receiving psychotropic medication: Individual #1, Individual #6, Individual #94, Individual #49, Individual #394, Individual #365, Individual #16, Individual #143, Individual #82, Individual #427, Individual #7, Individual #84, Individual #355, Individual #288, Individual #249, Individual #398, Individual #32, Individual #357, Individual #360, Individual #141, Individual #325, Individual #276, Individual #159, Individual #281, Individual #199, Individual #80, Individual #306, Individual #208, Individual #127, Individual #289, Individual #425, Individual#253, Individual #271, Individual #151, Individual #112, Individual #67, Individual #421, and Individual #246, the following sections of their medical records: • The annual medical history; • Physical Exam; • Active Problem List; • The psychiatry section; • The BSP/behavior services section; • Side effect (MOSES/DISCUS) screening section; • Rights section which includes "Human Rights section" and "consents"; • The pharmacy section; • The neurology section (from the consultation section); • Documentation concerning the use of medication for pre-treatment sedation for dental appointments. If the individual had a Rights restriction regarding pre-treatment sedation for dental appointments, documentation of the Desensitization Plan; o List of all individuals administered the Reiss Screen to date; o Blank chemical restraint consultation form; o Minutes of the pre-treatment sedation committee meetings held 8/23/10 and 9/16/10; o Evidence tab for presentation book for Section J of the Settlement Agreement; o Four examples of complete comprehensive psychiatric assessments; o The minutes of the monthly poly-pharmacy committee meetings for last six months and any attachments;

	○ List of individuals who have been administered the Reiss screen instrument in the last two years; ○ A copy of the Reiss screening instrument for every fifth individual that appeared on the list; ○ Any Quality Enhancement (QE) internal audits that were related to psychiatric services (Note: no audits had been completed. Thus, no documentation was available.); ○ List of individuals for whom psychiatric diagnoses had been revised since 1/1/10 with corresponding clinic notes; ○ Job description for psychiatrists; ○ List of psychiatrists employed at AUSSLC; ○ Curriculum Vitae (CVs) of all psychiatrists employed at AUSSLC; ○ Weekly schedules for psychiatrists; ○ List of meetings and rounds attended by psychiatrists; ○ List of blank forms used by psychiatrists; ○ List of individuals receiving pre-treatment sedation for dental procedures. No list of medical pre-treatment sedation available; ○ Criteria for determining usage of oral sedation or Total Intravenous Anesthesia (TIVA); ○ List of individuals receiving anticholinergic medication (with names of medication(s) prescribed, start/stop dates, and duration of use); ○ Facility-wide data regarding poly-pharmacy, including intra-class poly-pharmacy; ○ Individuals prescribed intra-class poly-pharmacy, including the names of medications prescribed and each medication's start date; ○ Separate lists of individuals receiving each of the following medications: a) anti-epileptic drugs being used for psychotropic purposes; b) lithium; c) tricyclic antidepressants; d) Trazodone; e) beta blockers being used for psychotropic purposes; f) Clozaril/Clozapine; g) Mellaril; and h) Serentil; ○ List of individuals with tardive dyskinesia; ○ List of individuals being monitored for tardive dyskinesia; ○ List of individuals receiving benzodiazepines (with names of medication(s) prescribed, start/stop dates, and duration(s) of use); and ○ List of continuing medical education activities attended by medical and psychiatry staff over the last 12 months. ▪ **Interviews with** ○ Members of the Psychiatry Department, including David Wallace, R.N.; Derek Ruiz, Psychiatry Assistant; and Scott Murry, M.D., on 10/5/10; ○ Jose Levy, Director of Behavioral Services, and Christy Pierce, Assistant Director of Behavioral Services, on 10/5/10; ○ Judi Stonedale, M.D., Staff Psychiatrist, on 10/6/10; ○ Scott Murry, M.D., Director of Psychiatric Services, on 10/6/10; ○ Kenda Pittman, Pharm D; and Donnie Lane, Pharm D, on 10/6/10; ○ Sue Neel, Dental Hygienist, on 10/6/10; ○ Priscilla Hackett, Chief Nurse Executive, on 10/6/10; ○ Nilima Mehta, M.D., Staff Psychiatrist, on 10/7/10; and

	○ Tushar Desai, M.D., Staff Psychiatrist, on 10/7/10. ▪ **Observations of:** ○ Tour of AUSSLC campus, provided by Ms. Patti Westfall, on 10/5/10; ○ Psychiatry Clinic, provided by Judi Stonedale, M.D., on 10/6/10; ○ Psychiatry Clinic, provided by Scott Murry, M.D., on 10/6/10; ○ Psychiatry Clinic, provided by Nilima Mehta, M.D., on 10/7/10; ○ Psychiatry Clinic, provided by Tushar Desai, M.D., Consulting Psychiatrist, on 10/7/10; ○ Observations of the following individuals: Individual #312, Individual #90, Individual #356, Individual #143, Individual #264, Individual #100, Individual #191, Individual #239, Individual #456, Individual #212, Individual #51, Individual #363, Individual #186, Individual #265, Individual #347, Individual #334, Individual #351, Individual #269, Individual #260, Individual #268, Individual #341, Individual #43, Individual #8, Individual #84, Individual #403, Individual #190, Individual #155, Individual #151, Individual #450, Individual #222, Individual #45, Individual #78, Individual #453, Individual #430, Individual #293, Individual #288, Individual #19, Individual #406, Individual #333, Individual #139, Individual #6, Individual #160, Individual #165, Individual #77, Individual #374, Individual #244, Individual #49, Individual #296, Individual #355, Individual #195, Individual #397, Individual #302, Individual #273, Individual #332, Individual #12, Individual #192, Individual #202, Individual #425, Individual #124, Individual #294, Individual #169, Individual #335, Individual #254, Individual #53, Individual #118, Individual #169, Individual #292, Individual #57, Individual #370, Individual #227, Individual #283, Individual #369, Individual #210, Individual #83, Individual #276, Individual #88, Individual #458, Individual #241, Individual #194, Individual #248, Individual #395, Individual #42, Individual #382, Individual #144, Individual #284, Individual #73, Individual #365, Individual #322, Individual #111, Individual #232, Individual #226, Individual #17, Individual #311, Individual #169, Individual #3, Individual #188, Individual #193, Individual #372, Individual #215, Individual #64, Individual #389, and Individual #342.
	Facility Self-Assessment: The psychiatry section of AUSSLC Plan of Improvement, dated 5/17/10, listed the Department as being compliant with the Settlement Agreement in the following indicators: ▪ J-1: The qualifications of the Psychiatrists; ▪ J-2: Evaluations are conducted by a qualified Psychiatrist; ▪ J-11a: There is a system in place to review monthly individuals whose psychotropic medications meet the criteria for poly-pharmacy; and ▪ J-11b: AUSSLC maintains a list of individuals with poly-pharmacy. The other items in section J were rated as "N" for Noncompliant. The Facility's self-assessment was consistent with the Monitoring Team's assessment. The 5/17/10 Plan of Improvement for the Psychiatry Services included Action Plans to reach compliance with the other elements of the Settlement Agreement. The degree to which these Action Plans were successful will be discussed in the following sections of this report.

AUSSLC also prepared a Supplemental Plan of Improvement, dated 7/2/10. The entry for Psychiatry (Section J) stated, "At the time this report was issued, information on the Facility's provision of psychiatric treatment was not available. Recommendations were not provided."

During the current on-site review, a request was made for any documents produced in the Evidence Book related to Psychiatry and none were received. A request also was made for any internal Quality Enhancement (QE) Reviews that had been performed related to psychiatry services. AUSSLC's response to this request was that no related documents were available.

The supporting documentation for the 10/4/10 initial meeting between the Monitoring Team and AUSSLC Staff listed the following new developments for the Psychiatry Department:

II. New policies/processes/forms/tools that have been added or revised since the April SAMT [Settlement Agreement Monitoring Team] Visit.
Discuss any departmental changes (staff changes, new protocol, etc.)
1. Dr. Nilima Mehta joined us as our 3rd full-time psychiatrist on August 1, 2010.
2. Our statewide policy for psychiatric services was released on July 28, 2010.
3. In response to the new psychiatric policy, we are in the process of developing a procedure to ensure appropriate monitoring of psychiatric medications.

III. Areas identified as needing improvement/change from the POI's or Recommendations from the April SAMT Visit and what we have done to make improvements.
1. In response to the need to minimize or eliminate the need for pre-treatment sedation for medical and dental procedures, we have started a "pre-treatment sedation" committee. This addresses section J.4 of the settlement agreement.
2. In response to the need to provide our individuals comprehensive psychiatric assessments and clinically justifiable diagnoses we have hired a 3rd full-time psychiatrist. We have made decisions about our caseload distribution which should assist us in completing these assessments. This addresses section J.7 of the settlement agreement.

As will be discussed in more detail below, the most important development with regard to the Psychiatry Department's efforts to meet the requirements of the Settlement Agreement had been the initiative to develop thorough Comprehensive Psychiatric Assessments that conformed to the specifications contained in the Settlement Agreement. The review of an initial sample of four of these documents indicated that they were very impressive, and represented a significant advance in the Psychiatry Department's efforts to meet the requirements of the Settlement Agreement.

Summary of Monitor's Assessment: The Psychiatry Department at AUSSLC had experienced a significant increase in professional resources in the last few years. Approximately three years ago, the Facility relied on seven hours per week of psychiatric consultation. At the time of the review, there were three full-time Psychiatrists (two of which had been added in the last year), as well as four hours per week of consultation time. The Facility had also recently added four full-time Psychiatric Nurses, in addition to the prior full-

	time Psychiatric Nurse. The Psychiatry Department had also added two full-time Psychiatric Assistants, who facilitated the work of the Department. The impact of the additional professional resources was not yet fully reflected in the conduct of Psychiatric Services, as based on the review of 37 medical records, which represented 20 percent of individuals receiving psychotropic medication. The current review identified deficits in the documentation of the symptoms that substantiate the psychiatric diagnosis, the periodic monitoring of individuals for side effects of the prescribed medications, and the empirical determination that the prescribed psychotropic medications had been established to be effective. Another issue was the degree to which the behaviors that were identified as targets of the psychotropic medication also were described in the Functional Analysis and Positive Behavior Support Plan as being related to environmental and behavioral factors. There were also concerns about the thoroughness of the evaluation process for assessing the risk versus benefit related to the prescription of a specific psychotropic medication. A significant, positive undertaking had been the development of an initiative whose goal was to complete a thorough, comprehensive psychiatric assessment for all individuals who had been prescribed psychotropic medication. Review of an initial sample of these assessments indicated that when this process is completed for all individuals receiving psychotropic medication, it will represent substantial progress toward meeting the provisions of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Three years ago, AUSSLC relied on seven hours of Psychiatry Consultation time per week. Dr. Scott Murry joined the Department on a full-time basis approximately two and one-half years ago. Within the last year, the Facility has added two additional full-time Psychiatrists: Dr. Judi Stonedale and Dr. Nilima Mehta. Dr. Tushar Desai had also continued to provide four hours per week of psychiatric consultation. The Psychiatrists who practiced at AUSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. Based on their previous employment, they had had extensive experience working with individuals who have intellectual and developmental disabilities (ID/DD). The Facility also had been able to add four full-time Psychiatric Nurses who worked under the direction of Dave Wallace, RN, a Psychiatric Nurse with a great deal of experience in this area. Two full-time Psychiatric Assistants also had been added. The impact of this relatively recent increase in professional resources will not immediately be apparent in the provision of psychiatric services and the documentation of those services. However, over time, they should produce significant improvements. At the time of the review, there were 180 individuals receiving psychotropic medications	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		at AUSSLC. Thus, if the caseloads were divided evenly between the three full-time Psychiatrists, each would have a caseload of 60 individuals, which is an acceptable number. The individual caseloads of the Psychiatrists were still being determined, as two of them joined the Facility recently. Dr. Desai also continued to be available to the Facility for four hours per week, and had an active caseload of individuals that included children and adolescents admitted to the Facility. Dr. Desai was also Board Certified in Child Psychiatry by the American Board of Psychiatry and Neurology. As the Director of Psychiatry Services, Dr. Murry also had administrative responsibilities that limited the number of individuals that he was able to follow directly. It is anticipated that by the time of the Monitoring Team's next review, the psychiatric caseloads of the current group of Psychiatrists should be more clearly defined.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	At the time of the review, the group of Psychiatrists who diagnosed and treated the individuals who resided at AUSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. The consulting psychiatrist was also Board Certified in Child and Adolescent Psychiatry. The Psychiatrists had extensive amounts of prior experience in the diagnosis and treatment of psychiatric disorders in individuals with intellectual and developmental disabilities. The individual interviews with the Psychiatrists indicated that their past experience with this population had alerted them to the specific considerations that must be taken into account when diagnosing and treating individuals with intellectual disabilities. The randomly selected medical records of 37 individuals (20% sample) who were receiving psychotropic medication were reviewed and revealed that none (0%) of the records contained a Comprehensive Diagnostic Assessment compatible with the requirements set forth in the Settlement Agreement. The Facility was aware of this deficit, and had begun an initiative to complete a thorough Diagnostic Assessment that would comply with the terms of the Settlement Agreement for all of the individuals who were receiving psychotropic medication. As this process had only been completed for a small number of individuals, it was not surprising that examples were not found in the randomly selected sample of 20 percent of individuals receiving psychotropic medication. During the on-site review, a sample of four newly completed Psychiatric Assessments was requested. In response to this request, the Comprehensive Psychiatric Assessments for the following individuals were produced: Individual #11, dated 2/11/10; Individual #291, dated 3/30/10; Individual #302, dated 2/1/10; and Individual #369, dated 8/13/10. These assessments were found to be very detailed, ranging in length from nine to 17 single-spaced pages, with an average of 14 pages. The review of these documents indicated that they did comply with the specifications of the Settlement Agreement. The diagnostic sections of the records provided a thorough description of the symptoms that	Noncompliance

#	Provision	Assessment of Status	Compliance
		supported the psychiatric diagnosis. Accordingly, completion of this process for all of the individuals who are receiving psychotropic medication will represent a significant advance toward meeting this provision of the Settlement Agreement.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	The individual interviews with the Psychiatrists, and the direct observations of the Psychiatry Clinics, as well as the review of the randomly selected medical records of 37 individuals who were receiving psychotropic medication, did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff or as a form of punishment. However, the record review did indicate that for a number of individuals, the behaviors that were identified as the "target behaviors" of the psychotropic medication were also identified in the functional analysis and related Positive Behavior Support Plan as being present on a behavioral basis and/or related to environmental factors. This finding will be discussed in greater detail below with regard to Section J.9 of the SA. This observation suggested that for these individuals, the prescribed psychotropic medication could be construed as having been utilized to suppress behaviors that were not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of this section of the Settlement Agreement.	Noncompliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The coordination of both the utilization of pre-treatment sedation medication for dental and medical appointments, as well as the monitoring of the implementation of the related desensitization plans, was being transitioned to the Psychology Department. In order to facilitate this process, a Pre-Treatment Sedation Committee had been established. Review of the minutes of the Committee Meetings from 8/23/10 and 9/16/10 indicated that those in attendance included representatives from Psychiatry, Medicine, Pharmacy, and Dental Services. The following excerpt from the 9/16/10 Meeting described the status of the initiative to reorganize the use of pre-treatment sedation as of that date. *On August 23, 2010, the Pre-treatment sedation met and recommended that representatives from psychiatry, pharmacy, medical, and dental meet to begin development of a formal procedure for selection of medications used for pre-treatment sedation. This was in response to Section J.4.1.A of the Plan of Improvement which states, "Pre-treatment sedation is coordinated with other medications, supports and services including appropriate psychiatric, pharmacy and medical service."* *The proposal from this meeting is that, following the monthly polypharmacy committee meeting, there will be a second meeting which would meet to make recommendations for medications to be used for pre-treatment sedation. At each meeting, one primary care provider would attend to discuss patients who lived on his or her homes. Over the course of*	Noncompliance

#	Provision	Assessment of Status	Compliance
		a year, each home would be discussed. Prior to each meeting, a list of names of individuals who receive pre-treatment sedation would need to be generated. It was suggested that the QMRPs would be able to provide this list. From this list, a pre-treatment sedation form could be generated for each individual. This form could have space for the medication recommended for pre-treatment sedation as well as room to document discussion. This form would also need to have spaces for each discipline (medical, dental, psychiatry, and pharmacy) to sign. It was suggested that this form be placed in the consult section of the individual's active record. The following review of the utilization of medication for pre-treatment sedation for dental and medical appointments was based on the information contained in the Rights section of the random sample of the medical records of 37 individuals who were receiving psychotropic medication. The database documented the existence of the use of pre-treatment sedation medication for dental appointments for 26 individuals (70%) within the random sample. There was also a reference to a related Desensitization Plan for each of these individuals. As is discussed in further detail below with regard to Section Q.2 of the SA, there were concerns about the consistent implementation of desensitization plans. According to the Dentist, there had been no improvement in outcomes for individuals requiring pre-treatment sedation and/or the use of physical restraint. As a result, it did not appear that the effectiveness of the plans was being reviewed regularly, and/or modifications made to the plans, as appropriate. The number of individuals for whom there was corresponding documentation that they required pre-treatment sedation medication for medical appointments identified only seven individuals (4%). There was reference to a Desensitization Plan to address this need for all of these individuals. The difference in the frequency with which individuals require pre-treatment sedation for dental, as opposed to medical, appointments and treatments is worthy of further investigation. It might be possible to identify specific factors that make it easier for individuals to cooperate with medical appointments, and then determine if those factors could be generalized to the dental appointments. This database did not provide any information that would document the degree to which the Desensitization Plans were actually being implemented. The consolidation of the responsibility for the development, oversight, and monitoring of the Desensitization Plans should facilitate the review of the Facility's compliance with this provision in the future.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or	As indicated in the comments concerning Section J.1 of the Settlement Agreement, at the time of the review, AUSSLC employed three full-time Psychiatrists and one part-time Psychiatrist who had a time commitment of four hours per week. There were 180 individuals receiving psychotropic medication. Thus, if the caseloads were divided	Substantial Compliance

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	contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	equally, each of the full-time Psychiatrists would be responsible for 60 individuals (without taking into account the four-hour time commitment of the one part-time Psychiatrist). The individual caseloads of the Psychiatrists were still being finalized. There will likely not be an even distribution as the Director of Psychiatric Services also had a number of administrative responsibilities. The Consulting Psychiatrist maintained a caseload of 37 individuals, which would appear to be disproportionate to his four-hour time commitment. However, the full-time Psychiatrists provided coverage for these individuals during the remainder of the week when he was not present. In addition to the staff Psychiatrists, the Facility also employed five full-time Psychiatric Nurses and two full-time Psychiatric Assistants to help coordinate the psychiatric care of the 180 individuals who were receiving psychotropic medication. Thus, the total composition of the Psychiatry Department at AUSSLC would appear to have sufficient resources to meet this requirement of the Settlement Agreement.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	As indicated above, the Facility had developed an initiative to complete a thorough Psychiatric Assessment for each individual receiving psychotropic medication, which they believed would meet the standards set forth in the Settlement Agreement. The review of the medical records of 37 individuals receiving psychotropic medication did not identify a complete Comprehensive Psychiatric Assessment for any of the individuals in the sample (0%). At the time of the on-site review, four examples of the new (completed) Comprehensive Psychiatric Assessments were requested. The content and quality of these assessments is discussed in further detail above with regard to Section J.2 of the SA. The review of these documents indicated that they did contain the information identified in the Settlement Agreement as being necessary for a satisfactory assessment. The progress of the AUSSLC Psychiatry Department in completing these Comprehensive Psychiatric Assessments for the entire population of individuals receiving psychotropic medication, will be monitored in future reviews.	Noncompliance
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the	The spreadsheet produced for the Monitoring Team listed the individuals who had been administered the Reiss Screen for Maladaptive Behavior from 11/30/09 (earliest date) to 9/9/10 (most recent date). This document indicated that the Reiss screen had been completed for a total of 142 individuals. The total census of AUSSLC on 10/6/10 was 376, of which 180 individuals were receiving psychotropic medication and had undergone a Psychiatric Evaluation and Assessment. Thus, this information indicated that 146 out of 196 (72%) of those individuals who were candidates for screening with the Reiss instrument had, in fact, undergone that screening process.	Noncompliance

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	Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	A copy of the actual Reiss screening instrument was requested for a random sample of 20% of those individuals that were identified in the Master Spreadsheet. Review of these documents indicated that the Reiss screen had been completed for all of the individuals in the random sample, as indicated below: ▪ Individual #147, on 4/9/10; ▪ Individual #222, on 4/6/10; ▪ Individual #117, on 4/5/10; ▪ Individual #81, on 4/2/10; ▪ Individual #379, on 3/29/10; ▪ Individual #299, on 3/19/10; ▪ Individual #51, on 3/11/10; ▪ Individual #308, on 2/23/10; ▪ Individual #35, on 2/8/10; ▪ Individual #414, on 1/14/10; ▪ Individual #78, on 12/18/09; ▪ Individual #322, on 12/10/09; ▪ Individual #278, on 10/5/10; ▪ Individual #307, on 9/10/10; ▪ Individual #354, on 5/6/10; ▪ Individual #48, on 7/6/10; ▪ Individual #97, on 2/9/10; ▪ Individual #111, on 8/3/10; ▪ Individual #239, on 7/21/10; ▪ Individual #432, on 7/14/10; ▪ Individual #113, on 7/9/10; ▪ Individual #96, on 6/29/10; ▪ Individual #363, on 6/18/10; ▪ Individual #416, on 6/2/10; ▪ Individual #200, on 5/21/10; ▪ Individual #229, on 5/18/10; ▪ Individual #121, on 5/10/10; and ▪ Individual #437, on 4/19/10. The individual documents that were produced for these individuals were not the actual Reiss Screening Forms, but were two to three-page reports that described the methodology (staff that were interviewed with dates, etc.). They also included a narrative discussion that included, not only a review of the actual Reiss results, but also the subjective opinions of the direct support professionals who were interviewed during the evaluation. The Reiss screens for the individuals in the random sample were all below the	

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		designated Reiss cut-off score that would prompt a formal Psychiatric Assessment, and none of the individuals in the random sample of 37 individuals receiving psychotropic medication had been identified as requiring a psychiatric evaluation because of the results of a Reiss screening. However, Individual #11, one of the four examples of the newly developed comprehensive psychiatric evaluations (see additional discussion with regard to Section J.2 of the SA) indicated that the evaluation had been prompted by the elevated scores on the Reiss screening evaluation that was completed on 1/12/10. The Psychiatric Assessment took place on 2/8/10. Subsequent monitoring reviews will continue to assess the Facility's progress in administering the Reiss Screen to those individuals at AUSSLC who have not had a psychiatric evaluation. In addition, further documentation will be reviewed to ensure that an elevated score on the Reiss screening instrument prompts a formal psychiatric evaluation, which is then completed in a timely manner.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The integration between Psychiatry and Psychology Services was apparent in the interviews with the four Psychiatrists, as well as the interview with the Director and Co-Director of Psychology Services. The collaboration was also visible in the observation of each of the Psychiatry Clinics, where it was apparent that the Staff Psychologist had a central role in both the conduct of the meeting, and the generation of the Behavioral Data upon which key decisions related to changes in the psychotropic medications were based. The conduct of the Psychiatry Clinics and the related documents that were produced illustrated the active collaboration between the two disciplines. A current deficit in this collaboration, in terms of case formulation, was illustrated by the frequent co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and also being present on a learned or behavioral basis in the Functional Analysis and the Positive Behavior Support Plan. It is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be clearly delineated. Developing a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision, would provide a mechanism to address this problem. This subject is also relevant to provision J.9 of the SA, where it is discussed in more detail.	Noncompliance
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric	As noted above with regard to Section J.8 of the SA, the integration of psychiatric and psychological behavioral services was evident in the conduct of the Psychiatric Clinics, as well as to a certain extent in the documentation that was found in the random sample of 37 medical records of individuals receiving psychotropic medication. The Psychiatrist relied heavily upon the data related to the frequency of those behaviors that had been	Noncompliance

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	care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	identified as the target behaviors of the prescribed psychotropic medication, when making decisions about potential changes in an individual's psychotropic medication. A significant deficiency in this process of integration related to the degree to which behaviors that were identified as being targets of a psychotropic medication were also identified in the Functional Analysis and the Positive Behavior Support Plan as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavior factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis, suggested that the medications were being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the Psychological Behavioral Treatment Plans were developed through parallel processes that were not fully integrated. The review of the random sample of the medical records of 36 individuals (the copy of the record for Individual #289 that was made available for review contained the Psychiatry section of the record, but not the Psychology section) receiving psychotropic medication identified 28 individuals (78%) for whom the dual classification of behaviors described above was present. An example of the dual identification of maladaptive behaviors as being present on both a psychiatric and behavioral basis was illustrated in the following excerpt from the 4/13/10 Positive Behavior Support Plan for Individual #427: *The primary function of [Individual #427's] aggression appears to be escape. An antecedent event may be a staff request that he complete scheduled training activities or when he cannot do something he wants to do (for example, sit outside all day in the sun). As a result of being aggressive, [Individual #427] avoids the completion of a training activity or tries to avoid a staff request. In addition, his visual challenges may cause [him] to be defensive when around other individuals served or unfamiliar staff and to then strike them. Sometimes he may be seated and suddenly hits whoever is sitting next to him with no apparent external provocation.* *According to BSPs records, [Individual #427] at one point had a replacement behavior of gaining staff attention appropriately. Attention-seeking is occasionally one function of his aggression, e.g., [he] may abruptly approach a staff and show aggression.* *The function of food stealing is automatic reinforcement and is an opportunistic behavior. Since his move to 788 from 789 approximately [in] January 2006 [he] began food stealing. From November 2006 until July 2008, he was placed on a gluten-free diet, something that*	

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		was considered as a setting event. However, after being taken off the gluten-free diet, [he] continued to seek food that is not of his modified texture and therefore not within his dietary restrictions. Setting events for food stealing include the presence of food in his environment and his perception that staff cannot see him. [Individual #427] may attempt to steal food from other clients' plates or he may attempt to go into the kitchen. *Previous interventions include verbal and physical prompts, verbal and physical redirection, praise for appropriate behavior, increased supervision, replacement behavior training to choose one of two food items as well as to signal when he wants a snack, replacement behavior to appropriately seek attention, and drugs for behavior management.* The Psychiatric Clinic Note from 8/10 indicated that Individual #427 was prescribed Tegretol and Risperdal for a diagnosis of "Mood Disorder secondary to Brain Injury." However, the identified target behaviors of the psychotropic medications were "aggression" and "food stealing," which had previously been identified as being present on a behavioral basis. A similar example appeared in the documentation for Individual #398, as illustrated by the following excerpt from the Functional Assessment Report, dated 2009 (no specific date was identified): *Aggression is currently defined as hitting, kicking, rolling his wheelchair onto others, throwing objects at others, or attempts to do so. Generally, [Individual #398] may strike out one or two times, more if the caregiver fails to withdraw. Occasionally, per history, he may act out further, e.g., chase others, but his physical condition largely prohibits this. Likewise, his physical condition limits his ability to effectively self-propel in a wheelchair. Note that he tends to walk with direct contact assistance from caregivers, and uses the wheelchair for longer distances (i.e., walking across campus). Physical aggression functions more as a means to escape situations, although the necessity of caregivers attending to the behavior may make it appear that the behavior also functions as a means to gain attention. The latter may be confounded by verbal aggression (yelling at others), because it was the most frequently report[ed] aggressive act. Usually this stemmed from having to wait for wants to be addressed; and this behavior seems to be a predictive behavior.* The Psychiatry Clinic Notes dated 4/22/10 indicated that this Individual was prescribed two psychotropic medications, Lamictal and Lexapro, for "Mood Disorder as evidenced by aggression." Thus, "aggression" was identified as being present both on a behavioral basis and a biological basis, without a plausible rationale for this dual classification. The records of the following individuals contained a clearer differentiation of the behaviors that were present due to biological factors, as opposed to behavioral	

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		determinants: Individual #365, Individual #7, Individual #249, Individual #360, Individual #325, Individual #159, Individual #199, and Individual #151. An example of this differentiation of maladaptive behaviors that was related to a psychiatric disorder was illustrated by the following excerpts from the Human Rights Committee (HRC) review of the Behavioral Support Plan for Individual #151, dated 5/6/10: *[Individual #151] has a BSP which includes disruptive behavior as a targeted behavior. Disruptive behaviors are defined as: resisting staff assistance during activities of daily living; pushing staff away; verbal outbursts (e.g., yelling, screaming, cursing); hitting, kicking, biting, or scratching others; hitting himself; biting fingers or hands.* *[Individual #151] has a diagnosis of Bipolar Disorder Not Otherwise Specified. He will occasionally begin a "manic phase" where he often becomes agitated and aggressive during daily care activities, such as bathing, changing, dressing, shaving, and trimming his fingernails. He will be calm and cooperative for months at a time, and then have a "cycle" where he is extremely agitated and aggressive. He has injured staff at these times.* *[Individual #151's] BSP focuses on preventing the behavior by staff telling him in advance what daily care they are about to conduct. This allows [him] to understand what is going to happen and thus he will be more cooperative. The BSP also focuses on limiting the number of staff working with him and limiting the number of demands placed on [him].* *Individual #151 takes medication to help control his behavior. He currently takes: Klonopin 4mg daily and Lamictal 400mg daily. Due to an increase in targeted behaviors and the needs for emergency medication, the psychiatrist added Benadryl 50mg PO BID to [his] medication.* In the Recommendation section of the Behavior Plan, the following information also amplified these points: *[Individual #151] becomes aggressive during what is considered a "manic" phase of his bi-polar disorder. Staff report at these times, he is "resistant to everything" and is aggressive "more than daily." At this point, staff need to remain a safe distance from [him] to avoid injury. When contact with [Individual #151] is necessary, staff should first give [him] a detailed explanation as to what they will be doing and why. Extra staff may be necessary to help talk to [him] and help him to focus on the task. Interaction with [Individual #151] should be done quickly and with a minimal of contact.* *When [Individual #151] becomes aggressive during an activity or workshop, he must be*	

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		moved and/or supervised so he does not hit at or attempt to injure other clients in the area. If this aggression occurred in an area when no such space is available (the workshop), he may be returned home. [He] will not get any work done during that time and may agitate other clients in the area. *[Individual #151's] aggression could be some form of depression. Until just a few years ago, [he] was ambulatory, enjoyed walking around campus "talking to the pretty girls" and generally functioned at a higher level than what he does now. Just a few years ago, [his] health started to decline, which was followed by a decline in functioning and mental abilities. [He] now requires a wheelchair for ambulation, total care in hygiene matters and generally verbal only when agitated. He functions with the Profound range of mental retardation.* *[Individual #151's] parents died a few years ago. They had always been active in [his] life. This fact, coupled with the loss of abilities listed above, could be causing some sort of depressive state in [Individual #151]. This could explain some of [his] aggression, especially when he needs to be fed or groomed (two things [he] used to do independently).* Another example of a plan that provided differentiation of the behaviors that were related to an underlying psychiatric disorder appeared in the HRC review of the BSP for Individual #249, dated 5/4/10: *Behaviors Targeted for Reduction:* *With regard to [Individual #249], signs of manic behavior may be evident when she continuously walks around her environment, is unable to sit down for even a brief period of time, is unable to sleep (day and night), becomes easily agitated, unable to be redirected, and/or pushes away from others. When such symptoms occur, [Individual #249] seems unwilling to tolerate the interaction of others and the symptoms persist throughout the day (as opposed to remitting as the day progresses). If the symptoms persist, she is more likely to push others aside (in an attempt to avoid them) and purposely push things from the shelf/area.* *Leaving a designated area consists of [Individual #249] walking out of her home, programming/training, away from a designated area, or recreation area without staff's permission or knowledge. When she displays such behavior, it [is] not known where she intends to travel. Yet, it is a safety risk for her to travel independently without someone (who is familiar with her). If [she] is given the opportunity to travel independently, it is likely that she will not be able to convey her wants/needs to others, figure out how to get back to the designated area, or defend herself against any perpetrator.* To the extent that the Psychotropic Medication Treatment Plan is developed in a parallel	

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		manner to the Psychological/Behavioral Treatment Plan, it is difficult, if not impossible, to effectively determine the least intrusive intervention (or combination of interventions) to address the Individual's maladaptive behaviors in the least intrusive manner. As required by Section J.8 of the SA, the development of combined Treatment Plans that integrate psychiatric and psychological considerations would address this deficiency.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	This provision of the Settlement Agreement addresses the risk versus benefit considerations related to the use of psychotropic medications for a specific individual. The discussion of these factors primarily occurred in the Human Rights Committee section of the medication record, as well as the Positive Behavior Support Plan. The review of these sections in the random sample of the medical records of 37 individuals who were receiving psychotropic medication indicated that these discussions always concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors that were identified as the targets of the psychotropic medication. Because the terminology that was commonly used in these sections of the records implied that the medication would produce the desired results, missing from this documentation was a discussion of the probability that the proposed medication would be effective. In a similar manner, the discussions of the side effects of the medication were presented in the form of a brief generic listing of the side effects of the proposed medication. There was no indication of the frequency with which those side effects could be expected to occur, nor was there specific delineation of the most medically significant side effects. Thus, the documentation that was identified in the medical record was not sufficient to make a reasonable decision regarding whether the benefits outweighed the risks. The process described above was also illustrated in the following excerpt from the Human Rights Committee Review of the Positive Behavior Support Plan for Individual #82, dated 4/1/10: *Risk vs. Risk Analysis:* *[Individual #82's] Personal Support Team (PST) reviewed the rationale and need for any interventions or treatments which are either highly intrusive or pose a risk for the individual. The following is a brief summary of the deliberations.* *[Individual #82's] PST identified the following maladaptive behaviors: refusals, aggression, inappropriate elimination, crying and inappropriate attention seeking. The potential*	Noncompliance

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		effects of these maladaptive behaviors include possible injury to self, fewer opportunities to participate in training activities and to develop more functional adaptive behaviors, fewer opportunities to interact socially with other individuals with whom he lives, and fewer vocational and residential placement alternatives. Restrictive measures to manage these maladaptive behaviors include: room checks, redirection, verbal and physical prompts, blocking and body positioning. *[Individual #82's] PST supports the use of psychotropic medication to manage maladaptive behavior. These medications include: Risperdal, Lamictal, Prozac and Rozerem. Possible side effects of Risperdal include drowsiness, abnormal movements, headache, insomnia, agitation, anxiety, runny nose, constipation, nausea, vomiting, weight gain, neuroleptic malignant syndrome. Possible side effects of Lamictal include dizziness, headache, ataxia, somnolence, diplopia, blurred vision, nausea, vomiting, runny nose, rash, Stevens-Johnson syndrome and toxic epidermal necrolysis. Possible side effects of Prozac include nervousness, anxiety, insomnia, headache, drowsiness, nausea, diarrhea, dry mouth and anorexia. Possible side effects of Rozerem include dizziness, tiredness, or daytime drowsiness.* *[Individual #82's] PST determined that the most effective treatment will require a combination of procedures which include a Positive Behavior Support Plan (PBSP) and the use of the aforementioned psychoactive medications. The therapeutic intent is to assist [him] with functioning adaptively in the greatest number of environments and situations.* *The PST concluded the possible adverse effects of the prescribed psychotropic medications and behavior management strategies are less harmful than the potential adverse effects of the listed targeted behaviors untreated. If the medications are not effective, they can be reduced or discontinued and other interventions developed. [Individual #82's] medications are monitored closely and reviewed monthly. Progress notes and updates are completed at least quarterly regarding [his] targeted behaviors. The psychiatrist, psychologist and the psychological assistant monitor all aspects of his care closely.* Another example of the standard format for the risk versus benefit discussion was contained in the following excerpt from the HRC review of the PBSP for Individual #365, dated 11/17/09: *Risk vs. Risk Analysis:* *The Team reviewed the rationale and need for any interventions or treatments which are either highly intrusive or pose a risk for the individual. The following is a brief summary of the deliberations.* *The Interdisciplinary Team (IDT) identified aggression as the sole problematic behavior to*	

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		be targeted in [Individual #365's] Behavior Support Plan (BSP). The potential effects of this maladaptive behavior include injury to [himself] with the potential for permanent tissue damage, injury to [himself] and/or others as a result of aggressive behavior, possible retaliation from the target of his aggression, fewer opportunities to participate in training activities and develop more functional adaptive behaviors, fewer opportunities to interact socially with other individuals with whom he lives, and fewer vocational and residential placement alternatives. *The IDT considered the behavioral intervention of medication for behavior management. [Individual #365's] psychotropic medication regimen consists of Risperdal and Inderal. Possible adverse effects associated with these medications are as follows: Risperdal – abnormal movements (EPS) [*Extrapyramidal Symptoms]*, drowsiness, headache, insomnia, agitation, anxiety, rhinitis, constipation, nausea, and weight gain; Inderal – congestive heart failure, fatigue, lethargy, bradycardia, hypotension, and agranulocytosis.* *The IDT concluded that the possible adverse effects that may result from the use of psychoactive medications and prescribed behavioral interventions were less harmful than the potential negative effects associated with no intervention. All staff members monitor [Individual #365] closely. If an adverse reaction to medication is apparent, staff members will document these observations and will immediately contact the appropriate medical personnel. If the prescribed medication is not effective, it will be reduced or discontinued and other interventions developed. The frequencies of targeted behaviors are monitored by the Associate Psychologist and the Psychological Technician.* This example contained more information concerning the negative effects of the maladaptive behavior of aggression. However, as with other risk versus benefit discussions, the potential benefits of the psychotropic medications were not specifically described, other than a reference to a plan to discontinue them if they were not effective. For purposes of this discussion, the two psychotropic medications of Risperdal and Inderal were treated as one pharmacological intervention when, in fact, both medications being prescribed had different therapeutic and side effect profiles. An example that included more specific information about the potential harm posed by the target behavior was illustrated in the following excerpt from the HRC Review of BSP for Individual #84, dated 5/11/10: *BSP Information: (to be completed by Psychologist)* *[Individual #84] has a behavior support plan to address <u>Self-Injurious behavior</u> (SIB): pulling her hair, scratching and causing injury to herself, or slapping her face, picking at her skin to the extent that it bleeds or reopening a scab and <u>inappropriate yelling or cursing</u> (Y/C): yelling and/or cursing at another when a different type of communication would be*	

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		more effective (such as stating what she wants or how she feels). She has a <u>Replacement Behavior</u>: Whenever [she] nods or says "yes" or "no" in response to the 7 questions. Justification: Fundamental Outcome *[Individual #84] has several interests such a socializing with friends and participating in outings especially going out to eat. When [she] engages in SIB or Yelling she alienates herself from her peers. [She] would have more opportunities to participate in social activities if she did not engage in these behaviors. Furthermore, [she] has caused moderate to severe injuries to herself due to her SIB. A decrease in this target behavior would benefit [Individual #84's] health.* *The interventions from last year are guided by the functional assessment which was completed in March of 2008. The information gathered from this assessment suggests that she screams and hurts herself to escape and avoid being placed in her bed for PNMP. Furthermore, [she] may also engage in SIB and inappropriate yelling to get attention or to communicate that she wants something or that she is not feeling well. Earlier evaluations also state that [her] target behaviors increase right before a seizure.* *Risk vs. Risk Analysis:* *[Individual #84's] SIB includes her pulling her hair, scratching and causing injury to herself, slapping her face, and picking at her skin to the extent that it bleeds or reopens a scab. The potential harmful effects of these behaviors include injury to self that could result in serious tissue damage due to the risk of infection, fewer opportunities to develop more functional adaptive skills, and fewer residential and vocational placement options in less restrictive settings. She is currently taking two psychotropic medications: Abilify and Lexapro. The primary and most likely potential side effects of Abilify include headache, insomnia, dizziness, sleepiness, agitation, weight gain, constipation, and nausea. The primary and most likely potential side effects from Lexapro include nausea, insomnia, sleepiness, increased sweating, and fatigue.* Although this discussion contained more detail as to the negative effects of the maladaptive behavior, it did not contain specific information related to the potential efficacy of the proposed medications. In addition, as with the other examples, the two different psychotropic medications were treated as one intervention, even though they have different mechanisms of action and side effect profiles. This observation was consistent throughout the records reviewed.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one	AUSSLC had formed a Committee that met monthly to review and monitor the Facility's progress toward reducing poly-pharmacy with psychotropic medication. The documentation of these meetings, which was referred to as the "Monthly Psychiatry Poly-	Noncompliance

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	year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Pharmacy Reduction Meeting Notes," was generated for the time period of 4/8/10 through 9/16/10. The meetings were attended by the: Psychiatrists, Director of Pharmacy Services, Clinical Pharm.D., Supervisor of the Psychiatric Nurses, and the Medical Director; and were facilitated by the Psychiatric Assistants. The Meeting Notes indicated that there was a detailed case-by-case discussion of individuals whose medication regimens met the criteria for poly-pharmacy. Documentation from the 9/16/10 Meeting provided a summary of the Facility's progress toward minimizing poly-pharmacy during the months of June, July, and August 2010. The following excerpt was taken from the Minutes of the 9/16/10 Meeting: *NUMBER OF INDIVIDUALS RECEIVING TWO OR MORE MEDS FROM THE SAME CLASS: I* *CATEGORY: (A)* *POLY-PHARMACY # JUNE 2010: 13* *POLY-PHARMACY # JULY 2010: 13* *POLYPHAMRACY # AUGUST 2010: 13* *NUMBER OF INDIVIDUALS RECEIVING THREE OR MORE MEDS REGARDLESS OF CLASS OR INDICATION: II* *CATEGORY: (B)* *POLY-PHARMACY # JUNE 2010: 52* *POLY-PHARMACY # JULY 2010: 49* *POLY-PHARMACY # AUGUST 2010: 49* *NUMBER OF INDIVIDUALS RECEIVING BOTH I & II: III* *CATEGORY: (A) (B)* *POLY-PHARMACY # JUNE 2010: 11* *POLY-PHARMACY # JULY 2010: 12* *POLYPHAMRACY # AUGUST 2010: 12* *NUMBER OF INDIVIDUALS ON POLY-PHARMACY:* *POLY-PHARMACY # JUNE 2010: 53* *POLY-PHARMACY # JULY 2010: 50* *POLY-PHARMACY # AUGUST 2010: 50* *NUMBER OF INDIVIDUALS RECEIVING PSYCHOTROPIC MEDICATION:* *POLY-PHARMACY # JUNE 2010: 186* *POLY-PHARMACY # JULY 2010: 184* *POLYPHAMRACY # AUGUST 2010: 184* *Note: I, II & III do not yield a total of 50 because of overlapping definitions of poly-*	

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		pharmacy. Another important metric with regard to poly-pharmacy was the number of individuals who were receiving more than three psychotropic medications. The August 2010 Report contained the following information with regard to the number of these individuals: ▪ Three medications = 33; ▪ Four medications = 14; ▪ Five medications = 1; and ▪ Six medications = 1. Historical data from several years ago was not available for comparison. This provision of the Settlement Agreement also states that it is necessary "to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated." Thus, this provision also relates to the documentation that all prescribed medications can be empirically demonstrated to be effective. At the time of the review, for many of the individuals in the sample, there was not documentation present for each medication prescribed to show empirically that it was clinically justified and/or that it was effective. This subject is discussed in further detail below, with regard to Section J.13 of the SA. The ongoing progress of AUSSLC in minimizing the use of unnecessary psychotropic medications will be followed in future monitoring reviews.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	This provision of the Settlement Agreement mandates systematic, quarterly monitoring for the emergence of side effects related to the utilization of psychotropic medication with the Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System: Condensed User Scale (DISCUS) instruments. The review of the random sample of the medical records of 37 individuals who were prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last three months), and had been performed quarterly for the past year was present for four out of the 37 individuals (11%). This included the following four individuals: Individual #32, Individual #141, Individual #325, and Individual #276. There was incomplete documentation for two individuals. The missing documentation was in the form of a missing page (page 2) of the MOSES reporting form, which contained the signature of the individual who completed the evaluation as well as the date. The specific individual's records that were missing one or more essential pages of information were as follows: Individual #16 and Individual #357. The individual records that contained a current (within the last three months) and completed MOSES form, but for whom there was a gap greater than three months in the completion of the evaluation during the past year were as follows: Individual #6, Individual #94, Individual #49, Individual #394, Individual #365, Individual #246,	Noncompliance

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		Individual #421, Individual #67, Individual #360, Individual #159, Individual #281, Individual #306, Individual #208, Individual #127, Individual #423, Individual #271, Individual #82, Individual #427, Individual #7, Individual #84, Individual #288, and Individual #249. Those individuals whose records did not contain documentation of the MOSES evaluation within the last three months were as follows: Individual #209, Individual #355, Individual #143, Individual #398, Individual #199, Individual #80, Individual #253, Individual #151, and Individual #112. The purpose of the DISCUS is to detect emergent motor side effects related to the use of antipsychotic medication. Those individuals whose records did not contain a current DISCUS, but who were also not receiving antipsychotic medication, were: Individual #398, Individual #141, Individual #80, Individual #271, Individual #49, and Individual #249. Of the sample of 37, 31 individuals needed to have a DISCUS performed. The review of records of this sample, for documentation that the DISCUS was current and had been performed quarterly for the past year, indicated that copies of the completed forms were found in the records of 19 of the 31 records (61%). This included the following individuals: Individual #394, Individual #16, Individual #84, Individual #355, Individual #288, Individual #32, Individual #360, Individual #325, Individual #276, Individual #159, Individual #281, Individual #199, Individual #306, Individual #208, Individual #425, Individual #151, Individual #112, Individual #421, and Individual #246. Those individuals whose records contained documentation of a current DISCUS (within the last three months), but for whom there were a gap of greater than three months between evaluations in the last year, were the following individuals: Individual #6, Individual #94, Individual #365, Individual #82, Individual #427, Individual #7, Individual #357, Individual #127, and Individual #67. A current DISCUS could not be located in the records of the following individuals: Individual #253, Individual #289, and Individual #143. The numbers for the individuals whose records comprised this sample have been provided to enable the Psychiatry Department to ascertain if the missing documentation was due to the evaluation not be completed, clerical errors in filing, or omissions of documents in the process of assembling them for this review. Progress in completing these evaluations according to the timelines established in the Settlement Agreement will be monitored in future reviews.	

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J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	This provision of the Settlement Agreement addresses processes that are essential for the appropriate use of psychotropic medication for individuals with intellectual and developmental disabilities. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the medical records of a randomly selected sample of 36 individuals receiving psychotropic medication indicated that a description of the specific symptoms that would support the psychiatric diagnosis of record could be identified for 16 individuals (44%). (Note: The Psychology section of the record of Individual #289 was missing in the documents produced by AUSSLC and, thus, was not scored for this section of the review.) Those individuals for whom this documentation could not be located included the following: Individual #6, Individual #94, Individual #49, Individual #394, Individual #143, Individual #82, Individual #427, Individual #84, Individual #288, Individual #398, Individual #357, Individual #141, Individual #325, Individual #289, Individual #425, Individual #253, Individual #112, Individual #67, Individual #421, and Individual #246. However, it should be noted that even in those records, where documentation of the symptoms that supported the psychiatric diagnosis could be located, the symptoms were not identified in a specific or consistent location in the records. Thus, it was only by reading through the narrative sections of the multiple Psychiatric and Psychological Progress Notes that the presence of these symptoms could be confirmed. The review of the four examples of the new Comprehensive Psychiatric Assessments that were being developed (see more detailed discussion with regard to Section J.2 of the SA) indicated that those documents did provide a comprehensive discussion of the symptoms that supported the psychiatric diagnosis. The discussion of the symptoms contained in those assessments brought together information from disparate sections of the records into one coherent review in the section of the evaluations designated for the psychiatric diagnosis. The ongoing documentation of the symptoms that support the psychiatric diagnosis could be greatly improved by implementing a system that carries this information forward in each Psychiatric Consultation Note. This process would also enable the interdisciplinary team to add or delete symptoms as the individual's presentation changed over time. This provision also addresses the need to identify "the objective psychiatric symptoms or	Noncompliance

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		behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were referred to in AUSSLC documentation as the "target behaviors" of the psychotropic medication. As noted in above with regard to Sections J.8 and J.9 of the SA, a pervasive problem with the documentation in AUSSLC records was the dual identification of a specific behavior as being both a "target behavior" of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis. This dual identification of behaviors was identified in 28 (78%) of the 36 records that comprised the random sample. Those eight records (22%) that contained a clear delineation between these two categories of behavior were the records of the following individuals: Individual #365, Individual #7, Individual #249, Individual #360, Individual #325, Individual #159, Individual #199, and Individual #151. Examples of this documentation are contained above with regard to Section J.9 of the SA. A related issue was the correlation between the psychiatric diagnosis and the behaviors that are identified as the targets of the psychotropic medications. In those situations where the target behaviors are not a direct manifestation of the identified psychiatric disorder, it should be possible to demonstrate the connection or lack thereof between the symptoms that support the psychiatric diagnosis and behaviors such as aggression and self-injury that are frequently monitored to assess the efficacy of the psychotropic medications. At the time of the review, the lack of this documentation created the impression that the medications were being used to suppress behaviors that might be related to environmental and/or interpersonal factors. A potential solution to this problem would be to create a sub-section in the discussion of the rationale for the psychiatric diagnosis, which specifies the connection between the symptoms of the identified disorder and the target behaviors of the prescribed medication. This provision also addresses the question of efficacy of the prescribed psychotropic medication. The review of the 36 records of individuals who were receiving psychotropic medication that contained adequate empirical evidence that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors could be documented in four of the records reviewed (11%). These records were those of: Individual #159, Individual #281, Individual #271, and Individual #298. However, as with the identification of the specific symptoms that would support the psychiatric diagnosis, this information was not located in a specific section of the record, and could only be determined by a detailed review of the longitudinal behavior data that was contained in the psychiatric and psychological sections of the records. There were numerous references throughout the records to subjective opinions that the frequency of the monitored target behavior had either decreased, or increased in response to a change in psychotropic medication, but these observations were not	

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		substantiated with objective, empirical evidence. AUSSLC Psychiatry and Psychology Progress Notes carried forward two years of objective behavioral data. In addition, the Psychiatry Progress Notes contained a flow sheet that listed the major changes in psychotropic medications that had occurred over the years along with the reasons for those changes. This is extremely valuable and clinically useful historical information. The utility of this information could be greatly enhanced by including a Summary of the Contemporaneous Behavioral Data that would support the subjective description of the reason for the medication change. This data base also would provide additional historical data points with which to make comparisons of current frequencies that would enable the Interdisciplinary Team to determine if a specific psychotropic medication could be determined to be effective from an empirical perspective. The final section of this provision relates to the frequency with which the individuals who are receiving psychotropic medication are reviewed by the Psychiatrist and the IDT. This review of a random sample of the medical records of 37 individuals indicated that Quarterly Reviews were performed as specified in this provision on a uniform basis (100% of the time). Documentation in the records also indicated that individuals were reviewed more frequently, as clinically indicated.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the medical records for the random sample of 37 individuals of those who were receiving psychotropic medication indicated that 25 individuals (69%) had a Guardian of the Person. Those individuals who did not have a Guardian relied on the Facility Director to review the material concerning risk versus benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The integrity of this process was directly compromised by the aforementioned deficits in the analysis of the potential clinical benefits of the proposed medication, as compared to the risks presented by the known side effects of the medication. As indicated with regard to Section J.10 of the SA, the description of the benefits of the proposed medications was uniformly described in general terms as a reduction in the frequency of the monitored target behavior. These discussions did not contain any reference to the probability that those beneficial effects would actually be realized. The Risk section of these discussions also had similar deficits. The discussion of the side effects consisted of a brief generic listing of side effects, which did not include a discussion of the frequency with which those side effects occur in the general population, as based on published data.	Noncompliance

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		The above referenced systemic deficits in the risk versus benefit discussion make it difficult, if not impossible, for a guardian or the Facility Director to render a truly informed consent regarding the use of psychotropic medication.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The methodology used to assess the degree to which the guidelines set forth in this provision were being adhered to, involved locating a recent (within the last two years) Neurology Consultation Note in the Consultation Section of the individual's record. The next step was to ascertain if the Psychiatrist had signed the document, and/or if there was a corresponding Note by the Psychiatrist in the Psychiatry section of the record that made reference to the Neurology Consultation. Neurology Consultation Notes were located in the Consultation section of the medical record for the following individuals: Individual #398, Individual #281, Individual #80, Individual #208, Individual #421, Individual #82, Individual #84, Individual #355, Individual #249, and Individual #246. Documentation could be located indicating that the Psychiatrist had directly reviewed the Neurology Consult for only one of the 10 individuals (10%), Individual #246. However there was documentation in the records of Individual #281 and Individual #84 indicating that the Primary Care Physician had spoken with both the Neurologist and the Attending Psychiatrist about the individual's anticonvulsant medication to facilitate the exchange of information between the two. The Primary Care Physician had initialed the other Neurology Consultation Notes, although this is a supposition, as the signatures were illegible. A solution to this problem would be to introduce additional signature lines for the Neurology Consultation Notes. This type of documentation clearly would indicate who has reviewed the Consultation Note and when. As noted above, an exception to this finding was found in the record of Individual #246. The Neurology Consultation Note dated 4/12/10 contained the following notation in the bottom right-hand corner: "I was with him on 4/12/10." This additional comment on the Neurology Consultation Note was not dated. Unfortunately, the initials of the individual who wrote this comment could not be deciphered, nor could those of the Consulting Neurologist. However, there was an additional handwritten entry at the end of the 6/8/10 Psychiatry Consultation Note. This entry, which was dated 7/12/10, read as follows: "Attended Neurology Clinic to review necessity of Lamictal and Tegretol for SZ D/O [seizure disorder]. [Individual #246] had 4 SZs [seizures] last year and 2 SZs this year. Anemia secondary to Tegretol is not likely a significant issue, so Neurologist recommends continuing on both meds at current dosages." The Attending Staff Psychiatrist signed this handwritten note at 13:50 hours on 7/12/10.	Noncompliance

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		This example illustrated the type of active collaboration between Psychiatry and Neurology that would meet the provisions of this section of the Settlement Agreement. During the on-site review, a member of the Psychiatry Department indicated that the Department was moving in the direction of establishing joint reviews of individuals by Psychiatry and Neurology for those individuals whose clinical care would benefit from this collaboration. The increase in the number of full-time Psychiatrists should facilitate this endeavor. It will be equally important to develop a system that adequately documents this collaboration on a regular, ongoing basis.	

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

1. The Psychiatry Department should continue to implement the initiative to complete thorough, Comprehensive Psychiatric Assessments that are compatible with the criteria set forth in the Settlement Agreement, for each individual who is receiving psychotropic medication.
2. A system should be established to clearly monitor and track the development and implementation of the behavioral Desensitization Plans for dental and medical appointments.
3. Treatment Plans should be developed that integrate both the psychiatric and psychological perspectives regarding the individual into one cohesive document, so that it is clear which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies.
4. Those individuals for whom behaviors that are identified as the targets of psychotropic medication also are co-identified as being present on a behavioral basis should be reassessed.
5. The risk versus benefit process should be reviewed as it relates to the utilization of psychotropic medication to ensure that the process is individualized.
6. An interdisciplinary review should be conducted of the Human Rights/Consent process with regard to the approvals for psychotropic medications with the goals of:
    a. Ensuring that approval is sought and obtained for each psychotropic medication, when more than one is prescribed;
    b. Improving the adequacy of the current listing of medication side effects to include the probability of their occurrence;
    c. Defining the potential that a psychotropic medication will be (or has been) effective in treating the identified target behavior; and
    d. Including analysis of the potential side effects of the psychotropic medication(s) as they relate to the potential harm posed by the symptoms to be addressed by the medication.
7. With regard to poly-pharmacy:
    a. Continue the monthly review of the Facility-wide use of psychotropic medication regimens that meet the definitions of poly-pharmacy;
    b. In the minutes, provide additional historical data concerning the rates of poly-pharmacy as adjusted for number of individuals receiving psychotropic medication; and,
    c. Document the efficacy of the individual medications for those combinations of medication that meet the definitions of poly-pharmacy and are deemed to be essential for the individual's psychiatric stability.
8. A method should be developed and implemented to incorporate the description of the symptoms that support the psychiatric diagnosis, as identified in the Comprehensive Psychiatric Assessment, into the diagnostic section of the Psychiatric Clinic Notes on a continuing basis.
9. The relationship between the psychiatric diagnosis and the monitored target behaviors of the medication should be clarified. This could be accomplished by adding a section to the discussion of the psychiatric diagnosis that clarifies how the symptoms of the disorder produce and/or contribute to the target behaviors.

10. A summary of the contemporaneous behavioral data should be included in the psychiatric progress notes that would support the subjective description of the reason for the medication change. This data base also would provide additional historical data points with which to make comparisons of current frequencies that would enable the Interdisciplinary Team to determine if a specific psychotropic medication could be determined to be effective from an empirical perspective.
11. The implementation of potential mechanisms for the longitudinal retention of historical behavioral data in the individual records should be investigated to facilitate the determination of the efficacy of psychotropic medication(s), which may have been started multiple years ago.
12. The efforts to conduct joint Neurology and Psychiatry Consultation reviews, for those individuals for whom such a review is clinically indicated, should continue. A system also should be developed and implemented that adequately documents this collaboration on a regular, ongoing basis.

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 Austin State Supported Living Center Core Plan of Improvement, Section K, dated 5/17/10; o Austin State Supported Living Center Supplemental Plan of Improvement, Section K, dated 7/2/10; o Austin State Supported Living Center Corrective Action Plan, Section K, dated 9/1/10; o Section K Presentation Book, including: Psychological and Behavioral Services Policy, dated 7/26/10; template for Positive Behavior Support Plan; Applied Behavior Analysis (ABA) Coursework Completed by Psychology Staff, dated 8/5/10; PBSP Peer Review template, dated 9/14/10; SPCI Peer Review template, dated 9/17/10; Functional Behavior Assessment (FBA) Peer Review template, dated 10/1/10; Plan for Recruiting Board Certified Behavior Analysts (BCBAs), dated 5/10; copies of e-mails between Jose Levy and Jim Forbes regarding external peer review, dated 9/1/10 and 9/24/10; sign-in sheet for Functional Behavior Assessment (FBA), Brief How To, dated 6/23/10; Structural and Functional Assessment Report template; copy of article by B.A. Iwata and C.L. Dozier (2008); template for Monthly Progress Note – Counseling; Initial Psychological Evaluation template, dated 7/05; Psychological Evaluation Update template, dated 7/05; Positive Behavior Support Curriculum Outline; Behavior Therapy Committee Meeting template; and Behavior Therapy Committee Review template; o Section R.2.9 from Section R Presentation Book – Communication Core Plan of Improvement: Communication Dictionaries – Procedure for Collaboration Between Psychology and Speech (e-mailed 10/1/10); Sample Communication Dictionaries; and BSP for Individual #409; o Positive Behavior Support Plan Summary for: Individual #351, Individual #53, Individual #429, Individual #428, Individual #319, Individual #404, Individual #97, Individual #16, Individual #88, Individual #267, Individual #10, Individual #182, Individual #395, Individual #401, Individual #8, Individual #77, Individual #412, Individual #354, Individual #167, Individual #350, Individual #165, Individual #288, Individual #320, Individual #117, Individual #19, Individual #74, Individual #360, Individual #139, and Individual #98; o Positive Behavior Support Plan for: Individual #332, Individual #351, Individual #429, Individual #233, Individual #428, Individual #49, Individual #42, Individual #319, Individual #30, Individual #234, Individual #249, Individual #277, Individual #404, Individual #253, Individual #289, Individual #448, Individual #143, Individual #97, Individual #16, Individual #88, Individual #267, Individual #10, Individual #401, Individual #8, Individual #412, Individual #354, Individual #312, Individual #5, Individual #165, Individual #288, Individual #320, Individual #117, Individual #202, Individual #19, Individual #410, Individual #98, Individual #280, and Individual #188;

	○ Communication Dictionary for: Individual #42, Individual #234, Individual #249, Individual #404, Individual #97, Individual #16, Individual #10, Individual #354, Individual #312, Individual #5, Individual #165, Individual #117, Individual #202, and Individual #280; ○ Functional Assessment Reports for: Individual #251 and Individual #277; ○ Structural and Functional Assessment Reports for: Individual #210, Individual #328, Individual #276, Individual #97, Individual #16, Individual #8, Individual #350, Individual #320, Individual #117, Individual #212, Individual #83, Individual #19, Individual #341, and Individual #139; ○ Data Sheets/Behavior Observation Notes for: Individual #351, Individual #333, Individual #108, Individual #339, Individual #406, Individual #246, Individual #84, Individual #49, Individual #277, Individual #395, Individual #80, Individual #312, Individual #167, Individual #243, Individual #165, Individual #442, Individual #219, Individual #169, and Individual #188; ○ Counseling Treatment Plans and Progress Notes for: Individual #175, Individual #108, Individual #154, Individual #424, Individual #395, Individual #291, Individual #167, Individual #158, Individual #19, and Individual #360; ○ List of Individuals with Safety Plan for Crisis Intervention, dated 9/9/10; ○ Unit tracking of dates of reviews, plans, consents, and plan implementation; ○ Progress Notes: Individual #84, Individual #49, Individual #277, Individual #80, Individual #167, Individual #26, and Individual #442; ○ Behavior Therapy Committee Meeting minutes, from 3/9/10 through 8/6/10; ○ Human Rights Committee Meeting minutes, from 4/1/10 through 9/23/10; and ○ Psychology Department Meeting minutes, from 2/23/10 through 8/24/10. ▪ **Interviews with**: ○ Jose Levy, Director of Behavioral Services; and Bruce Weinheimer, DADS Coordinator of Behavioral Services, on 10/5/10 and 10/6/10; ○ Kim Ingram, Caryl Price, and Jan Taylor, on 10/5/10; and ○ Members of the Psychology Department, on 10/7/10; ▪ **Observations of**: ○ Residence 501, Residence 727, Residence 729, Residence 730, Residence 732, Residence 772, Residence 779, Residence 781, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; ○ Infirmary; ○ Workshop 503, Workshop 510, Workshop 527, Workshop 532, Workshop 544, Workshop 732, and Workshop 775; ○ Life Skills Center 512; ○ Incident Management Meeting, on 10/4/10; ○ Behavior Therapy Committee, on 10/5/10; ○ Personal Support Planning Meeting for Individual #26, on 10/5/10;

	o Psychiatry Clinic, on 10/6/10; o Human Rights Committee Meeting, on 10/7/10; and o Timber Creek Unit Meeting, on 10/7/10.
	Facility Self-Assessment: A review of the Facility's Plan of Improvement, Section K, indicated that there generally was agreement regarding compliance/non-compliance between the Monitoring Team's findings and the Facility's self-assessment. There were two areas, however, where the Monitoring Team did not find substantial compliance as noted by the Facility. Specifically, counseling objectives were not written in observable and measurable terms, and Positive Behavior Support Plans had not been developed for every individual who exhibited challenging behavior. The Director of Behavioral Services reviewed the steps the Facility had taken to meet the requirements outlined in the Settlement Agreement. Steps had been taken to increase the number of psychologists who were also Board Certified Behavior Analysts. Three staff had completed coursework and several others were enrolled in a program offered through the University of North Texas. The State was providing support and continuing its efforts to recruit certified professionals. According to the Director of Behavioral Services, steps also had been taken to improve the peer review process. Changes had been made to the Behavior Therapy Committee, enhancing its role as an internal peer review mechanism. Tools had been developed to guide staff as they completed Positive Behavior Support Plans, Safety Plans for Crisis Intervention, and Structural and Functional Assessment Reports. Plans for the development of an external peer review process involving staff from Lubbock State Supported Living Center were underway at the time of the visit. As reported by the Director of Behavioral Services, functional behavior assessment had been completed for 24% of the individuals residing at the Facility who had identified problem behaviors. Positive Behavior Support Plans had been revised to include the necessary components outlined in the Settlement Agreement. Summaries of these plans were also in development to provide a quick reference for the staff working with the individuals. The Psychology Department had expanded its library of assessments and was in the process of evaluating its policy with regard to annual assessment. Based on the Facility's assessment of its progress, other areas that had been addressed included an expansion of new employee orientation, with plans to introduce competency-based training.
	Summary of Monitor's Assessment: As noted in the Director of Behavioral Services' review of the Facility's efforts to meet the standards outlined in the Settlement Agreement, positive action had been taken in many areas. Efforts to expand the number of psychology staff who were Board Certified Behavior Analysts were commendable. Several staff had completed the requirements, with many others enrolled in classes. Ongoing supervision was provided on-site, enhancing timely completion of all requirements. There also had been improvements made to the peer review system. Changes made to the Behavior Therapy Committee had resulted in improved internal peer review, and steps had been taken to develop an external peer review system. The Director of Behavioral Services had put effort into providing Facility-

	based support to improve the quality of services through the development of monitoring tools and on-site training. Expanded new employee orientation also had occurred. The Structured and Functional Assessment Reports reviewed were well-written and comprehensive in scope. Valuable information was gained from these assessment efforts. Necessary steps should be put in place to ensure that this new information, particularly as it relates to preventative and antecedent management strategies, becomes part of the individuals' Positive Behavior Support Plans in a timely fashion. Individuals who were placed frequently in restraint had been given priority for completion of functional behavior assessment. A system should be implemented to ensure ongoing review of and updating of completed assessments. An area that remained of great concern was the data collection system. Decisions continued to be made based on data that was questionable with regard to its accuracy. Staff reported completing data at the end of the shift, one staff member was observed completing data prior to the end of the designated block of time, and a review of records revealed missing or incomplete data. Without accurate and reliable data, important decisions, including medication changes, were being made based on hearsay and subjective report.

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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 15 psychologists, all of whom had a graduate degree. One board certified staff member had left since the baseline visit, but an additional Board Certified Behavior Analyst/Licensed Professional Counselor had been hired. One psychologist had taken the exam to obtain board certification and two others were scheduled to take the exam in January. Six other psychology staff members were enrolled in coursework through the University of North Texas (UNT). As of June 2010, all newly hired psychology staff were expected to enroll in coursework through UNT after six months of employment. Additionally, the Assistant Director of Behavioral Services had obtained her State provisional license to practice psychology. She was scheduled to take her final exam for full licensure in January. The State is commended for supporting increased board certified staff through its policy of covering staff tuition costs upon course enrollment. Ongoing recruitment of Board Certified Behavior Analysts continued through a variety of venues including advertisements in trade publications, internet job postings, and conference networking. The Director of Behavioral Services and the DADS Coordinator of Behavioral Services also discussed the development of practicum/internship opportunities for students from local universities that offer training in Applied Behavior Analysis. In particular, they were exploring relationships with the University of Texas at Austin and Texas State	Noncompliance

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		University in San Marcos. The Behavior Analyst Certification Board has approved both of these universities as training sites. With introduction to the work available at the Facility, these interns or practicum students might choose to stay on once they have completed their degrees. This provision item was rated as noncompliance because the professionals in the psychology department were not yet demonstrably competent in applied behavior analysis as required by this provision item, as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the SA.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	Jose Levy remained as the Director of Behavioral Services. He is a Board Certified Behavior Analyst with over five years of experience working with individuals with developmental disabilities. Shortly before the baseline visit, he obtained state licensure as a psychological associate.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Meetings of the Behavior Therapy Committee were scheduled weekly. A review of the minutes of these meetings revealed a change in the format in late July/early August of this year when an agenda was introduced and peer review was introduced. Psychologists began to present their plans to colleagues and supervisors who provided feedback and support. This was an important change as previously the author of the plan under discussion was not always in attendance. Between 9/14/10 and 10/1/10, The Director of Behavioral Services also introduced monitoring tools to help guide the development of Positive Behavior Support Plans, Safety Plans for Crisis Intervention, and Structural and Functional Assessment Reports. Each of these tools listed required elements related to each of these plans. The plan was rated using a three-point scale: a rating of "2" indicated the criterion was met, a rating of "1" suggested partial compliance with the requirement, and a rating of "0" indicated necessary information was missing. What was particularly helpful was the section for comments. Reviewers were encouraged to provide specific feedback whenever compliance was not fully met. This should strengthen the tool's usefulness as an effective teaching strategy. The Psychology Department is commended for including staff members from the Communication and Nursing Departments in this peer review process. Communication staff proved to be active participants in the support planning process, particularly as it related to replacement behaviors and functional communication training. During the Behavior Therapy Committee meeting attended by the Monitoring Team, a Speech	Noncompliance

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		Language Pathologist demonstrated good insight and offered excellent suggestions with regard to specific communicative behavior for Individual #53. The original description of replacement behavior indicated this person would communicate his emotions. The SLP suggested that this was vague and a more appropriate communication would involve teaching him a way to access preferred items/activities (i.e., "I want"), or protest a non-preferred activity (i.e., "I don't like). Likewise, nursing staff can help inform members of the committee on specific healthcare issues and medication concerns that have either a direct or indirect impact on the individual's overall performance. While not in place at the time of the visit, the Director of Behavioral Services also had made contact with Jim Forbes, a Board Certified Behavior Analyst and Director of Behavioral Services at Lubbock State Supported Living Center, to work collaboratively to establish an external peer review system. This will surely enhance the breadth of feedback provided to staff as they develop, implement, and analyze support plans. This collegial exchange of ideas, tools, and feedback will strengthen the services provided to the individuals at the Facility. Staff are encouraged to schedule monthly peer review meetings, with consideration given to on-site visits provided quarterly.	
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.	Many of the concerns related to data collection that were raised in the baseline report remained valid. Data sheets for 19 individuals were reviewed. Still in use were data sheets that required the staff member to note the frequency of problem behavior within an eight-hour shift. This was seen for 12 individuals (63%). Shifts were identified as AM, PM, or Nite/Night. As noted previously, this form of data collection encouraged staff to recall what occurred during the previous eight hours, often, for multiple individuals with multiple behavior problems. Data sheets for two individuals (11%) provided spaces for recording over a four-hour period. Data sheets for five individuals (26%) provided a space for recording during each hour of the day. Although this might improve data collection, in no case did the Monitoring Team find repetitive marks indicating that data was recorded as the behavior occurred. Whole numbers were recorded, again suggesting that staff were relying on memory to record the occurrence or non-occurrence of multiple problem behaviors. During the on-site review of the Facility, members of the Monitoring Team observed several individuals engaged in problem behavior. A review was conducted of individual data sheets to determine whether there was agreement between these observations and collected data. The findings are outlined below: ▪ Individual #165 was observed displaying aggression on 10/4/10. However, a review of her behavior observation notes and data sheet for that day suggested a lack of correspondence. The behavior observation notes indicated no problem during the second shift, while the data sheet appeared to indicate four occurrences of problem behavior. Further concerns arose because there was no	Noncompliance

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		data recorded for the first and third shifts on that day. ▪ Several individuals were observed to engage in problem behavior, yet when a request was made for copies of their Positive Behavior Support Plans, the Monitoring Team was informed that such plans did not exist. Individual #137 was observed to hit herself three times in succession, scream, and then hit herself again on the morning of 10/7/10. Individual #15 was observed in her room, doubled over in her wheelchair, and screaming, between 11 a.m. and noon on 10/6/10. Individual #416 was observed biting her hand between 11 a.m. and noon on 10/6/10. Because these individuals did not have Positive Behavior Support Plans, these behaviors were not being measured, or more importantly addressed in any systematic manner. ▪ Individual #488 was observed to hit herself 12 times and bite her hand five times on 10/6/10. On the Facility's list of the Monitoring Team's document request, there was a note that this individual did not have a Positive Behavior Support Plan, and, therefore, there was no data to be provided. This was a discrepancy, because a plan was provided to the Monitoring Team. ▪ Individual #169 was observed hitting himself 32 times over a brief period (eight occurrences in 15 seconds). A review of his data sheets, for the time period in question, reflected zero occurrences of self-injury. If individuals display problem behavior, it is essential that accurate measures be collected to determine the current rate of the behavior. Equally important is the development of a Positive Behavior Support Plan (following a functional assessment) that can be implemented with a high degree of integrity in order to bring about behavior change. Ongoing, accurate, and reliable measurement will be critical to determining the effectiveness, or lack thereof, of the plan. Additional concerns related to specific individuals were as follows: ▪ Data sheets were requested for Individual #80. Included in the documents provided was a note that data sheets were lost at work for the month of August. This same month, the residential staff did not request additional data sheets when they ran out, therefore, there was no residential data for August as well. ▪ During the on-site review, the Monitoring Team observed Individual #179 sleeping or very lethargic in both the workshop area and his Residence. When a request was made to review his sleep data, the Monitoring Team was informed that this data could not be found. Concerns also were raised when reviewing the data sheets, because instructions to staff were not always included. In seven cases (37%), no guidelines were provided. In five cases (26%), the instructions directed staff to place a check mark or "Y "whenever the behavior occurred. However, the space provided for recording prohibited recording of	

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		multiple letters (Y). Other data sheets provided a definition of a behavioral episode, directed staff to record the number of times the behavior occurred, indicated behavior incidents should be recorded as they occur, or noted that Y/N/NA should be used to track replacement behavior. With such a variety of data sheets, some with and others without directions for recording, there is a concern that the expectations for staff are not clear. Consideration should be given to using standardized data sheets that might collect different information based upon the individual and his/her needs, but that would be familiar to all direct support professionals working at the Facility. Each data sheet should include clear guidelines regarding the manner in which data should be collected. The Monitoring Team was provided behavior support plan progress reports, for a period of six months, for seven individuals. The individual's response with regard to behavioral objectives was noted as "progression," "regression," or "stable." A summary was provided regarding the individual's response to treatment, notes were recorded regarding the quality of plan implementation, and recommendations were made. While it appeared that ongoing review of the individual's progress or lack thereof was conducted, concerns were raised with regard to program implementation and actions taken to enhance progress. Specific examples are provided below: ▪ In progress notes for Individual #84, recommendations consistently noted "encourage staff members to maintain treatment integrity by implementing preventative procedures outlined in the BSP." While encouraging staff to follow the plan as written is positive, it does not ensure that the plan is implemented with a high degree of integrity. Appropriate treatment implementation can only be ensured with ongoing competency-based training. ▪ The exact same recommendation was made in every review of progress for Individual #277. Progress reports over a six-month period reflected regression in self-injury and aggression for a total of four and three months, respectively, yet there were no recommendations for revisions to the behavior support plan. ▪ Progress notes for Individual #80 consistently indicated that the "PBSP appears to be implemented correctly," or "carried out in the manner for which it was intended." Again, objective measures of treatment integrity would provide a clearer understanding of how effectively the plan was being implemented. ▪ Individual #167 was noted to have behavioral contracts with psychology staff, that "are sometimes more detrimental," yet there were no recommendations made regarding a revision or discontinuation of these contracts. Also noted were problems related to the shared use of the residence phone. The report indicated that staff were working on a solution to this problem, however, it was unclear why solutions were not suggested in the body of the progress report. ▪ Two consecutive monthly progress reports for Individual #442 noted that "data gathered regarding behavior associated with mania is not consistent and does not appear to be accurate," yet the recommendations simply stated: "ensure	

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		accurate tracking sheets are being utilized." It is unlikely that data collection will improve without on-the-job training provided to the staff. It should be noted that the progress notes for Individual #26 did indicate that additional in-service training took place for staff for whom this was indicated following observation. The Facility should include specific recommendations regarding improved implementation and/or revision of plans when progress is not observed.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	The Facility provided a list of tools that had been obtained since the baseline visit to help with required psychological assessments. These included: ▪ Diagnostic Assessment for the Severely Handicapped II (Matson, 1995); ▪ Assessment of Dual Diagnosis (Matson, 1997); ▪ Anxiety Depression and Mood Scale; ▪ Motivation Assessment Scale (Durand & Crimmins, 1988); ▪ Psychopathology Inventory for Mentally Retarded Adults (Matson, 1988); ▪ Peabody Picture Vocabulary Test, Fourth Edition (Dunn & Dunn, 2007); ▪ Vineland Adaptive Behavior Scales, Second Edition (Sparrow, Cicchetti, & Balla, 2007); ▪ Wechsler Adult Intelligence Scale, Fourth Edition (Wechsler, 2008); and ▪ Wechsler Intelligence Scale for Children, Fourth Edition (Wechsler, 2003). Incorporating these tools into regular assessment will be helpful in ensuring that needs are clearly identified and plans are developed to be comprehensive in their scope. Of particular use will be the Vineland Scale in assessing adaptive behavior. A total of 16 Structural and Functional Reports or Functional Assessment Reports were reviewed. Ten of these had been completed since the baseline review. The following summarizes the results of this review: ▪ All of these reports (100%) reflected the use of both indirect and direct measures to develop an understanding of the function served by the targeted problem behaviors. Tools used for indirect assessment included one or more of the following rating scales, the Functional Analysis Screening Tool (Iwata, 2005), the Questions About Behavioral Function (Matson, 1995), or the Motivation Assessment Scale (Durand & Crimmins, 1988). Additionally, informal or formal interview using the Functional Assessment Interview Form (O'Neill, Horner, Albin, Sprague, Storey, & Newton, 1997) were conducted. The psychologist conducted direct observation, with further information revealed through a review of the Individual's behavior observation notes. ▪ Each report (100%) also contained information regarding: a) learned versus biologically based behavior; b) relevant setting events, antecedents, and consequences; c) hypothesized function; and d) a summary identifying the variable(s) possibly maintaining the problem behavior(s).	Noncompliance

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		▪ A list of potential reinforcers was included in each report, but in every case the list was generated through interview with familiar staff, and in some cases, the individual him/herself, or observation. The use of structured preference assessments was not identified, nor did it appear to be standard practice. ▪ Lastly, replacement behaviors were clearly identified in only 63% of the reports. Several of the reports (e.g., Individual #350, Individual #320, Individual #117, Individual #83, and Individual #19) provided a wealth of important information with regard to preventative and antecedent management, found in the summary tables located at the end of the reports. The reports for Individual #350 and Individual #320 also noted conditions associated with low rates of problem behaviors. Comments regarding specific reports are as follows: o Individual #210 was noted to display problem behavior when he was stopped from viewing inappropriate material on the internet. A consideration for his team would be to block such access on computers to which he has access, with appropriate approvals for a rights restriction. o Reportedly, Individual #328 engaged in vocalizations or rocked from side to side in his wheelchair in an apparent attempt to gain attention from staff. Specific recommendations were not provided to staff to respond to these communicative intents. o Individual #16 and Individual #341 were both identified as displaying problem behavior more often when in pain. Management of pain, and/or teaching a response to indicate pain both should be explored.	
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.	Problems with data collection are discussed in detail with regard to Section K.4 and K.10 of the SA. Until there is a system in place to ensure that all staff are well trained in data collection, including competency-based training, with effective practices to ensure that data are accurate and reliable (i.e., a system for assessing inter-observer agreement), confidence in the data as currently presented is poor. This requirement should become a focus of the Facility's Plan of Improvement.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's	The Monitoring Team requested copies of recent psychological assessments for identified individuals. Records for 20 individuals were provided. Only 14 out of 20 (70%) had a report addressing psychological or behavioral health, either in the form of a Reiss Screen, a Structural and Functional Assessment Report, or a summary addressing progress related to skill development and/or problem behavior. In addition, there were concerns regarding several reports that were quite dated. For example: ▪ Individual #210 and Individual #410 were both school-aged individuals. Their last evaluation of cognitive ability was completed on 8/29/07 and 11/29/05, respectively. Because school-aged individuals should be re-evaluated every	Noncompliance

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	standard psychological assessment procedures.	three years, both should be scheduled for cognitive assessments as early as possible. ▪ The record for Individual #49 included a psychological update from 1/10/00. ▪ Individual #267 had a psychological evaluation update completed on 10/7/97. ▪ The record for Individual #80 included a psychological evaluation update dated 1/21/98. Psychological assessments should be completed, at a minimum of, once every five years. As the Director of Behavioral Services works to revise the policy and format for psychological assessments, he should ensure that the following areas are addressed: a) assessment of cognitive ability; b) assessment of adaptive skills; c) screening for psychopathology, emotional, and behavioral issues; d) review of biological, physical, and medical status; and e) review of the individual's history. It should be noted that the Reiss screens, and recent Structured and Functional Assessment Reports contained valuable information about the individuals. Expansion of the library of assessments, as noted in Section K.5, will help the Facility as it takes steps to meet this standard.	
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.	Austin State Supported Living Center employed two psychologists who were licensed professional counselors. One of these psychologists was providing both individual and group counseling to individuals residing at the Facility. As of 8/17/10, there were 13 individuals receiving counseling services. A review of their treatment plans revealed information related to initiation of services, diagnosis and medications, reason for referral, identified goals with a statement indicating how attainment of the goal would be determined, and finally an agreement between the individual and the counselor signed by both parties. The Monitoring Team reviewed treatment plans for 10 individuals. The following summarizes the results of this review: ▪ For some individuals, goals addressed problems that had been identified in their PBSP and therefore measures were in place to determine the efficacy of treatment. For example, Individual #175 had two goals: a) alleviate or reduce intensity of depressive symptoms; and b) express emotions positively and effectively. These goals would be determined to be completed when she demonstrated a reduction in her targeted problem behaviors, for which objective measures had been identified in her Positive Behavior Support Plan. ▪ Others goals identified outcomes that could prove difficult to measure objectively. For example, Individual #154, Individual #424, and Individual #19 all had goals to learn to better manage their anger, agitation, and/or frustration. Attainment of these goals was to be determined by the person's ability to state two physical cues and two triggers with a prompt. Relevant information that was missing from these goals included the following: a) the condition under	Noncompliance

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		which the behavior would occur; b) a description of how the behavior would be measured; c) a statement indicating how often the behavior must occur and for how long it must be sustained; and d) an examination of the individual's success in maintaining the skill and generalizing it to other situations and environments. While the progress notes reported the individual's attendance, participation, and cooperation during counseling sessions, individual goals that are not measurable should be revised to ensure that progress is measured objectively to determine the efficacy of treatment.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Thirty-eight Positive Behavior Support Plans were reviewed (in addition to those reviewed with regard to Section C of the SA). The following summarizes this review: ▪ All of these plans (100%) included operational definitions of targeted problem behaviors, a potential function(s) of the behavior(s), identification of what was named a replacement behavior(s), baseline or comparison data, measurable expectations for improvement, and strategies to apply contingent upon the problem behaviors. The quality of a number of these components is discussed below in further detail. ▪ Written either in clear terms or implied within the text of the plans was a rationale for the proposed interventions. In general, the interventions were written clearly. The "Directions for Staff" were particularly useful. ▪ Although the author of the plan was identified in eight cases (21%), none (0%) of the plans were signed. ▪ Many of the plans also reviewed the history of previous interventions (76%), outlined strategies to address setting events and antecedent conditions (87%), provided guidelines for teaching desired behavior (74%), identified consequences for problem behavior (92%), and gave instructions for data collection (92%). ▪ Six of these plans (16%) were dated over 12 months previous to the review. At a minimum, plans should be updated annually. The Monitoring Team reviewed the unit tracking document, on which the date that consent was received for the behavior support plan was recorded. An analysis was completed for the 38 individuals whose plans were reviewed. The dates of the plans provided to the Monitoring Team were used in the analysis. Four of the individuals (Individual #267, Individual #10, Individual #202, and Individual #19) could not be located on this document. Of the remaining 34 individuals, "Consent Received" dates were identified for only 15 (44%) of the individuals. In six of these 15 cases (40%), consent was received on the same day as the date of the plan, or less than six days later. In five of these 15 cases (33%), the date of consent preceded the date of the plan. Of the remaining four plans (27%), consent was noted to have been received 19 to 56 days after	Noncompliance

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		the plan was developed. The Director of Behavioral Services reported that consents for medication changes were particularly difficult to obtain. Members of the Psychology Department also noted that obtaining consent was often difficult and impeded the implementation of plans in a timely manner. Plan training and implementation dates were recorded for only three of these 15 individuals (20%). Dates of the plan, consent, and training are provided below.	

Individual	Date of plan	Consent received	Implementation
Individual #16	8/14/10	7/22/10	9/9/10
Individual #8	3/18/10	5/5/10	6/30/10
Individual #312	8/1/10	5/5/10	6/1/10

It will be important for the Facility to improve its method of tracking information related to Positive Behavior Support Plans and Safety Plans for Crisis Information to ensure that all necessary information is recorded accurately. Consent should be obtained in a timely manner with competency-based training occurring within 14 days.

While replacement behaviors were identified, the opportunity to practice these replacement behaviors was oftentimes very infrequent. Examples included:

- Individual #332 was to practice his replacement behavior of removing himself from a noisy, crowded, or chaotic environment 10 times per month;
- Individual #428 was to say "break" or "water" 30 times per month, because escape and thirst were suggested functions for self-injury;
- Individual #42 was learning to say/sign "done" or "finished," but only in music therapy. Once she mastered the skill, she would practice this in other environments;
- Individual #289 was to tell staff he did not want to engage in an activity five times in a month, although the data suggested that his problem behavior occurred an average of 23 times per month;
- Individual #5 was to complete 15 minutes of sensory training, scheduled to occur four times each week as replacement for problem behavior that occurred over 100 times each month; and
- Individual #188 was to accept a "vibrating snake" when offered 30 times per month as a replacement for self-injury which occurred an average of six times per day.

Without multiple opportunities to learn new, replacement behavior, the development of functional alternatives is not likely to occur. As a result, a corresponding decrease in identified problem behaviors likely will not result.

Confidence regarding adherence even to these identified schedules for teaching of

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		replacement behavior was further compromised when data was reviewed for identified individuals. For example: ▪ In the month of August, the data for Individual #49 indicated he had no opportunity to learn or practice his identified replacement behavior. ▪ Similarly, the August data for Individual #167 reflected two opportunities to practice her replacement behavior in the workshop, and only one opportunity in the residence. New behavior cannot be learned and recently acquired skills cannot be maintained unless the behavior is encouraged and practiced. Additional concerns were raised when the Monitoring Team examined the identified replacement behaviors. Specific examples are provided below: • Individual #319 was to be provided materials to tear as a replacement for tearing sheets. Learning to recognize acceptable from non-acceptable material requires very good discrimination skills and might prove to be difficult for this individual. Examining the quality and breadth of activities available to this individual, identifying those that might be preferred, and then teaching Individual #319 ways to request and engage in these alternative activities might result in the identification of a more appropriate replacement behavior. • Similarly, Individual #249 demonstrated elopement behavior, hypothesized to occur when she was bored or wanted to explore other areas. The replacement behavior was to engage in a sensory activity during her leisure time. Again, the quality and variety of available activities should be explored in an attempt to identify what might be of interest to this individual. Once identified, the individual could learn to request and engage in these activities. • Individual #143 had listening to music identified as a replacement behavior for three problem behaviors (aggression, property destruction, and self-injury) that were hypothesized to serve an escape and attention-seeking function. A more appropriate replacement would be to give him a way to communicate these two wants. ▪ Individual #288 was to be encouraged to draw once per shift to replace his problem behavior of property destruction. The hypothesis suggested that the behavior was automatically reinforced based upon the gross motor and physical exertion characteristics of the behavior. A more appropriate replacement behavior might be to teach this individual to request and engage in a greater variety of physical activities. ▪ The identified replacement behavior for Individual #202 was to go for a walk every day, although the plan's author noted this was not functionally equivalent to any of his targeted problem behaviors. These behaviors were hypothesized to serve as a means of escape, to gain attention, or to obtain automatic	

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		reinforcement. To help identify more appropriate replacement behavior, staff should examine the quality of this individual's environment and methods he has for communicating his wants and needs. One area of the Positive Behavior Support Plans that needed to be more carefully reviewed and strengthened was the use of reinforcement strategies sufficient to improve behavior. For some individuals, delivery of reinforcement was planned as the end of a shift as long as the problem behavior had not been exhibited. This is a very lean schedule of reinforcement, and one that is not likely to result in desired behavior change, particularly when environments are devoid of interesting and varied activities. Examples include: ▪ Individual #234 who was scheduled to receive an edible reinforcer, and a pat of the back for displaying positive behavior at the end of the AM and PM shift; and ▪ Individual #401 and Individual #320 were to receive a token at the end of the shift, and the end of the school day, for the absence of targeted problem behaviors. Reinforcement must be offered on a dense enough schedule to effect behavior change. Reinforcement strategies also should be outlined clearly so they can be understood and followed with ease. Occasionally "behavior money" or "behavior contracts" were mentioned, but specific guidelines were not provided, making it difficult for staff to implement these strategies effectively. Regularly scheduled preference assessments also would expand and improve the identification of potential reinforcers. Other concerns were raised when reviewing the strategies applied contingent upon targeted problem behavior. Twenty-seven of the 38 plans reviewed (71%) included interventions that guided staff to first tell the individual to "Stop" the behavior. Additional steps often called for separating the individual from others, and then praising the individual once calm. While there may be similarity between a number of plans, this appeared to be a standard intervention applied to a range of individuals exhibiting a range of problem behaviors that served a variety of functions. Additional concerns arose when the recommended intervention posed a risk of reinforcing the very behavior that was targeted for reduction. Examples included: ▪ Individual #42 could be encouraged to move to a quiet area following property destruction. Noisy and crowded environments were an identified unpleasant situation for her. Therefore, by allowing her to escape such an environment contingent upon property destruction, this behavior might be negatively reinforced; ▪ Individual #97 could be escorted to his bedroom if strategies did not effectively interrupt his public masturbation, thereby, providing him time to engage in this behavior in his room; ▪ Individual #267 was to be redirected to a quiet environment if his aggression	

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		continued for five to 10 minutes. Noisy environments were identified as unpleasant for him, therefore his aggression allowed him to escape an aversive situation, resulting in a strengthening of the behavior; ▪ A similar pattern was identified for Individual #10. Prolonged self-injury or aggression resulted in a change of environments to a quieter location; and ▪ Staff were encouraged to get Individual #288 engaged in an activity such as drawing or listening to music if he displayed aggression or property destruction. Both of these activities had been identified as potential reinforcers. While attempts to stop problem behaviors from continuing are understandable, the actions taken by staff should not inadvertently reinforce the behaviors targeted for reduction. The immediate effects might be what is desired, but in the long-term, the problem behavior will only be strengthened. Rather than providing attention immediately after an individual displays self-injurious behavior, for example, the staff member could delay interacting until the individual had not engaged in the challenging behavior for approximately 30 seconds. At that point, the staff member could provide attention and try to determine if the individual was comfortable, needed anything, etc. In addition, an attempt should be made to gain an understanding of the function of the behavior through careful assessment, preventative and antecedent strategies should be put in place to minimize the occurrence of the behavior, a functionally alternative behavior should be strengthened or taught, environments should be enriched through an offering of varied and interesting materials/activities, reinforcement for appropriate behavior should be increased, and effective consequences should be applied following the problem behavior. It will also be necessary to ensure that staff are competently trained and effectively supported to follow these plans. A total of 29 Positive Behavior Support Plan Summaries were reviewed. Fifteen (52%) provided information regarding the operational definition of the problem behaviors, identification of a replacement behavior, preventative strategies, and contingencies to follow upon behavior occurrence. The remaining 14 summaries provided too little information for staff to implement the plan in full. For example: ▪ The summary for Individual #88 and Individual #412 only provided intervention (i.e., consequence) guidelines. ▪ The remaining 12 summaries incorporated a template that listed the following information: name, problem behaviors, replacement behavior, preventions, interventions, and programmed restraint. Missing from these summaries were operational definitions of both the problem behaviors and the replacement behavior, and a clear and comprehensive description of what to do to minimize problem behavior, specific plans for reinforcing alternative behaviors or the absence of problem behavior, and how to manage problem behavior when it did occur. For example:	

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		o The summary for Individual #77 suggested that social reinforcement and avoidance of demands should be used as preventative strategies. However, social reinforcement was not defined, nor was there a schedule for delivery of this reinforcement. Demands are naturally occurring daily events that are difficult to avoid. This same summary included the following under interventions: "… phone program, guidelines for SIB, guidelines for medication refusal…" Without specific information regarding these programs/guidelines, the summary was not helpful. o The summary for Individual #167 directed staff to monitor for precursor behaviors with changes in supervision, but these precursors were not identified. Interventions included "… conditional reimbursement for stealing from another." It was unclear what specific action should be taken and by whom. o The summary for Individual #165 advised preventative strategies that included "recognize antecedents" and "arms length." Without reviewing the full Positive Behavior Support Plan, it was doubtful that staff would be able to correctly interpret and/or implement these strategies. o Individual #74, Individual #360, and Individual #139 all had privilege systems identified under prevention. A description of this system or corresponding implementation guidelines was not included. ▪ The date of implementation was missing from 23 of these summaries (79%). ▪ Missing from every summary was the signature of the psychologist who authored the plan. ▪ Most full plans that were reviewed included a section entitled "Directions for Staff." This would prove a more helpful document for use as a summary. Of these 12 individuals, programmed restraint was not indicated for five (42%). The summaries for the remaining seven individuals included a description of restraint (58%). Only four of these seven (57%) had a Safety Plan for Crisis Intervention, however, even in these cases the reader of the summary was not directed to review the safety plan. Programmed restraint should no longer be a part of any individual's behavior support plan. A review of the minutes from the Human Rights Committee Meetings held between April and September of 2010 was completed. Discussion and actions taken were well documented. Psychologists were present to review plans, community members were in attendance, and individuals who reside at the Facility also were present. A few issues should be addressed. First, there should be consistent presence of medical personnel at these meetings to ensure that questions regarding health matters and/or medication changes can be addressed adequately. Several questions were raised related to	

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		medication at the Human Rights Committee Meeting attended by the Monitoring Team. A medical professional would have been the most appropriate person to address these questions. Second, although it is commendable that individuals in residence at the Facility participate in these meetings, caution should be taken when the discussion relates to an individual's housemate or good friend. For example, on 7/22/10, issues related to Individual #133 were discussed in the presence of one of his housemates, Individual #291. Third, a request was made for approval for a change in diet for Individual #393; due to "…poor judgment regarding bite size and eating pace," his food was going to be presented as a chopped diet. There appeared to be no discussion regarding the development of a teaching program to address this issue. Lastly, although not a matter related directly to the role of the Human Rights Committee, there were several individuals reviewed over the course of the six months of meetings who presented with visual impairment. It would be beneficial to these individuals to have a consulting mobility and orientation specialist who could provide advice and assistance in the development of support plans (both skill development and behavior reduction), as well as training to staff.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The concerns raised following the baseline visit remained valid. Therefore, the feedback provided in the first report is repeated here. At the time of the second visit, data was presented graphically using monthly averages. This did not allow an individual's team to determine trends in behavior, or subtle changes, and improvements in response to treatment. Although these same graphs noted medication dosages, it was difficult to determine changes in behavior following the introduction of medication, change in dosage, or discontinuation of medication, due to the grouping of data in monthly averages. Even when medications are slowly titrated, a change in behavior might be observed at a dose lower than that which has been identified as therapeutic. Without an ongoing review of daily changes in behavior, therapists could be unaware of this positive effect of medication at a lower than prescribed dose. Changes in targeted behavior can occur even when over-the-counter medication is introduced. Monthly reporting of the average occurrence of targeted behavior does not allow for a clear understanding of the effects of behavior support plans, medications, illness, or any of the other daily influences to which an individual is exposed. Graphic depiction of data can allow staff to better understand the effects of counseling sessions, family visits, sleeping patterns, bowel issues, menstruation discomfort, and any of the many other social and healthcare factors that can influence an individual's behavior. Without ongoing review of daily changes in the target behavior, timely revisions to behavior support plans will not occur. As is discussed with regard to Section K.4 of the SA, the validity of the data was questionable. Several members of the Monitoring Team identified the same concerns regarding the validity, accuracy, and reliability of data. There remained no plans for implementing a system to ensure a high degree of treatment integrity.	Noncompliance

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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.	Sections of the Positive Behavior Support Plans entitled "Directions for Staff" or "Staff Directions" offered clear, concise directions for plan implementation. As noted in Section K.9 of the SA, not all plans reviewed included information that was sufficient to ensure that direct support professionals could understand and implement them. Psychology staff should ensure PBSP Summaries contain sufficient information for staff to be able to identify both target behaviors and corresponding replacement behaviors. In addition to modifications recommended with regard to Section K.9 of the SA, one addition to both the PBSP and the Summary should be a brief section outlining the individual's communication skills, particularly as related to pragmatics (e.g., ways to ask for attention, tangible items including food and drink, a break, the bathroom, a means of protest, a way to indicate pain, etc.).	Noncompliance
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.	As noted by the Director of Behavioral Services and the Director of Active Treatment, new employee orientation had been or will be expanded to provide more in-depth information regarding positive behavior support and teaching strategies. While such foundational knowledge is essential to performing essential job responsibilities, it remains true that competency-based training is critical to ensure that behavior support plans and teaching programs are implemented with a high degree of integrity. At the time of the visit, there remained no evidence of competency-based training.	Noncompliance
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.	As of 9/1/10, AUSSLC employed 15 psychologists, one Licensed Professional Counselor intern, and eight psychological assistants, all of whom had a minimum of a bachelor's degree (one held a master's degree in social work), and one administrative technician. Of the 15 psychologists three carried unit caseloads, and the other two had responsibilities related to counseling individuals and training staff. With 376 individuals in residence at the Facility, there were a sufficient number of staff to meet the identified criterion. The ratio of psychologists to individuals was 1:29. There was at least one such psychology assistant for every two such professionals. However, as noted with regard to Section K.1 of the SA, this provision has been rated as noncompliance because the professionals in the psychology department were not yet demonstrably competent in applied behavior analysis as required by the SA, as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Staff are commended for their pursuit of certification. It is anticipated that at the time of the next visit, there will be three additional BCBAs in the department.	Noncompliance

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

1. The Facility and State should continue their efforts in recruiting Board Certified Behavior Analysts, including continuing the support offered to current employees to complete the requirements for this certification.
2. The Facility should pursue its initial contact with the Director of Behavioral Services at Lubbock State Supported Living Center to ensure that external peer review is provided on a regular basis. Regular on-site visits should be scheduled throughout the year.
3. It is essential that the Facility improve its data collection system to ensure that collected measures are reliable and valid. Reliance on systems that encourage staff to enter information at the end of their shifts should be eliminated. 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, be able to identify the presence and absence of the same, and collect measures that provide an accurate reflection of the frequency and severity of the problem. Consideration should be given to using standardized data sheets that might collect different information based upon the individual and his/her needs, but that would be familiar to all direct support professionals working at the Facility. Each data sheet should include clear guidelines regarding the manner in which data should be collected.
4. The Facility should conduct a review of the individuals in residence to ensure that every person who displays problem behaviors is provided appropriate support to reduce these behaviors and thereby experience a greater quality of life.
5. While the progress notes reported the individual's attendance, participation, and cooperation during counseling sessions, individual goals that are not measurable should be revised to ensure that progress is measured objectively to determine the efficacy of treatment.
6. Positive Behavior Support Plans should be developed with greater emphasis placed on: a) identification of functionally equivalent replacement behaviors, particularly functional communication skills, with adequate teaching opportunities to develop these skills; b) introduction of dense schedules of differential reinforcement, be it reinforcement for the absence of identified problem behaviors, reinforcement for alternative and/or incompatible behaviors, or reinforcement for lower rates of identified problem behaviors; and c) evaluation of the consequences that are applied contingent upon problem behaviors. Consideration should be given to the array of strategies that can be used to reduce the occurrence of problem behaviors (refer to Cooper, Heron, & Heward, 2007), but are neither noxious nor painful. Many of these strategies are widely accepted (e.g., loss of privileges, time out) and can be highly effective in bringing about positive behavior change.
7. Improved methods for obtaining consent in a timely manner should be identified. Additionally, tracking of approvals, consents, and implementation dates should be reviewed to ensure accuracy and completeness.
8. When improved behavior is not observed, as reflected in an Individual's progress report, recommendations should be made to improve plan implementation and/or revision.
9. There should be continued focus on the completion of Structural and Functional Assessment, particularly for those individuals who continue to be placed in frequent restraint or for those whose problem behaviors are resistant to intervention.
10. The Facility also should take steps to ensure that timely changes are made to the individual's Positive Behavior Support Plan based upon the new information gleaned from the Structural and Functional Assessment. Ongoing review of functional assessment and revision of behavior support plans is essential and should occur no less than annually.
11. Identified replacement behavior should be functional and related to the hypothesized purpose served by the problem behavior. Continued collaboration with staff from the speech and language department should occur particularly with regard to the development of functional communication skills.
12. Training of replacement behavior should be scheduled frequently enough to ensure acquisition of the identified skill(s).
13. Positive Behavior Support Plan Summaries should offer essential information to direct support professionals. Included should be operational definitions of both problem behaviors and replacement behaviors, a brief description of the individual's communication skills, particularly as related to pragmatics, a list of potential reinforcers, a clear outline of preventative and antecedent management strategies (including reinforcement strategies), identification of steps to take contingent upon problem behavior, and finally, instructions for data collection. Staff are referred to Carr (2008) for further information.

14. With regard to the Human Rights Committee, there should be consistent presence of medical personnel at these meetings to ensure that questions regarding health matters and/or medication changes can be addressed adequately, and the HRC has adequate information with which to make informed decisions.
15. 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, and 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.
16. Training on individual behavior support plans should occur across all shifts as these plans are developed and revised. The policy that requires 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 on all plans, with follow up conducted on-the-job.
17. Measures of treatment integrity should be collected on a regular basis with samples taken on a variety of plans across shifts.
18. Inter-observer agreement should be assessed regularly, but no less than once each month.

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

1. Consideration should be given to providing support, similar to that being provided to psychologists, to bachelor's level psychological assistants who are interested in obtaining certification as assistant behavior analysts.
2. The Director of Behavioral Services and DADS Coordinator of Behavioral Services are encouraged to make affiliation with local universities a priority. Such affiliation, with sites approved by the Behavior Analyst Certification Board, will contribute to their efforts to recruit appropriately credentialed and trained staff. An added benefit, of student interns from special education programs, will be their training in developing and implementing teaching programs for individuals with developmental disabilities.
3. Staff should refer to Johnston (2010a, 2010b) for additional thoughts on the peer review process.
4. With regard to the Behavior Therapy Committee's monitoring tools, comments should be provided whenever the criterion for an element of a plan is not met (e.g., when a score of "1" or "0" is given). This will enhance the effectiveness of these tools in guiding staff as they become increasingly familiar with the plan requirements.
5. With regard to the Human Rights Committee:
    a. Although it is commendable that individuals in residence at the Facility participate in these meetings, caution should be taken when the discussion relates to an individual's housemate or good friend.
    b. When issues are identified that relate to skill deficits, Facility staff should encourage discussion regarding the development of a teaching program to address such issue.
    c. There were several individuals reviewed over the course of the six months of HRC meetings who presented with visual impairment. It would be beneficial to these individuals to have a consulting mobility and orientation specialist who could provide advice and assistance in the development of support plans (both skill development and behavior reduction), as well as training to staff.
6. Consideration should be given to creating a more flexible schedule for psychology staff. For example, staff assigned to residences in which school-aged individuals reside should consider altering their work schedules so that they are available during the hours that the individual is in the residence. Others may want to consider varying their hours from day-to-day or week-to-week to allow interaction with a greater number of staff across more hours of the day.

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SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of women over 50, date of last mammogram (if not done, reason listed); o Medical Records for the following individuals: Individual #72, Individual #163, Individual #426, Individual #396, Individual #39, Individual #81, Individual #137, Individual #283, Individual #122, Individual #22, Individual #199, Individual #216, Individual #182, Individual #362, Individual #278, Individual #243, Individual #157, Individual #442, Individual #50, Individual #398, Individual #68, Individual #43, Individual #302, and Individual #1; o Infirmary Census list, dated 10/6/10; o Infirmary Census list, dated 10/7/10; o List of individuals with pneumonia, since 1/1/10; o List of individuals with aspiration pneumonia, from 11/3/08 through 7/22/10; o Physician caseloads, undated (approximately 10/8/10); o Texas Department of Aging and Disability Services State Supported Living Centers Policy: Medical Care Policy Number 009, dated 7/20/10; o Health Care Guidelines, dated May 2009; o Exhibit B: United States Preventive Services Task Force Guidelines; o American Cancer Society Guidelines for Breast Cancer Screening: Update 2003; o American Cancer Society Guidelines for Breast Screening with MRI as an Adjunct to Mammography, dated 2007; o Targeted Tuberculin Testing Screening Form; o Targeted Tuberculin Testing Screening Form Instructions; o Tuberculosis Questionnaire for Children; o Patient Profile Report, dated 10/12/10, for the following individuals: Individual #321, Individual #307, Individual #353, Individual #375, Individual #297, Individual #228, Individual #54, Individual #357, Individual #301, Individual #396, Individual #93, Individual #319, Individual #381, Individual #249, Individual #215, Individual #434, Individual #181, Individual #311, Individual #247, Individual #137, Individual #148, Individual #121, Individual #43, Individual #312, Individual #323, Individual #239, Individual #107, Individual #227, Individual #458, Individual #232, Individual #79, Individual #306, Individual #423, Individual #161, Individual #235, Individual #337, Individual #370, Individual #160, Individual #3, Individual #372, Individual #94, Individual #102, Individual #191, Individual #143, Individual #452, Individual #292, Individual #57, Individual #278, Individual #70, Individual #223, Individual #11, and Individual #120; o Persons with Chronic Constipation, dated 10/5/10; o Fracture Reports for 1/1/1930 (sic) through 10/5/2010 (it appeared this should have been 2003); o Bone densitometry reports for the following individuals: Individual #384, exam on

	6/1/09; Individual #279, exam on 12/18/06; Individual #274, exam on 6/12/10; Individual #72, exam on 12/1/06; Individual #21, exam on 5/18/10; Individual #262, exam on 12/11/07; Individual #307, exam on 4/23/07; Individual #113, exam on 2/6/04; Individual #3, exam on 10/9/08; Individual #184, exam on 4/28/10; Individual #214, exam on 1/23/09; Individual #168, exam on 10/5/08; Individual #53, exam on 8/23/10; Individual #429, exam on 10/13/08; Individual #430, exam on 4/8/10; Individual #78, exam on 12/6/06; Individual #213, exam on 5/11/09; Individual #24, exam on 4/29/09; Individual #390, exam on 1/14/09; Individual #180, exam on 8/25/10; Individual #457, exam on 6/4/09; Individual #144, exam on 1/14/09; Individual #304, exam on 7/30/08; Individual #454, exam on 1/5/04; Individual #34, exam on 2/6/04; Individual #269, exam on 3/31/09; Individual #126, exam on 3/24/09; Individual #261, exam on 7/28/09; Individual #84, exam on 9/12/08; Individual #201, exam on 3/5/09; Individual #368, exam on 10/6/08; Individual #224, exam on 6/2/09; Individual #93, exam on 8/6/07; Individual #398, exam on 4/19/10; Individual #268, exam on 9/15/09; Individual #23, exam on 9/21/10; Individual #82, exam on 6/22/09; Individual #87, exam on 6/21/10; Individual #37, exam on 5/18/09; Individual #181, exam on 2/11/08; Individual #253, exam on 12/4/08; Individual #335, exam on 11/25/08; Individual #45, exam on 3/10/09; Individual #22, exam on 4/1/09; Individual #155, exam on 12/10/03; Individual #17, exam on 8/11/05; Individual #185, exam on 10/23/09; Individual #100, exam on 10/30/06; Individual #322, exam on 9/19/08; Individual #199, exam on 3/31/04; Individual #331, exam on 10/17/08; Individual #326, exam on 8/5/09; Individual #88, exam on 5/22/09; Individual #413, exam on 6/8/04; Individual #182, exam on 8/20/02; Individual #149, exam on 6/2/10; Individual #140, exam on 12/17/04; Individual #241, exam on 10/7/09; Individual #318, exam on 8/19/05; Individual #103, exam on 7/31/09; Individual #91, exam on 6/26/09; Individual #8, exam on 5/27/09; Individual #433, exam on 10/8/08; Individual #118, exam on 5/25/10; Individual #385, exam on 10/10/08; Individual #196, exam on 2/25/04; Individual #362, exam on 5/20/10; Individual #80, exam on 12/18/08; Individual #31, exam on 4/2/09; Individual #173, exam on 9/22/09; Individual #99, exam on 4/28/10; Individual #166, exam on 4/3/09; Individual #340, exam on 6/26/07; Individual #455, exam on 1/9/09; Individual #194, exam on 2/23/10; Individual #4, exam on 10/12/09; Individual #278, exam on 4/7/08; Individual #14, exam on 7/29/04; Individual #346, exam on 2/12/10; Individual #243, exam on 2/23/09; Individual #270, exam on 9/30/04; Individual #405, exam on 8/17/09; Individual #458, exam on 3/6/09; Individual #352, exam on 2/9/09; Individual #186, exam on 4/30/04; Individual #265, exam on 4/22/04; Individual #117, exam on 2/12/04; Individual #28, exam on 10/21/09; Individual #212, exam on 1/6/04; Individual #223, exam on 5/16/08; Individual #389, exam on 3/23/09; Individual #456, exam on 3/26/09; Individual #63, exam on 4/27/10; Individual #170, exam on 4/27/09; Individual #222, exam on 2/5/04; Individual #95, exam on 8/31/10; Individual #52, exam on 9/23/09; Individual #195, exam on 6/13/08; Individual #235, exam on 1/9/04; Individual #287, exam on 10/2/08; Individual #416, exam on 11/4/09; Individual #309, exam on 3/17/09; Individual #169, exam on 1/7/08; Individual #439, exam on 11/10/04;

	Individual #393, exam on 3/8/04; Individual #365, exam on 5/4/09; Individual #280, exam on 10/10/03; Individual #172, exam on 9/1/10; Individual #188, exam on 5/26/04; Individual #363, exam on 3/30/09; Individual #68, exam on 1/8/04; Individual #73, exam on 2/11/10; and Individual #138, exam on 12/8/09; o "Client Hospital Update" for the following individuals: Individual #121, admission on 9/15/10; Individual #309, admission on 9/20/10; Individual #5, admission on 9/25/10; Individual #31, admission on 9/28/10; Individual #22, admission on 9/27/10, Individual #426, admission on 10/1/10, Individual #39, admission on 9/24/10; and Individual #199, admission on 9/24/10; o Distribution List for "Client Hospital Updates," undated; o Information tree for "Client Hospital Updates," undated; o Infirmary 24-hour logbook, for 10/5/10, and 10/7/10; o Since January 1, 2010, a list of all individuals admitted to the Facility's Infirmary, and the length of stay; o Since January 1, 2010, a list of all individuals admitted to the hospital; o For those individuals over 50, most recent colonoscopy; o Percentage H1N1 vaccine given in 2009; o Percentage flu vaccine given in 2009; o Austin State Supported Living Center Physician Services (flow diagram); o List of all staff who work in the Medical Department, including names and titles; o All policies and procedures related to seizure management: Austin SSLC-Health Services Operational and Policy Manual; Neurological Assessments and Procedures: Vagal Nerve Stimulator Use, dated 3/08; and Seizure Management, dated 3/08; o Example of Hospital Liaison Nurse documentation for one individual for somebody who has been discharged back to Facility: Individual #413; o List of individuals with Do Not Resuscitate Orders (DNRs), including reason; o List of those with GERD; dated 10/5/10; o Seizure records/data for the following individuals: Individual #422, dated 7/15/08 through 9/13/10; Individual #39, dated 8/13/09 through 8/18/10; Individual #84, dated 3/23/09 through 6/28/10; Individual #410, dated 3/25/09 through 9/29/10; and Individual #302, dated 4/3/09 through 8/15/10; o List of those with pica or history of ingesting inedible objects, dated 10/5/10; o For individuals with pica, types of objects ingested, recent BSPs, and addendums after BSP was completed: BSP info and tracking, date last revised 9/30/10; and o BSP and subsequent addendums for the following individuals: Individual #424, dated 8/19/09 (annual), with interim reports, dated 1/14/09, 1/23/09, 2/11/09, 4/22/09, 6/1/09, 6/4/09, 8/21/09, and 9/22/09; and Individual #212, interim report, dated 4/8/10, 5/19/10, and 7/12/10, and annual BSP, dated 8/13/10, with interim report, dated 9/30/10. ▪ **Interviews with**: o Fred Bibus, MD, Medical Director; o Alfredo Cisneros, MD, Staff Physician;

	○ Archie Smith, MD, Staff Physician; ○ Jae Yang, MD, Staff Physician; ○ Jodie Friedrich, Advanced Practice Registered Nurse; ○ Scott Murry, MD, Chief; ○ Nilima Mehta, MD, Psychiatrist III; and ○ Judith Stonedale, DO, Psychiatrist III. ▪ **Observations of**: ○ Individual #398, Individual #117, Individual #408, Individual #182, Individual #113, Individual #206, Individual #2, Individual #22, Individual #455, and Individual #413.
	Facility Self-Assessment: The Medical Department's self-assessment contained in the POI indicated there was currently noncompliance in all areas. This was consistent with the Monitoring Team's findings. This represents an opportunity for change and progress. The Medical Department had identified needs. For example, there was the awareness of the need for clinical pathways and guidelines. The Medical Department was in the planning stages of progress toward compliance with the SA. The Medical Director oversaw the Psychiatry Department, which allowed for a close relationship with the professionals in both departments.
	Summary of Monitor's Assessment: The Medical Department did not have in place many of the basic structures from which to make progress. The database system was not adequate, and the information was incomplete. It is important for the Medical Department to have accurate and complete information. With regard to general medical care, there was overall appropriate routine care. Some concerns were noted with regard to appropriate response to acute care needs. However, there was a lack of critical clinical thinking in prevention of acute serious illness. For many of the individuals reviewed, numerous hospitalizations should have been followed by prompt, aggressive evaluations and treatments until the hospitalizations were minimized. Unfortunately, many of these serial hospitalizations were not followed by further evaluations and consultations once the individuals returned to AUSSLC with the goal of preventing further hospital admissions. Additionally, the Medical Director should take a leadership role and engage in ongoing communication and collaboration with the Facility's administration in resolving a complex array of problems. Without such leadership and collaboration, a number of the problems noted in the Monitoring Team's review could continue to hinder the Facility's progress in reaching compliance with the SA. Issues that needed attention included timely filing of information in the medical record, review of physician caseloads, review of nonclinical physician duties, and providing respiratory therapy services. At the time of the review, there was no medical quality assurance program in place. As is noted above with regard to Section L.1, there was a database available, but there were issues with regard to comprehensiveness of the information included in it, the accuracy of the information, as well as the ability to request meaningful reports. There was no evidence that a comprehensive set of clinical indicators had

	been developed, or that the data available was being used to identify issues requiring the development of corrective action plans. While a more comprehensive medical quality assurance system is being developed and implemented, existing data should be utilized to begin to make changes that would positively affect outcomes for individuals.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sub-sections 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, routine care, preventative care, acute care, mortality reviews, Do Not Resuscitate Orders, and emergency medical drills. Additional information regarding medical care is found below in the section addressing Sections L.4 of the SA. <u>Staffing</u> At the time of the review, there were four primary care physicians and one physician extender. The Medical Director carried a caseload of 12 individuals with medical complexities, and supervised the Advanced Practice Registered Nurse, who had a caseload of 72 individuals. The other PCPs had caseloads ranging from 95 to 99 individuals. There were currently two administrative positions providing secretarial and clerical support. Based upon interviews with each of the PCPs, it was clear that staff were caring and attentive to the individuals served by AUSSLC. There was also excellent rapport with the community hospitals. On interviewing each of the PCPs, there was a common theme to the discussions. There was a concern amongst the medical staff that while other departments had increased staffing to meet the compliance requirements with regard to documentation and attendance at meetings, as well as other administrative duties, there had been no increase in staff or resources for the Medical Department. It was reported that the Medical Department lost two administrative assistants. The Psychiatry Department recently had begun to be staffed appropriately to meet the needs of the population, with caseloads approaching about half the size of the caseload of a PCP, with additional psychiatry assistants. It was unusual to have nearly as many psychiatrists as PCPs in a Facility and given the multitask job description and duties of the PCP, this should be a strong indication that there were insufficient PCPs at AUSSLC. If there is that much need for psychiatry staff, then there likely is even a greater need for medical staff. It appeared that, although the psychiatry staffing had increased to an appropriate level, there was an insufficient number of PCPs to meet the needs of the population.	Noncompliance

#	Provision	Assessment of Status	Compliance
		It is strongly recommended that the PCP caseload goal be set at no more than 70 individuals per PCP. This could be accomplished by increasing both the physician and physician extender positions. In discussing the daily and weekly routine with the PCPs, it became clear that most of their time was spent completing non-clinical work. Based on report, only about 10 to 20 percent of their time was spent providing direct medical care to the individuals. The remainder was spent processing paperwork and attending meetings. Most PCPs reported working a 10-hour day to provide essential continuity of care. It would be important for the Medical Director to work with the new administration to review current staffing levels, as well as job duties, and implement needed changes. This is necessary to assure PCPs do not become frustrated due to the increasing expectations placed upon them without additional resources. The lack of staffing also impinged on the Medical Director's ability to complete the essential duties of his position. He currently had a small caseload, but supervised the physician extender. AUSSLC was introducing a number of new and improved systems that will require the attention and direction of the Medical Director. A Medical Director, who also has primary care responsibilities, will hamper these efforts. The Medical Director should not have a designated caseload of individuals for which primary care is provided. Just a few of the areas in which the Medical Director needs to focus include: ▪ The PNMT needs a strong physician presence, and consideration should be given to the Medical Director playing a role as co-director to ensure success. This team will need considerable guidance from the physician on a daily basis. In the end, the impact will be enormous, with reduced events in such areas as aspiration and pneumonias, as well as saving time for the other members of the Medical Department in evaluating and treating PNMT concerns as they arise. ▪ The AUSSLC medical policy and procedure manual needs to be developed and implemented, using the Health Care Guidelines. Updated information will need to be regularly reviewed and incorporated into the policies and procedures. ▪ Clinical pathways and guidelines need to be developed and implemented. ▪ Quality assurance initiatives will require considerable time and attention. This will involve creating clinical tools and goals, then monitoring effectiveness, collecting and interpreting data, and developing and implementing corrective actions to address issues identified. In addition, it is recommended that the Medical Director have routine meetings with the Facility Administration to resolve a number of diverse issues. The Medical Director should play a leadership role and ensure active and effective communication with administration to obtain needed supports to address the many needs of the Medical Department. Without the correction of some of these issues, the Medical Department will not be able to fulfill its essential role. A few examples of areas of need at the Facility,	

#	Provision	Assessment of Status	Compliance
		on which the Medical Director needed to work collaboratively with Facility Administration to resolve, include the following: ▪ Physician duties needed to be reviewed, and potentially revised. Given the large caseloads, and the ever-increasing expectations with regard to meeting attendance and documentation, the concern was that the physicians were at risk of not meeting requirements related to their clinical responsibilities. A list of meetings at which physician's presence is required should be reviewed with the Facility Director to determine which are of priority and which are not necessary, and/or could be addressed in a different manner (e.g., submitting a report to a PST, or attending a portion of the meeting as opposed to the entire meeting). For example, additional discussion and research might need to be completed to determine if current requirements were necessary based on federal or state regulations. For example, there was discussion on-site regarding an allegation of neglect and whether or not, if a nurse completed a head-to-toe exam, there was a regulatory requirement for a physician to repeat the exam. This became more cumbersome when all individuals in a residence required examinations due to an allegation of neglect for the entire residence. Additionally, the physician who was called to examine the individual(s), reportedly was not allowed to know the reason for the allegation. This presented concerns, because there might be a need for a clinically focused or in-depth evaluation of one part of the body depending on the history provided (e.g., the type of trauma, etc.). It would also be valuable to document, with some detail if there were no findings. For example, if the person was allegedly slapped on the back, but the findings indicated no marks. Without appropriate history, the necessary evaluation might not be completed or documented. These types of issues should be reviewed with Facility Administration, as well as other departments. ▪ At the time of the review, there were three individuals with tracheostomies in the hospital with aspiration pneumonias. As of August 2010, of the seven deaths listed for which causes were provided, five of these were due to pneumonia and other pulmonary problems. There is an urgent need for a team of full-time respiratory therapists to join the AUSSLC community. There were many individuals needing the attention of a respiratory therapist. Assigning such duties to nurses who are responsible for an array of other urgent concerns is not appropriate. There were many individuals at risk for aspiration pneumonia, pneumonia, Chronic Obstructive Pulmonary Disease (COPD), and asthma who needed evaluation by, and treatment from, a respiratory therapist. Given the size of the campus and the number of individuals hospitalized for respiratory issues, there should be respiratory therapy support 24 hours a day. ▪ The lack of filing information in records was another important issue that needed to be resolved quickly. The Medical Director needed to meet with Facility Administration as soon as possible to resolve this issue. The tasks of	

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		filing lab results, annual medical assessments, consult reports, etc. was not being accomplished in a timely manner. Apparently out of frustration, and in order to have access to updated information regarding individuals on their caseloads, medical staff had compiled "green" files. These were copies of labs, consult reports, etc. that the medical staff copied before sending the original to the individual's residential building. Medical staff reported that they were not certain if the lab tests or reports were filed in the record, or how long it took to accomplish this task. To circumvent this, they had created their own internal files. Given the lack of time physicians had to complete their various duties, this was added time and frustration, which would not have to occur if a timely and efficient filing system were in place. While on site, the Monitoring Team found issues with regard to the timely and appropriate filing of information in individuals' records. For example: o In attempting to find documents related to Individual #39, the most current annual medical evaluation in the record was dated 1/8/09. Reportedly, when a new one was placed in the record, the old one was removed. When the Monitoring Team inquired about the document, a more recent annual medical assessment had been completed on 12/23/09, which provided evidence of compliance with yearly evaluations. However, this showed that it had not yet been placed in the record, close to 10 months later. Physicians cannot be expected to complete their duties without accurate and up-to-date records. ▪ Recently, a new system had been put in place, called the Individual Notebook, or I-book. It allowed the direct support professionals to carry a notebook, in which documentation could be entered, rather than needing to go to the individual's Active Record, the concept being that information would be recorded when an event actually occurred, making the data more reliable. There were certain benefits to the direct support professionals writing information while it was still current in their thoughts. However, at a medical staff meeting, there were serious concerns raised about the I-book system, and the Medical Director should meet with administration to resolve these issues promptly. In one instance, at a neurology clinic, there were no recorded seizures for two months, and the neurologist was considering decreasing the dosage of medication. The I-book was not available. It was learned, however, that there had actually been eleven seizures in the two months discussed. There appeared to be no system for promptly getting the information from the I-book into the permanent medical record. Further, if such information is going to be maintained in the I-books, then the I-book should be with individuals at all times, including when the individual goes to meetings and appointments. This lack of process is causing the potential for individuals to be at risk of harm. If the neurology clinic	

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		team had not realized the information was not updated, and the neurologist had lowered the dose of medication, the outcome could have been serious. ▪ At the time of the review, when a physician needed a medical record, there was no dedicated space in the various residences where the medical record could be reviewed in a quiet office setting. Consequently, the medical record was brought to the physician's office for review. Unfortunately, the campus only had one driver who had several assignments. These included taking individuals for off-campus lab tests, and hospital tests, as well as delivering and picking up medical records. At times, the records did not arrive in a timely manner as the driver had other obligations. One PCP estimated that about 20 percent of the time the requested medical record did not arrive in a timely manner. Further, it was not clear how nursing and other departments completed their documentation if the record was taken to the physician's office, and might not be in the residence when needed. To resolve the medical record transport issue, and for a variety of other reasons, one potential option would be to create a dedicated exam room in each of the units. Records could be brought over by direct support professionals or the nurse at the time of the visit. Also, the physician would be able to obtain information from the nurse and direct support professional who know the individual. Further, signing off on records could be completed readily on the unit, rather than waiting for a driver to deliver them at some point. In the past this system was attempted, but the unit or residence nurse reportedly was not available during the physician clinic visit. This would certainly defeat the purpose. If such an initiative were attempted again, the Nursing Department would need to make it a priority that a nurse assigned to a particular residence or unit assist the physician in completing the tasks in the unit. Consideration should be given to completing this as a pilot program with one unit, and as the inefficiencies are resolved, then replicated across the campus. Alternatively, there should be more than one runner to gather records and take them to the physicians. The final recommendation would be for a system with improved medical record retrieval to be implemented. ▪ There were ongoing equipment needs that remained unresolved. There was little reason to justify not obtaining small pieces of equipment the physician needed to complete the job. For instance, one PCP had been waiting a year for the purchase of an otoscope. A bladder scan had been requested, but the Medical Department was still waiting for this equipment. ▪ There were only two administrative assistant positions, and there was need for a transcription service that could provide quick turn around time in filing documents in the record. Dictation of the PCP review of consultant recommendations would assist in ensuring compliance with the SA, as well as	

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		provide easy-to-read documents for other members of the team. At the time of the review, the PCPs typed their own annual medical assessments. As these were lengthy documents that took time to compose, having transcription abilities might free up some time to be used for other needs. Also typing up Integrated Progress Notes should be considered, although there would need to be rapid turnaround time and placement in the medical record. ▪ During Infirmary rounds, it was learned that Individual #182 had the need for a hospital bed. He had a feeding tube placed recently, and there was a requirement that the head of his bed be elevated. It was learned that Medicaid and Medicare denied payment, and there was discussion about the next step. There was discussion that he would have to pay for it out of his own funds. In the meantime, his stay in the Infirmary was prolonged due to not having a hospital bed in the residence. The Medical Director should meet with Facility Administration to determine the next best step. The concern was that the Facility was not meeting the needs of the individual. Regardless of insurance or Medicaid/Medicare reimbursement, it appeared that the Facility was not providing for his health and safety needs, to the extent that the individual would have to pay for items required to maintain his health. It was not clear whether or not Facility Administration was aware of this, and communication from the Medical Director would be important. ▪ In improving efficiency for both nursing and medical staff, and in providing treatment with minimal delays, an area needing discussion was standing orders for a variety of comfort medications. At the time of the review, even to give a Tylenol for an ache or pain, a physician needed to be contacted. Provided a nurse had taken the history and examined the individual to rule out significant problems, there would seem to be little purpose to requiring an order from the PCP. There could be a monitoring system in which the PCP was notified the next morning of any pro re nata (PRN, or "as needed") medications, whether it was Tylenol, a laxative, etc. The standing orders could be individualized to meet the needs and safety issues of the individual. What was lacking for many of these issues was a direct line between the Medical Director and the Facility Administration in resolving the issues. Many of these issues, if unresolved, increase the potential for individuals to experience harm, and others create inefficiencies that do not have to exist, but demoralize the medical staff. The Medical Director should coordinate with the new Facility Administration to resolve these issues. There was a daily morning medical meeting, which included all PCPs and psychiatrists, as well as several nurses (Hospital Liaison Nurse, Infirmary nurses, and a nurse who provided information from the Infirmary 24-hour logbook). It provided a snapshot of clinical concerns on campus to the Medical Director and all physicians. However, a few	

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		observations were noted. There were no minutes recorded of these meetings. There were three documents from the Nursing Department, including the "Infirmary 24-hour logbook," the Hospital Liaison Nurse daily report, and the Infirmary census log, which included admissions, medical observations, and local hospital inpatient log. Information from these documents was briefly shared. It would be important to have minutes of what was discussed at these meetings, because this was the forum to discuss choices and options in treatment, and indicate the responsiveness of the Medical Department to Infirmary concerns, hospital issues, etc. Such minutes also might be used as a potential resource from which to gather future medical quality assurance topics. Also noted when discussing hospital cases and urgent concerns on campus, medical staff did not ask the necessary critical questions and probes to ensure aggressive treatment for a wide array of medical and behavioral issues encountered regularly at AUSSLC. It should be a forum in which the brief discussion of individual concerns, and options for treatment leads to standardization of care across campus. PCPs should recall those discussions as a similar clinical problem arises in another individual, to influence clinical decision-making. It also should provide rapid feedback for clinical issues needing urgent discussion and/or administrative assistance from the Medical Director. The morning meeting had great potential for assisting in standardizing care, and raising the standard of care across the campus in many areas of medicine and nursing. In this respect, it is recommended that the Chief Nursing Executive (CNE) or her designee also attend. These meetings would provide important and timely communication of information to the Nursing Department, and also would hold the nurse representative accountable to provide feedback when the issue is resolved, or if there was a need for further dialogue, bring this back to the physician staff. <u>Routine Medical Care</u> Routine medical care included annual medical assessment. A review of submitted annual medical assessments was completed with focus on timeliness of completion, including comparing the date of assessment/completion to the prior annual medical assessment and physical examination date of assessment/completion. The following annual medical assessments were reviewed and were considered timely because they were completed within the anniversary month of the prior annual exam: Individual#216, with annual exams dated 10/27/09 and 9/25/10; Individual #442, dated 9/11/09 and 9/23/10; Individual #278, dated 10/2/09 and 9/21/10; Individual #243, dated 9/18/09 and 9/15/10; Individual #362, dated 9/11/09 (only physical examination submitted) and 9/14/10; Individual #50, dated 10/1/09 with physical exam dated 10/2/09, and 9/14/10 (with physical exam dated 7/29/10); Individual #157, dated 9/24/09 and 9/11/10; Individual #283, dated 8/7/09 (with physical exam dated 8/28/09), and dated 9/10/10; and Individual #137, dated 10/1/09 and 9/9/10.	

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		The following annual medical assessment was not considered compliant, and was completed beyond the anniversary month of the prior annual exam: Individual #163, dated 8/28/09 and 9/23/10. Compliance with regard to the timely completion of annual medical assessments was 90% (9/10). However, there were some issues noted with regard to the quality of some of these assessments, because not all of them included information from recent physical examinations. As noted above, there was one evaluation with the physical examination six weeks prior to the annual medical assessment (Individual #50). Although reasons were not listed, it is important to synchronize the physical evaluation with the annual medical assessment to ensure that the information in the annual medical assessment captures all findings from the recent physical evaluation. Also, the next physical exam, if it were completed at the time of the annual medical assessment, would potentially exceed the 12 months between exams by six weeks. In another case, for Individual #283, the physical examination was completed three weeks after the annual medical assessment. The annual medical assessment did not reflect an updated physical examination, but relied on the prior year's examination, which reduced the quality of the information available. It is recommended that the physical examination be completed by the time of the annual medical assessment. It is also recommended that the Medical Department create some guidelines for all PCPs to follow to ensure these instances are reduced as much as possible, and to include any reason for delay in the examination, or separation in time between the examination and the annual medical assessment. It also was observed that the PCPs used different formats for completion of their physical examinations. This should be standardized within the Facility. <u>Preventative and Emergency Care</u> A sample of screenings for preventive care also was reviewed. According to the United States Preventive Services Task Force (USPSTF) Guidelines, for women age 50 to 74, mammograms are recommended every two years. This is an updated recommendation since the HCGs were published. Based on this most current recommendation, not all 111 women residing at AUSSLC, at the age of 50 or greater, had had a mammogram within the past two years. For the most part, exceptions fell into two categories: those in which the body habitus prevented a mammogram from being completed, and guardian non-consent. All but two individuals had a reason listed for not having a mammogram. For Individual #316 and Individual #376, a specific reason was not listed. The compliance rate for having a timely mammogram or a documented reason for not undergoing a mammogram was 109 out of 111 individuals, or 98%. The SA is based on an agreement that the Medical Department will adhere to the HCGs. The HCGs recommend a yearly mammogram from women age 50 to 70 as a preventive test. There were three women listed of the 111 over 50 who were overdue for a	

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		mammogram, according to the HCGs. An additional individual was over 70 years old when the last mammogram was done, but she would not be recommended for further mammogram testing. The compliance rate, following the HCG guidelines, would equal 95% (105/110). In other words, there were 111 women over 50, and one older than 70, resulting in 50 requiring mammograms. There were two for which no information was provided and three who were overdue. For the annual flu vaccine administration in 2009, 99 percent of the individuals received the vaccine. In addition, 23 percent of the staff received the vaccine. For the H1N1 influenza vaccine in 2009, 99 percent of the individuals received the vaccine. In addition, 25 percent of the staff received the vaccine. For the administration to individuals, this was a highly successful administration program. For the employees at the Facility, the challenge is to have increased percentage of employees receiving the flu vaccine each year. This is important to provide immunity, not only to the employee so that the number of sick days is greatly reduced and staffing ratios are not affected, but also to reduce the opportunity of staff bringing the virus into the Facility and infecting individuals and other staff members. The Medical Director should be involved in supporting the annual influenza vaccine campaign in order to improve the rate of employee vaccination. A list of individuals over the age of 50 and having a diagnosis of osteoporosis was generated. A patient profile report was then generated for each individual on the list to determine the current drug regimen. The date of all patient profile reports generated was 10/12/10. The drug regimens of the following individuals were reviewed for treatment of osteoporosis: Individual #321, Individual #307, Individual #353, Individual #375, Individual #297, Individual #228, Individual #54, Individual #357, Individual #301, Individual #396, Individual #93, Individual #319, Individual #381, Individual #249, Individual #215, Individual #434, Individual #181, Individual #311, Individual #247, Individual #137, Individual #148, Individual #121, Individual #43, Individual #312, Individual #323, Individual #239, Individual #107, Individual #227, Individual #458, Individual #232, Individual #79, Individual #306, Individual #423, Individual #161, Individual #235, Individual #337, and Individual #370. For 35 out of the 37 individuals reviewed (95%), treatment of osteoporosis was appropriate. Specifically, the two not meeting appropriate treatment included the following: ▪ Individual #423 was not prescribed a vitamin D supplement, which is recommended. He was prescribed Reclast as an annual infusion, and vitamin D is recommended as well as Calcium, which had been prescribed. ▪ Individual #43 was on Calcitonin nasal spray, but was not prescribed calcium or vitamin D as additional supplements, which are recommended with Calcitonin.	

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		For treatment of osteoporosis, the compliance rate was 35 out of 37 individuals, or 95%. However, of significant concern, was the fact that the list was incomplete. For example: ▪ The medical record of Individual #22, recently admitted to the Infirmary during the Monitoring Team's visit for post operative care of a repaired fractured right femur, indicated osteoporosis dating back to 12/02. However, Individual #22 was not on the list of those with osteoporosis over 50. Further, he was taking Miacalcin and Calcium/Vitamin D supplements. Yet despite this, he sustained a fractured hip. There are several next step choices to consider in the treatment of his osteoporosis. When asked how the team was going to prevent a fracture in the other leg, there was no response. The Facility treated the acute problem well, but the critical thinking of how to prevent a reoccurrence had not matured. If the PCP cannot decide on a regimen, then referral to an osteoporosis specialist, or endocrine specialist might be indicated. It will be important to demonstrate an aggressive treatment approach to his osteoporosis, as he is at high risk for a second fracture. Additionally, bone densitometry reports were submitted for those who had them completed. Sixty-eight (68) individuals were 50 or over, and had osteoporosis, according to the report, in one or more bones scanned, but were not included in the previously mentioned submitted list for those with osteoporosis. These individuals included: Individual #384, exam dated 6/1/09; Individual #274, exam dated 6/17/10; Individual #21, exam dated 5/18/10; Individual #262, exam dated 12/11/07; Individual #113, exam dated 2/6/04; Individual #3 (on the submitted list for osteopenia, but the reading indicated osteoporosis); Individual #53, exam dated 8/23/10; Individual #429, exam dated 10/13/08; Individual #213, exam dated 5/11/09; Individual #180, exam dated 8/25/10; Individual #457, exam dated 6/4/09; Individual #304, exam dated 7/30/08; Individual #454, exam dated 1/5/04; Individual #34, exam dated 2/6/04; Individual #269, exam dated 3/31/09; Individual #261, exam dated 7/28/09; Individual #84, exam dated 9/12/08; Individual #368, exam dated 10/6/08; Individual #268, exam dated 9/15/09; Individual #82, exam dated 6/22/09; Individual #45, exam dated 3/10/09; Individual #22, exam dated 4/1/09 (mentioned above); Individual #8, exam dated 5/27/09; Individual #433, exam dated 10/8/08; Individual #385, exam dated 10/10/08; Individual #196, exam dated 2/25/04; Individual #362, exam dated 5/20/10; Individual #173, exam dated 9/22/09; Individual #166, exam dated 4/3/09; Individual #340, exam dated 6/26/07; Individual #455, exam dated 1/9/09; Individual #4, exam dated 10/12/09; Individual #278, exam dated 4/7/08 (on the submitted list for osteopenia, but the reading indicated osteoporosis.); Individual #14, exam dated 7/29/04; Individual #243, exam dated 2/23/09; Individual #270, exam dated 9/30/04; Individual #405, exam dated 8/17/09; Individual #155, exam dated 12/10/03; Individual #185, exam	

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		dated 10/23/09; Individual #100, exam dated 10/30/06; Individual #322, exam dated 9/19/08; Individual #331, exam dated 10/17/08; Individual #326, exam dated 8/5/09; Individual #413, exam dated 6/8/04; Individual #182, exam dated 8/20/02; Individual #149, exam dated 6/2/10; Individual #140, exam dated 12/17/04; Individual #318, exam dated 8/19/05; Individual #352, exam dated 2/9/09; Individual #186, exam dated 4/30/04; Individual #265, exam dated 4/22/04; Individual #117, exam dated 2/12/04; Individual #223, exam dated 5/16/08 (on the submitted list for osteopenia, but the reading indicated osteoporosis); Individual #389, exam dated 3/23/10; Individual #456, exam dated 3/26/09; Individual #63, exam dated 4/27/10; Individual #170, exam dated 4/27/09; Individual #95, exam dated 8/31/10; Individual #287, exam dated 10/2/08; Individual #416, exam dated 11/4/09; Individual #169, exam dated 1/7/08; Individual #365, exam dated 5/4/09; Individual #280, exam dated 10/10/03; Individual #172, exam dated 9/1/10; Individual #188, exam dated 5/26/04; Individual #363, exam dated 3/30/09; Individual #68, exam dated 1/8/04; Individual #73, exam dated 2/11/10; and Individual #138, exam dated 12/8/09. Additionally Individual #93 was listed as having osteoporosis, but the bone densitometry reading of 8/6/07 indicated normal findings. Earlier reports were not available for review to determine if there was a prior reading of osteoporosis prior to treatment. A list of individuals over the age of 50 and having a diagnosis of osteopenia also was generated. A patient profile generated 10/12/10 was provided, listing the current individuals' drug regimens. The drug regimens of the following individuals were reviewed for treatment of osteopenia: Individual #160, Individual #3, Individual #372, Individual #94, Individual #102, Individual #191, Individual #143, Individual #452, Individual #292, Individual #57, Individual #278, Individual #70, Individual #223, Individual #11, and Individual #120. A few irregularities were noted in the treatment of osteopenia. ▪ Calcitonin was prescribed for Individual #278, Individual #3, and Individual #102, but it is only indicated for treatment of osteoporosis, and not approved for the treatment of osteopenia. ▪ Individual #452 was prescribed Reclast on an annual basis, but in a dosage recommended for osteoporosis. The dosage schedule for osteopenia is an infusion every two years. ▪ Alendronate 70 milligrams (mg) weekly was prescribed for Individual #120, Individual #70, Individual #94, and Individual #372. It is usually prescribed 35 mg for prevention of osteoporosis; the 70 mg dosage is for treatment of diagnosed osteoporosis. These irregularities may simply mean the diagnoses were not updated in the computer, and these individuals had osteoporosis, but the submitted forms indicated only	

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		osteopenia and the treatment provided was not indicated for this condition. For eight out of the 16 individuals (50%), treatment of osteopenia was appropriate. Additionally, the submitted list for osteopenia was incomplete. Individual #199's Annual Medical Assessment, listed osteopenia on the active problem list. Several bone densitometry exam results for several other individuals were reviewed. The following is a list of other 40 individuals living at AUSSLC who were not on the list of those over age 50 with osteopenia, but who had one or more sites diagnosed with osteopenia: Individual #279, exam dated 12/18/06; Individual #72, exam dated 12/1/06; Individual #307 (the submitted list included her with those diagnosed with osteoporosis; there was no additional older reports to determine if she did have a diagnosis of osteoporosis in the past and if medication had improved the condition or whether her name was placed on the osteoporosis list inadvertently); Individual #184, exam dated 4/28/10; Individual #214, exam dated 1/23/09; Individual #168, exam dated 10/15/08; Individual #430, exam dated 4/8/10; Individual #78, exam dated 12/6/06; Individual #24, exam dated 4/29/09; Individual #390, exam dated 1/14/09; Individual #144, exam dated 1/14/09; Individual #126, exam dated 3/24/09; Individual #201, exam dated 3/5/09; Individual #398, exam dated 4/19/10; Individual #23, exam dated 9/21/10; Individual #87, exam dated 6/21/10; Individual #37, exam dated 5/18/09; Individual #181, exam dated 2/11/09 (her name is listed on the osteoporosis list, but the reading indicated osteopenia. There was no information about prior scan results); Individual #253, exam dated 12/4/08; Individual #335, exam dated 11/25/08; Individual #91, exam dated 6/26/09; Individual #118, exam dated 5/25/10; Individual #80, exam dated 12/18/08; Individual #31, exam dated 4/2/09; Individual #99, exam dated 4/28/10; Individual #194, exam dated 2/23/10; Individual #346, exam dated 2/12/10; Individual #224, exam dated 6/2/09 (report was incompletely submitted); Individual #17, exam dated 8/11/05; Individual #88, exam dated 5/22/09; Individual #241, exam dated 10/7/09; Individual #103, exam dated 7/31/09; Individual #458, exam dated 3/6/09; Individual #28, exam dated 10/21/09; Individual #212, exam dated 1/6/04; Individual #222, exam dated 2/5/04; Individual #52, exam dated 9/23/09; Individual #195, exam dated 6/13/08; Individual #235, exam dated 1/9/04 (the submitted list for osteoporosis included his name, but the submitted report indicated osteopenia. No other prior or more recent reports were submitted); Individual #309, exam dated 3/17/09; Individual #439, exam dated 11/10/04; and Individual #393, exam dated 3/8/04. It was problematic that there were these numbers of individuals who were either not on the osteoporosis list, but had documented osteoporosis, or not on the osteopenia list, but had documented osteopenia. The Medical Department needs accurate and complete information to develop treatment that will have a positive impact. There appeared to be issues with regard to the reliability of the data collection system, database management, and/or proper identification of relevant diagnoses on individuals' problem lists. The	

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		Medical Director should explore the reason so many individuals were left off the osteoporosis and osteopenia lists. Further, bone densitometry testing should be done at intervals of one to three years, especially if there is prior osteopenia or osteoporosis. It assists with determining the impact of any medication prescribed, or suggests the need to reconsider the current medication being utilized for an individual if there is no improvement or worsening of the bone densitometry readings. If these were the latest test results available, then there should be criteria for retesting included in a clinical pathway for osteoporosis/osteopenia, and a system created to ensure that updated testing is completed for those who are recommended for a bone densitometry at the appropriate intervals. Additionally, a list of those individuals sustaining a fracture was submitted. The Fracture report was entitled "Fracture Reports for 1/1/1930 (sic) - 10/5/2010." On review, it would appear to document fractures back to 2003. When tabulating the yearly results, the information that was submitted in this document included 14 fractures for 2008, and 16 fractures for 2009. There were only six fractures recorded through 10/5/10 for 2010. On quick review, this 2010 list was incomplete. The last entry was in May 2010. As confirmation of incomplete data entry, Individual #398 had a hip fracture in August 2010, but this was not on the list. It is important to verify that the list is updated to include fractures consistent with the heading of the report. It also would be difficult for medical and other departments to begin to develop goals and protocols, as well as consider Drug Utilization Evaluations (DUEs), when information is incomplete. Routine, preventive colonoscopies are recommended every 10 years beginning at the age of 50 for those with no family history or signs of symptoms of problems. A list of individuals over the age of 50 was provided, with the date of the most recent colonoscopy. If completed, the reason for the colonoscopy was not indicated, whether preventive or as part of a diagnostic evaluation for signs and symptoms. Of the 234 individuals listed: ▪ There were 90 for whom no information was available (in the column under "last colonoscopy," there was only a "?" listed). This represented 38 percent of the individuals for whom no information was available in the medical records to suggest this had been completed. ▪ There were another 10 individuals (4%) for whom the colonoscopy procedure was pending the scheduling of an appointment. ▪ Additionally, there were 31 individuals for whom there was a referral to the GI clinic for recommendations (13%). ▪ To date, there were a total of 133 individuals over age 50 without a screening colonoscopy completed. This was a compliance rate of 101 individuals out of 234 (43%).	

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		However, there had recently been considerable effort in obtaining these screening colonoscopies. The number of pending procedures to be scheduled and the number of referrals to the GI clinic for recommendations provided evidence of this. For those individuals who would not clearly benefit from a procedure (life expectancy is limited, or the individual is on hospice, for example), or those for whom the procedure would be high risk and exceed the benefits of a preventative screening, there should be a rationale listed in the medical record and in the annual medical assessments. <u>Acute Care</u> Acute care was evaluated by reviewing the medical records, with a focus on the time period prior to transfer to the Infirmary and prior to transfer to the hospital, as well as immediate post-Emergency Room (ER), and post-hospital care back at the Facility. The following provides examples of the records reviewed, and the problems associated with each: ▪ The nurse examined Individual #398 at 0700 on 8/9/10 for fever of 101.4, and grimacing when the left leg was manipulated. He refused to use the left leg during transfers. When notifying the Infirmary nurse to have the PCP examine the individual that morning, there was a follow-up request to have a rectal temperature obtained. The nurse then went to four different residences and could not find a rectal thermometer. The Infirmary added the name of the individual to the follow-up list with the PCP. The physician documented an evaluation at 1000. The individual was noted to be unable to stand up. There was no tenderness on movement of the extremities. The Dilantin level was elevated at 34, and the diagnosis was made of Dilantin toxicity. Follow-up lab work was ordered, and vital signs (VS) were ordered three times a day (TID). At 1350, with continued inability to bear weight on the left side, and not being able to feed himself, the physician ordered him to be sent to the ER. There, a diagnosis was made of a Urinary Tract Infection (UTI), and he was returned to the Infirmary. On 8/10/10, the PCP wrote a follow-up note, indicating the individual had no complaints. On 8/11/10, the PCP's note indicated he had continued grimacing specific to left hip manipulation. He was sent for hip x-rays, and a fracture of the left femoral neck was discovered. According to the PCP note, the radiologist described the fracture as about one to two weeks old. At that point, an orthopedic consultation appointment was made for the next day, and there was the additional note that there was a faint greenish bruise to the left hip. On 8/12/10, there were two PCP entries. The first indicated that pain medication was adjusted for comfort care, and that Individual #398 had developed a fever of 101.8, and blood work and a chest x-ray were ordered. There was a second note that documented the discussion with the surgeon and the use of Deep Vein Thrombosis (DVT) prophylaxis. Thrombo Embolic Deterrent (TED) hose was also recommended. An 8/13/10 MD note indicated	

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		that the chest x-ray reading indicated pneumonia of the right lung, and that his pain control for his hip fracture was good. He was placed on Levaquin for the pneumonia. Then, on 8/13/10 at 2320, he developed hypoxia. The MD was paged, but there was no response. Emergency Medical Services (EMS) was called, and he was transferred to the ER. The Facility was later informed he was admitted to the Intensive Care Unit (ICU). The Facility's Hospital Liaison Nurse wrote visit notes for 8/16/10 through 8/20/10, and 8/23/10 through 8/25/10. His discharge diagnosis was right lower lobe pneumonia and respiratory failure with hypoxia. He also had severe dysphagia, and a left hip fracture. During the hospitalization, he "was noted to have an absence of gag reflex during his entire hospitalization. Repeat swallow studies demonstrated frank aspiration. Ultimately, the patient received a PEG prior to being dismissed." Concerning his hip fracture, the decision was made to allow the individual to recuperate for one to two weeks before proceeding with hip surgery, and he was returned to the Facility on 8/25/10. The MD wrote a readmission note on 8/26/10, and noted the individual was not having pain from the fracture, the hip surgery was scheduled for 9/1/10, and the dietitian had been consulted for nutrition recommendations. On 8/26/10, a second MD note reviewed the dietary recommendations and concurred. On 8/27/10, the MD note indicated he was tolerating the tube feedings, and he was not indicating pain, even when asked. There were additional physician entries on 8/28/10, and 8/29/10. On 8/30/10, the physician note documented that the pneumonia was resolved. On 8/31/10, the physician note indicated plans to send the individual to the hospital for admission through the ER per the orthopedic surgeon's instructions, that the individual remained without fever six days after the IV antibiotics for pneumonia were completed, and that he was tolerating the tube feedings. The Hospital Liaison Nurse wrote visit notes for 9/1/10 through 9/3/10. He returned to the Infirmary on 9/3/10. The physician wrote a note on 9/4/10, providing a brief physical exam with focus on the incision site, with plans to continue Lovenox, and Norco, as well as to resume previous orders. There were additional MD notes on 9/5/10, 9/7/10, 9/8/10 (with initial comments about orders for being up in a chair three times daily and to begin physical therapy), 9/9/10, 9/10/10, and 9/11/10 at 0925. A second MD note on 9/11/10 at 0900 indicated he had a one minute 15 second seizure. A Dilantin level was ordered. On 9/12/10, the MD indicated the Dilantin level was low, and when corrected for the albumin, was in the low therapeutic range, and an additional dose was ordered. On 9/13/10, the MD note indicated there was an episode of increased residual of feeding, but this was resolved with a dose of Reglan. Pain medication was reduced from Norco to Tylenol. On 9/14/10, the surgical staples were removed. There were further MD notes on 9/15/10, 9/17/10, and 9/21/10 (with plans to increase the tube feeding rate). On 9/22/10, the MD note	

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		indicated that he was more sleepy than usual, was grimacing, and a Dilantin level was ordered. Tylenol was given without effect, but Norco was given, which relieved his grimacing. Darvocet was ordered, and the prior lab order for Dilantin was discontinued as further history suggested he was not sleepy. On 9/23/10, the MD note reviewed labs drawn that morning. The Dilantin level was low, and the MD noted he already had a neurology clinic appointment, and follow up hip x-rays were ordered. A physician note on 9/24/10 indicated a chest x-ray done that day indicated the pneumonia had resolved. On 9/27/10, the MD note indicated he planned to discharge him from the Infirmary to his residence when the residence was ready, that his Dilantin daily dose had been increased, and that a Dilantin level was to be drawn in one week. The next MD note was on 10/7/10, in which it documented that the "home in process of receiving for discharge from the Infirmary." On 10/11/10, the MD note indicated that PT and OT had recommended that the head of his bed be elevated, and that he was to remain upright 1.5 hours after meals. He had also developed a UTI and was placed on antibiotics. A second MD note indicated that the individual had been to the orthopedic clinic, and he was to resume ad lib activities, and was to be allowed weight bearing as tolerated. There were no further hip precautions. This was a complex case beginning on 8/9/10 with pneumonia, severe dysphagia with feeding tube placement, and complicated by a hip fracture with repair, finally resolving on 10/11/10. There were a few observations: ▪ The reason for the MD not answering the page was not clear, and the Medical Director should review this particular concern, as well as the frequency with which this occurs, making systemic changes to resolve this issue. ▪ He was discovered to have severe dysphagia in the hospital setting. This likely did not just suddenly occur, but he was probably having symptoms at each meal, and the worsening dysphagia was missed. This underscores the need for an active and full time PNMT to instruct staff on triggers of dysphagia and monitor high-risk individuals. ▪ Once the pneumonia was diagnosed, the acute care was appropriate and timely. What was lacking was the preventive aspects as to why there was pneumonia and how it could be prevented. In this case, it was the hospital physicians who diagnosed the severity of the problem and took steps to prevent further pneumonias rather than the Facility physicians. ▪ There was no information in the Integrated Progress Notes that there was consideration given to the next step that would be taken to prevent the next fracture. ▪ When the nurse had to travel from residence to residence in search of rectal thermometers, there was delay in monitoring the individual, as well as	

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		inefficient use of time. The Facility should resolve this problem, and create an inventory and stock supply system that is dependable. ▪ The MD notes were hand written. It would provide increased legibility and assist the medical staff in efficient use of time if these notes were dictated and transcribed. For those individuals residing at an Infirmary more than 48 hours, it would be helpful to the team and other entities to have a dictated summary of the events from the time of illness necessitating Infirmary admission to return to the residence. Particularly in these long and complex cases, an interim typed summary is helpful. The medical record for Individual #68 also was reviewed with regard to the provision of acute medical care. An incidental nursing note from 8/1/10 indicated a shortage of Norvasc, and the physician was called and gave an order for Clonidine and to recheck the blood pressure in one hour. He was noted by nursing to develop a fever on 8/5/10 at 0100, but without shortness of breath or wheezing. He had some red pruritic areas on his extremities and back. On 8/6/10, he had a Complete Blood Count (CBC) drawn, and the results indicated an elevated White Blood Count (WBC) (27,000). The MD was notified, and he was sent to the ER. He was admitted to the hospital. The Hospital Liaison Nurse completed visit notes for 8/9/10 through 8/11/10. He was diagnosed with a UTI (he had a history of stable chronic renal insufficiency). He returned to the Facility on 8/11/10. The MD wrote a readmission note on 8/12/10. He was to finish his IV antibiotic, and Catapres was added for blood pressure control, and labs were to be checked to ensure renal recovery back to his baseline. On 8/13/10, the MD note indicated that his blood pressure was well controlled, he had low potassium and a supplement had been prescribed, and that his chronic renal disease was stable. There were further MD notes on 8/14/10, 8/15/10, and 8/16/10 (last dose of IV antibiotic). On 8/17/10, tests were ordered to determine the cause of anemia. On 8/18/10, the MD note indicated a record review was being done to determine the extent of any prior work-up for the chronic renal failure. A second note, later on 8/18/10, indicated worsening renal failure. A Foley catheter was to be placed to ensure that obstruction was not the cause of the worsening kidney disease. He was also discovered to have a Vitamin B12 deficiency and supplementation was ordered. On 8/19/10, the MD note indicated that the catheterization was unable to be completed, and he was sent to the ER for this procedure. This also could not be done in the ER, and he was admitted on 8/19/10 to the hospital. The Hospital Liaison Nurse visit notes were completed 8/19/10 through 8/20/10, and 8/23/10 through 8/26/10. An ultrasound of the bladder indicated no residual, and a catheter was not indicated. He was discharged back to the Infirmary on 8/26/10. Later that day, he vomited. There were MD notes on 8/27/10, 8/28/10, 8/30/10, 9/3/10 (planning for discharge from the Infirmary back to his residence), and 9/6/10 (discharged to the residence). Later in the month, on 9/24/10, he pulled out his own Jejunostomy Tube (J-tube). He was sent to the ER, where it was	

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		replaced. On 9/27/10, the MD note indicated referral to a nephrologist, checking a renal ultrasound and checking post void residuals. With complex cases such as chronic renal failure, to assist the covering physicians, the PCP should dictate a summary of work-up and findings with current medication and potential future options. This could be incorporated into the annual assessment or elsewhere, depending on the agreed upon location by the medical staff so that it can be readily accessed when needed. The Medical Department needs to develop a goal to reduce inadvertent tube removals by the individuals, with action steps that are unique to the individual. Individual #1 was admitted to the hospital on 8/9/10 for syncope, and found to have persistent atrial fibrillation, and subsequently required a pacemaker placement. The IPNs contained no entry discussing the occurrence of 8/9/10 that led to his hospitalization. The only hint of what occurred was from the Hospital Liaison Nurse visit notes, dated 8/9/10 through 8/17/10, which recorded that he lost consciousness while at the workshop at Austin Stated Hospital (ASH). He returned to the Facility on 8/17/10. There was an MD note on 8/18/10, updating the history and physical exam. On 8/18/10, the MD note indicated that he did well, and the residence at that point believed they could meet his needs. He was discharged from the Infirmary. There was a follow-up note on 8/23/10 by the physician indicating he continued to do well. The lack of documentation for the critical event is concerning. The record, despite copious nursing notes, had no entry as to what happened at the workshop. According to the Medical Care Policy #009, when an individual is sent to the ER: "the PCP and/or the nurse will telephone the receiving Facility concerning the transfer and document this conversation in the Integrated Progress Notes." However, there was no evidence of the communication that occurred, if any. There should be a system in place so that when there is an off site emergency, there is someone assigned responsibility for updating the IPN. There was no information as to whether the Facility ever sent a transfer packet to the hospital, or when it was sent, or by what conveyance. The Medical Director and Nursing Administration should establish guidelines for off-site emergencies, with focus on documenting events, and ensuring the transfer packet was sent in a timely manner to the hospital. Individual #302 had nine seizures recorded on 8/14/10, but refused to go to the Infirmary for evaluation and observation. He had a history of intermittent refusal of medication, and refusing to have vital signs taken. On 8/15/10, the MD note indicated that labs were drawn for multiple seizures in the prior 24 hours. He had labs drawn on 8/14/10, but from interpretation of the note, it appeared the wrong lab was ordered or obtained. During the phlebotomy procedure, he had another seizure and vomited coffee	

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		ground emesis, which was heme positive. Based on his recent uncontrolled seizures and GI bleed, he was transferred to the ER. A hospital operative note indicated he had an esophagogaastroduodenoscopy (EGD) on 8/17/10 with findings of erosive esophagitis. There were no Hospital Liaison Nurse visit notes submitted to indicate he was followed at the hospital. He returned on 8/21/10 to the Infirmary. On 8/22/10, the MD wrote a readmission note. He had polydipsia and hyponatremia (the sodium level was down to 108), and the PCP discussed with the hospitalist therapeutic steps, including fluid restriction. The electroencephalogram (EEG) and Computed Tomography (CT) scan of the head, done at the hospital, were also reviewed. On 8/23/10, the MD note indicated he was on a proton pump inhibitor for the GI bleed, and had a follow-up with the GI clinic in six weeks, his hyponatremia was due to polydipsia, and he had gross hematuria, for which a urinalysis (UA) was ordered (bleeding may have been due to a Foley catheter placement), and there was also serial blood work to check on the sodium level. He returned to his residence on 8/23/10. He originally had a 1250 cubic centimeter (cc) per day fluid restriction, which was liberalized to 1500 cc per day. However, an 8/26/10 nursing note indicated he had consumed 2060 cc of fluid on two shifts. A later entry on 8/28/10 by a nurse indicated he was not compliant with fluid restriction. On 8/31/10, he consumed 2250 cc in two shifts. On 9/2/10, the nurse's notes indicate he consumed 3840 cc, and had exceeded the 2200 cc ordered. He still requested more sodas. There may have been an increase in fluid allowed per order of physician, to be consistent with the entry that 2200cc was offered, but there was no MD note in the IPNs to indicate when this occurred, or the rationale for liberalizing the diet. Also on 9/2/10, there was an entry by the psychiatric RN indicating: "the team met to assess the patient for a quarterly psychiatric review," and that the "team assessed the patient as stable." On 9/7/10, an MD note indicated his blood glucose was elevated, and his Blood Urea Nitrogen (BUN) was very low, with the assessment that he was getting too many sodas, and he was placed on a fluid restriction of 1800 cc per day. On 9/8/10, an MD note indicated his sodium level had corrected to 135, and that his Vitamin D level was low. On 9/15/10, the MD note indicated that an order was given for the head of the bed to be elevated 30 degrees after meals. On 9/28/10, there was a nursing note indicating that the psychologist requested a trial of Gatorade as a substitute for soda, and the MD agreed and ordered this. Throughout this time period, the nursing notes reflected intermittent noncompliance with taking medications, as well as resisting cooperation with basic nursing care and assessments. The following concerns were raised in reviewing this record: ▪ That staff, and the PST, appeared to be unaware of the polydipsia until he had uncontrolled seizures was problematic. Once finding a Sodium (Na) level of 108 (Na levels below 110 are associated with status epilepticus and worsening seizure control), there was little urgent response from the psychology department. An important entry on 9/28/10 suggested a resolution to this	

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		problem, but he had returned from the hospital on 8/21/10, and it took the psychology department five weeks to respond to a critical behavioral issue. ▪ He continued to be noncompliant with medications and nursing assessments, and noncompliant with fluid restrictions, but the team did not respond to these concerns. Although team meeting minutes might be maintained elsewhere, the Integrated Progress Notes should reflect some of the action steps taken by psychology and other departments, especially as it impinged on a potentially life threatening healthcare issue, but documentation was absent. ▪ The psychiatry team met for a quarterly review just after he returned from the hospital, but did not indicate that they were even aware of the polydipsia or hyponatremia, nor of the noncompliance and agitation, which included assaulting staff and later kicking a peer in the face on 9/5/10. ▪ That his noncompliance with the fluid restrictions did not meet with immediate intervention from the team is problematic, because he had demonstrated ability to develop severe hyponatremia. ▪ The involved departments should meet to review the timing of therapeutic interventions (or lack of interventions) to determine how to respond in a timely manner to any future events he may have, and use it as a template for quick response to meet the medical needs of any individual residing at AUSSLC. The current IPNs for this event did not reflect psychology, psychiatry, or other team responses to the urgent needs of the individual. Individual #43 was documented to have a change in health status. On 8/2/10 at 1520, the direct support professional reported the individual "does not look good." She was observed to have labored breathing, with respirations of 36 per minute and her Oxygen (O2) saturation on room air was 84 to 90 percent. The physician was contacted and orders were given to call EMS. From the hospital discharge summary, her final diagnoses were community acquired pneumonia, a small right pleural effusion, and a pacemaker interrogation with normal function. There was no Hospital Liaison Nurse visit note. She returned to the Infirmary on 8/4/10. There was an MD readmission note on 8/5/10, with an updated history and physical evaluation completed. A follow-up MD note on 8/9/10 recorded that she was continuing to do well. She was returned to her residence on 8/9/10. On 9/15/10, the MD noted persistence of infiltrate on chest x-ray. Occupational Therapy (OT) was consulted to consider a modified barium swallow, and she was ordered another course of antibiotics. There was another MD note on 9/17/10, in which recent lab tests were reviewed. The following concerns were noted: ▪ This record also did not have a physician or nursing note indicating communication with their counterparts at the ER at the time the individual was being transferred. The sudden decline occurred on a business day in mid-	

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		afternoon, but the physician did not go to see the individual prior to or while the transfer was being conducted. There was no evidence that there was any communication between the PCP and the ER physician. One would anticipate that this would not occur after hours, but should occur during regular business hours. ▪ The direct support professional only reported that she "does not look good." This suggested the need for a rigorous training program of direct support professionals to be able to observe early changes in the individual's health, and also be able to articulate and describe accurately their findings. It is likely that she developed early recognizable signs and symptoms of pneumonia somewhat earlier than is documented, when she suddenly was found to have respiratory distress with grunting and rapid breathing. It is recommended that a formal training program be developed and implemented specifically for the direct support professionals, with health status change the main focus of education. Individual #72 had a seizure disorder and was fed by gastrostomy (G-tube). Her normal oxygen saturation was 91 percent on room air on 7/27/10. On 8/7/10, she had a one minute seizure, following which her respirations were 16, and described as even and unlabored. Her O2 saturation was recorded as 82%, and heart rate was 129 per minute. The nurse took her temperature (98.5T), examined the abdomen and checked for impaction. The nurse then repositioned the individual. The O2 saturation increased to 86 percent, and the individual was placed on four liters per minute (4LPM) of O2. The O2 saturation then ranged from 82 to 88 percent. EMS was called and arrived at 0739, and the physician was notified. She returned to the Infirmary at 1415 with oxygen saturation at 93 percent, and was back to her baseline and in no distress. The Medical Director might want to review this case with the physicians. It would appear the physician was called after the transfer rather than during the nursing interventions, which may have been appropriate. This might indicate the need for a post ictal tracking sheet with serial vital signs to determine if the individual is stable in the post ictal period or is unstable. The nurse made the correct judgment of administering oxygen. There was not clear information as to the timing between steps taken. Her stay at the ER was brief. Individual #122 required regular infusions for his hemophilia. On 8/23/10 at 1730, he stated he hurt his right elbow on the bus while going to school that morning. There was pain at the elbow joint, but no bruise or swelling. He was due for a "hemophiliac" infusion and the nurse called the Hemophiliac Center to determine if an additional amount of infusion should be given, but there was no response back from a page directed by their answering service. The routine amount of infusion was given, along with Tylenol for pain. At 2000 hr, he complained of right elbow pain. Although there was no swelling or bruise, he had pain on motion. The physician on-call was notified, and ordered	

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		transfer to the ER for evaluation. He returned and was in bed by 8/24/10 at 0045. When an individual was transferred to the hospital, an emergency transfer packet of information was sent with the individual. The emergency transfer packet was reviewed as one of quality indicators of emergency care, providing completeness of information when it is most urgently needed. The transfer packet of Individual #413 was reviewed, as an example of what was transferred on 10/1/10. To assist the staff in compiling all needed information, there was a "Records Verification Checklist for Hospitalization," which listed the "records to be sent to the hospital with individual" at the time of transport. The packet of information included an annual medical assessment, correspondent information, current lab [most recent copies of CBC, Comprehensive Metabolic Panel (CMP), and other recent lab from 7/19/10 to the time of transfer]. There was a form entitled "Admissions Pre-Registration Form" that included the reason for the ER visit, and other identifying information, the Integrated Progress Notes from 9/26/10 to the date of transfer, a copy of the most recent Physical Nutritional Management Plan (revised 9/7/10), a copy of recent physician orders (dated from 9/3/10, including a typed order sheet dated 9/22/10, which listed resuscitative status, diet, orders for lab and lab frequency, preventive actions (PPD, flu vaccine), special orders (weigh daily, mechanical lift for all transfers, may use wheelchair for transportation, may stay in residence when weather is 40 degrees and below, and blood pressure twice a day with parameters when to hold, positioning orders). Current Medication Administration Record (MAR) (for 10/1/10 to 11/1/10), a patient profile report that included diagnosis, PCP of record at the Facility, active regular medications and PRN active medications, enteral flow record, a completed signed copy of the out-of-hospital Do Not Resuscitate (DNR) order, and active problem list and significant medical events/findings. On the day of discharge from the hospital, the hospital physician routinely contacted the Facility physician to provide an update, review critical clinical information and current status. Most readmissions were routed to the Infirmary. If the Infirmary nurse was contacted by the hospital about a readmission, the nurse verified that the hospital attending physician had discussed the readmission with the Facility physician. This was a system that worked well, according to the Medical Director. At the time of the Monitoring Team visit, this was observed during the transfer of Individual #22 to the Infirmary from the area hospital. The PCP was contacted by phone by the attending hospital physician. The physicians were updated daily about any hospitalized individuals through the Hospital Liaison Nurse. This nurse reported at each morning medical staff meeting, providing the latest information on progress, and allowing for early planning of readmission, especially if there were new needs concerning PT/OT evaluation, adaptive	

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		equipment, etc. Physicians were made aware of the hospital progress, so that when the hospital physician contacted the Facility physician, the Facility physician already had a good understanding of the current status and needs of the individual. The Hospital Liaison Nurse also provided a document through the email entitled "Client Hospital Update," which was a running log of clinical information each day the individual was at the hospital. This report was widely distributed through the email to those who would need to have the information in order to prepare for the individual's return, including all home supervisors, all physicians, all QMRPs, all shift coordinators, the OT/PT distribution list, and the Infirmary nurse distribution list, as well as the personal support team of the individual. The Medical Director stated that the information provided by the Hospital Liaison Nurse was of great value, and indicated the creation of this nursing position had been beneficial for the PCPs. "Client Hospital Updates" were reviewed for the following individuals: Individual #121, admission on 9/15/10; Individual #309, admission on 9/20/10; Individual #5, admission on 9/25/10; Individual #31, admission on 9/28/10; Individual #22 admission on 9/27/10; Individual #199, admission on 9/24/10; Individual #426, admission on 10/1/10; and Individual #413, admission on 10/1/10. Content included reason for transfer, treatment in ER, test results, and a daily snapshot of clinical findings and updated information, including behavioral issues. Additionally, the Hospital Liaison Nurse ensured the PNMP and the "special considerations page" were in the hospital record, and made the hospital nurse aware of the information. There was only one "Client Hospital Update" for Individual #309 that was difficult to follow. It appeared this individual was hospitalized for surgery, but there was no further entry until a week later when he was hospitalized, at which time the second entry briefly mentioned the surgery, discharge, and the readmission. It is recommended that the Hospital Liaison Nurse update each hospital admission separately so as not to confuse the reader especially when there are hospital readmissions within a short period of time. Copies of the discharged orders were often faxed to the Facility for review. In this way, the orders could be reviewed and written, and sent to the pharmacy for their review before the close of the business day, because the actual transfer of the individual could occur late in the day. It also provided time for the PCP to address every previously prescribed medication to determine if it should be continued. Justification for each medication was required. Usually within 24 hours the Medical Department received the hospital discharge summary, at which time the PCP readmission note was written in the IPN, capturing the important points from the discharge summary, as well as the packet of information received when the individual returned to AUSSLC. Respiratory infection was a significant cause of morbidity in the population at AUSSLC. At the Infirmary, on 10/7/10, out of a census of 10 admissions, three individuals had	

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		pneumonia or aspiration pneumonia. The hospital census indicated that three out of four individuals had "R/O [rule out] aspiration pneumonia" as a working diagnosis. The Facility submitted two computer-generated lists for pneumonia and aspiration pneumonia. For a list entitled "pneumonia" with dates ranging from 1/1/10 to 8/12/10, 74 percent were due to aspiration, and 63 percent were tube-fed individuals. For a list entitled "aspiration pneumonia" with dates ranging from 11/3/08 to 7/22/10, it was noted that 75 percent of the individuals had enteral tube feeding. Although the feeding tubes were placed due to dysphagia in most instances, the bouts of aspiration pneumonia suggested further workup was needed to rule out GERD, a common associated problem in this population. Examples included: ▪ Individual #396 was reported to be wheezing on 8/8/10 at 1300, with oxygen saturation at 93 percent on room air, using accessory muscles for breathing, and responded well to nebulizer treatment. She was reported to have lung sounds that were clear bilaterally on 8/9/10 at 0900, but by 1645 developed dyspnea and audible wheezing. A prn nebulizer treatment was given with good response. On 8/11/10 at 2130, she was noted to have no wheezing, but by midnight had wheezing and dyspnea, again responding to nebulizer treatment. Within one hour she no longer had wheezing. Later that morning, at 1135, she had wheezing, and responded again to prn nebulizer treatment. She then developed respiratory distress with wheezing on 8/19/10 at 1515, and was seen by the MD. Respirations were shallow and labored. She was ordered a nebulizer treatment, and then transfer to the ER for evaluation was ordered. She returned to the Infirmary at 2150, and by 2230, she was noted to have no wheezing. She was tube fed at a rate of 120cc per hr. This individual had frequent bouts of wheezing, readily responding to nebulizer treatment. She also had a G-tube. She remains at high risk for possible GERD with reflux and aspiration. Aspirations may present as wheezing and bronchospasm. It was unclear why she had not had a workup for GERD and if significant, further evaluation and treatment would have been indicated. The PCP is challenged to critically think about the reason behind the recurrent, abrupt onset of wheezing. If GERD was significant, she might have needed a gastroscopy to determine the extent, or not, of esophagitis, or presence of Barrett's esophagus. Consideration might have needed to be given to one or more surgical options such as a Nissen fundoplication and or Jejunostomy tube (J-tube) placement, if she had severe reflux or gastroparesis. Feeding through a G-tube with significant GERD can cause reflux with aspiration. ▪ Individual #182 developed congestion on 8/6/10 at 0100. He had a small amount of vomitus on his bedding. He had coarse lung sounds in the upper airways. His vital signs were normal and his oxygenation was 91 percent on room air. At 0800, he was documented to not be swallowing properly, and that he was drooling. His temperature was 99.6. The MD was notified and ordered a	

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		CBC and Tylenol. The nurse raised the concern about his drooling and need for a swallow evaluation but the MD "did not want to do it now." At 1130 on 8/6/10, his temperature was 98.8. He did well on 8/7/10, and then on 8/8/10, the MD examined him for rhinorrhea, and temperature of 99. He was unable to check the throat. There was upper airway noise. He was diagnosed with an upper respiratory infection and prescribed Augmentin and Sudafed, and a repeat CBC as the WBC was elevated at 13.3. On 8/10/10, the nasal drainage had subsided. On 8/11/10, at 1005, he was noted to be doing well. Labs came back within normal limits. Then at 1600, he was noted to be pale, lethargic, breathing rapidly and with difficulty. Crackles were heard when lungs were auscultated. His O2 saturation was 54 percent on room air. It increased to 78 percent on 2LPM (liters per minute) of oxygen. EMS was called, and he was sent to the hospital. In this case, staff had concerns about swallowing ability, but there appeared to be a delay in the MD recognizing this as a possibility. That he dramatically worsened suggested he aspirated food or drink, or that he was refluxing severely, or that he had vomited and aspirated. At the time of the Monitoring Team's visit in October 2010, he had recently returned from the hospital with a G-tube in place. Physicians should respond to concerns about swallowing by consulting a Speech Language Pathologist/Occupational Therapist, or order a swallow study, or both. This would either ensure he is safely prescribed the correct texture of diet and correct thickening, or demonstrate the need for a therapeutic diet. In the future, the PNMT would be a valuable resource to the physician in such a situation. ▪ Individual #81 was transferred to the ER for increased emesis on 9/11/09, and returned later that day with an IV for fluid replacement. A 10/13/09 GI consult commented on the decreased esophageal and gastric motility, and suggested adding Erythromycin 400 mg four times a day (QID) to his regimen for 10 days to determine if there was any improvement. He had a PEG tube and laparoscopic fundoplication done on 12/5/09 for silent aspiration during swallowing, poor oral intake, weight loss, and reflux. He was hospitalized from 3/26/10 to 4/2/10 for hypoxia and right lower lobe pneumonia. On 4/27/10, his tube-feeding rate was increased to six cans per day. Prior feedings were associated with no residuals. As of a dietitian note on 4/16/10, this individual was still offered pleasure foods of pudding and OT was notified of this, due to safety concerns of him taking food orally. On 5/10/10, he was noted to be gagging 30 minutes after the feeding was completed. A 5/15/10 Advanced Practice Registered Nurse note indicated that he was offered snacks by mouth in order to maintain oral skills related to eating, but that he refused any offers of food. Liquids were not attempted due to aspiration. As of 5/25/10, his feeding	

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		orders were nothing by mouth (NPO) with 356 milliliters (ml) of formula and 175 ml of water five times a day via pump. He was to remain upright one hour after feeding, and the head of the bed was to be elevated. He was hospitalized again on 6/10/10 to 6/16/10 for pneumonia. From 6/25/10 to 6/30/10, he returned to the hospital for pneumonia. This individual is highly complex as he has a history of repeated pneumonias despite a PEG-tube and a fundoplication. It was unclear if consideration had been given to the issue of feeding rate. He received bolus feedings, and even the number was increased on 4/27/10, which would potentially aggravate his history of hypomotility in his stomach. It would aggravate this, as it likely would further increase the residual volume left in the stomach when the next bolus is due. To increase the number of bolus feedings per twenty-four hours requires the stomach to be empty even sooner than previously when there was more time between the bolus feedings. It was not clear if consideration had been given to providing him a lower rate continuous feeding. It also was not clear if attention had been given to positioning, and around the clock monitoring of positioning, to ensure that he was not lying flat at any time during or after his feeding for one hour, or if emphasis was placed on his not lying flat during bathing. Because no clinical guidelines or pathways were in place, the Monitoring Team could not determine if the expectations were that other alterative treatments would be considered during the clinical course if these methodologies failed. For example, other alternatives would have included placement of a J-tube if the aspiration continued to be reflux aspiration from his stomach, or if this did not reduce or eliminate aspiration pneumonias, then a laryngeal tracheal separation or tracheal esophageal diversion, with the risks carefully weighed against the benefits. The development and implementation of clinical pathways/guidelines would ensure that appropriately aggressive treatment was considered for each individual. ▪ Individual #39 had been hospitalized for many occurrences of pneumonia since 1980. She had a G-tube (placed 1988) and a tracheostomy (placed 2010?). She was hospitalized for post emesis respiratory distress on the following dates: 1/22 to 2/2/09, 2/3 to 2/4/09, 5/7 to 5/19/09, 6/15 to 6/22/09, 7/10 to 7/22/09, 8/17 to 9/2/09, 10/16 to 23/09 (aspiration pneumonia), and 11/4 to 11/20/09 (aspiration pneumonia). Since that time she was also hospitalized for aspiration pneumonia on the following dates: 1/2 to 1/12/10, 2/5 to 3/16/10, 6/29 to 7/7/10, and she was hospitalized at the time of the Monitoring Team's visit. This individual was at risk for severe GERD and aspiration, and during the week of the Monitoring Team's visit, a gastrografin study was completed and indicated significant GERD. Again, clinical pathways were not in place to ensure that appropriate options were considered, including, for example, a fundoplication; ensuring her positioning needs are met at all times, including when being bathed; and/or placement of a J-tube to decrease gastric volume at	

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		any one time and the risk of reflux, especially if she develops gastroparesis. Reduction of her reflux with aspiration is likely to improve her clinical course with asthma. She may develop less bronchospasm and reactive airway disease if some of the episodes of wheezing are due to reflux with aspiration. ▪ Individual #199 had a G-tube placed in 2004, a tracheostomy in 2005, and a fundoplication in 2005. Since 2005, he has had many hospitalizations for pneumonia and aspiration pneumonia: 8/15 to 8/21/07, 1/29 to 2/11/09, 2/23 to 3/5/09, 4/26 to 5/11/09, 8/11 to 9/2/09, 10/10 to 10/28/09, 1/2 to 1/13/10, 2/17 to 2/24/10, and 9/24/10 (continued to be hospitalized during the Monitoring Team's visit). An evaluation for GERD was suggested, and he underwent an upper GI (UGI) series, which indicated significant GERD. Again, clinical guidelines were not in place to guide next steps. Such clinical guidelines would need to consider and/or provide guidance with regard to the following clinical questions or decisions and cover a wide array of circumstances: o Was there a need to review the current function of the fundoplication, and whether or not it needed revision if it had become unwrapped? o He was already on continuous tube feeding, but for an individual who was not, should this be considered? o Was he a candidate for a J-tube placement? o Would he benefit from a referral to ENT to determine the feasibility of a laryngeal tracheal separation or tracheal esophageal diversion (given that he already had a tracheostomy, the ENT would be able to determine if this was a feasible option or made more complex by prior surgery in the neck)? o Additionally, if he has gastroparesis, that would aggravate the GERD, then other medical management or surgical interventions might be available from the local hospital community, or a referral to a university medical center outside of the Austin area might be an important consideration given his complexities. However, such a referral would require ensuring all the relevant documents are included in a packet and sent with him, and there would need to be communication/follow-up after the consultation to ensure the consultant addresses the questions and concerns of the PCP. ▪ Individual #426 had a G-tube placed (date unknown), as well as a tracheostomy (2/23/09). In the recent months, he was hospitalized from 11/1 to 11/6/09 for possible aspiration pneumonia, and recurrent emesis, from 1/14 to 1/27/10 for pneumonia, on 5/31/10 for an unknown period of time for aspiration pneumonia and respiratory failure, and from 6/19 to 6/24/10 due to acute chronic respiratory failure. At the time of the Monitoring Team's visit, he was hospitalized (admission date 10/1/10). A work up for GERD was suggested, and significant GERD was found. Clinical guidelines would help to define next	

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		options, including a fundoplication, J-tube placement, or other treatments and procedures. It needs to be emphasized with many of the individuals served by AUSSLC that when there is a hospital admission, and especially a repeat hospital admission for the same condition, the PCP needs to critically review the health care needs and search for causes and additional treatments to prevent further hospitalizations and clinical deterioration. When a treatment works (whether medical or surgical or PNMP option), that should not mean that the PCP becomes less vigilant. At some point, as treatments no longer work, due to functional or neurological or other physiological decline, and the individual requires hospitalization, the critical process of determining the reason for the deterioration should be aggressively pursued until treatment is successful. For many of the individuals reviewed, the numerous hospitalizations should have been followed by prompt, aggressive evaluations and treatments until the hospitalizations were minimized. Unfortunately, many of these serial hospitalizations were not followed by further evaluations and consultations once the individuals returned to AUSSLC with the goal of preventing further hospital admissions. It should not have to require an acute care admission with severe pneumonia or other illness to discover that an individual has severe dysphagia or severe GERD. These are conditions that should be diagnosed and treated methodically in order to prevent acute illness when at all possible. A list of individuals with pica or history of ingesting inedible objects was submitted. This totaled 23 individuals. A separate list was submitted of those with BSPs, including those having pica for which a BSP was implemented. The two lists were not similar. If the interpretation of the BSP list is accurate, 15 of the 23 individuals with pica had a BSP. It is not known if the pica habit was remote or recent as the medical record was not available at the time of this review. Also, the list of 23 individuals with pica was an incomplete list, as the BSP list for those having pica included other names, including Individual #175, Individual #424, Individual #246, Individual #224, Individual #277, Individual #364, Individual #26, and Individual #124. It is recommended the Facility review its database management in order to ensure complete and accurate information. BSPs and staffing reports were reviewed. The following provides some examples of concerns resulting from these reviews: ▪ The team met concerning Individual #424 for an annual BSP review on 8/19/09. She ingested coins, keys, nails, and paperclips. According to the BSP, this had increased during the six months prior to the review. A number of steps were taken to minimize this behavior, including random searches of rooms, not wearing torn clothing or those with buttons, searching her clothing for inedible objects, conducting pica sweeps, and creating a pica safe work area. Individual #424 had an interim meeting because of swallowing a paperclip on 1/13/09,	

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		and an attempt to swallow a nail, but she was prevented from doing so. She was placed on a one-to-one supervision level. On 2/11/09, an interim meeting was held because she swallowed a thumbtack when she ran into an office and grabbed a thumbtack off a corkboard. At the time, she was placed in the Infirmary as the team deliberated options such as placement elsewhere on campus, creating a pica residence for women on campus, or referral to Richmond State Supported Living Center, where there is a pica residence for females. She ultimately was to return to the residence with two-to-one staffing while awake, all staff working with her were to have special training, all sharp objects were removed from the residence, all items on the wall in the office were to be encased in glass, and all cabinets and closets in shared living areas would be locked, among other action steps. Eventually, there were plans to move her to a residence modified as a female pica-safe unit when it opened. On 4/22/09, she was walking back from her workshop, tore off her mitten restraints, saw a paperclip on the ground, and swallowed it. The team recommended training on the correct use of mitten restraints, referral to San Angelo State Supported Living Center, and continued planning on moving to the female pica-safe unit on campus when it was renovated. Information was not available after the BSP of 8/19/09, the latest submitted in response to a request for information through the time of the on-site review. The team was sensitive to the many aspects of this individual's pica habit, did meet regularly, and was creative in promoting a pica safe residence for women. During the review of the BSP material, the remainder of the medical record was not available for reference. However, a clinical pathway on pica would offer assistance in directing the PCPs to provide a standardized approach to individuals who may have ingested inedible items. She was placed in the Infirmary after ingestions, which would require the PCP to be aware of her condition. The clinical pathway should be written to provide guidance regarding what tests should be ordered and when to order them, as well as discuss options of nutritional importance, such as adding zinc or iron supplementation. This individual was not listed on the list of 23 that was provided. ▪ Individual #212 had an interim meeting on 4/8/10, for consideration of extraction of teeth to reduce ripping and tearing of items for ingestion (she is G-tube fed). The Facility Director was not in agreement with this very invasive method of addressing the issue of pica. She remained on one-to-one staffing. The physical medicine physician had referred her for a Dysport injection. The team met for her annual PSP on 8/13/10. A PSP addendum report of 9/30/10, included a summary paragraph documenting her severe history of eating bits of clothing, threads, hair, and foam rubber, and that she had had numerous surgeries to remove these. Back in 3/5/09, surgery removed 20 to 25 foreign bodies. The surgeon subsequently stated: "it was unlikely any additional	

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		surgeries could be performed successfully." This individual had been on one-to-one staffing since March 2009, but the team was meeting one year later to begin to change her one-to-one staffing to enhanced supervision. There was no information recorded as to whether the PCP agreed or not to the loosening of supervision. However, given the surgeon's warning, it is recommended that the entire medical staff meet to review the medical and surgical history, and under the guidance of the Medical Director, determine/recommend a plan. She presumably had done well under one-to-one supervision, but the intense staffing could be the reason for the success, and to remove or reduce the supervision could increase unnecessary risk, depending on the medical and surgical history. Meeting as a group also would allow all physicians to be aware of the history of this individual, as well as to begin to standardize the medical care of those with pica habits. Based on this meeting, the PST for this individual should be provided with guidance/ recommendations. The Medical Director should review the BSPs and subsequent addendums of those with ongoing pica behavior to ensure his knowledge of the type and frequency of pica, as well as to determine whether the PST of the individual needs further medical guidance to provide ongoing protection of the individual and minimize risk. There may need to be written correspondence to the PST from the Medical Director that the PCP could share with the team during a team meeting. <u>Mortality Reviews</u> Records were reviewed on those who had died in the past six months. The reviews included the pertinent clinical information from which to derive conclusions about quality of care, and quality of life. There was considerable detail as to the series of events prior to death, including a list of diagnoses, prior procedures, consultations and findings, information concerning prior hospitalizations, and end of life decisions. The QE nurse spent considerable time reviewing the nursing care from the perspective of following procedures, documentation requirements, medication variances, and systems concerns for nursing administration. This part of the review was excellent in both the level of detail that was documented, as well as the recommendations based on findings. There were four deaths in the prior six months, and the reviews appeared to focus on areas of major concern needing review and potential change or improvement. The emphasis of the review was clinical. There was also an administrative review, which included findings of clinical concern, but looked at more global concerns including abuse and neglect, and changes in administrative policy. Based on the recommendations from the clinical review, there were no additional findings of concern or gaps in researching all clinical areas. The findings and recommendations were practical and based on the historical facts.	

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		The following summarizes these reviews: ▪ Individual #136 had a gastrointestinal bleed in 10/08 requiring hospitalization, and respiratory distress from aspiration of secretions in 4/09. She had a prior feeding tube placement and had a seizure disorder. She developed a fever on 4/20/10, 4/24/10, and 4/25/10, but it was not until 4/25/10 that the physician was notified and ordered transfer to the ER. She was admitted to the hospital, but developed bilateral pneumonia and respiratory failure. She died in the hospital. A clinical death review was completed, and a QE nurse reviewed nursing services. There were a number of findings for which nursing administration would be responsible for follow-up, such as requesting that the company representative calibrate scales used to weigh individuals because they provided inaccurate results. Additionally, there were some ongoing, unresolved issues that would need continuing nursing administration management, such as ongoing training and retraining of nursing staff regarding expectations such as follow-up of rapid weight loss, giving tuberculosis skin tests according to guidelines, and when to refer a concern such as congestion or fever to a physician. The clinical death review summary focused on nursing services. The QE nurse review was excellent and detailed, providing information concerning both specific individual nursing care, and systemic nursing issues. ▪ Individual #44 had a G-tube and a fundoplication. He developed esophageal carcinoma diagnosed on 1/15/08. On 7/1/10, he developed fever and was sent to the Infirmary. He then was sent to the ER on 7/2/10 for possible pneumonitis. The family requested discharge to hospice, and this occurred on 7/4/10. The administrative death review had no recommendations. ▪ Individual #27 had a G-tube placed. She developed aspiration pneumonitis in 10/08, and 7/09. On 7/21/10, reportedly within a six-hour timeframe, she developed respiratory distress, with a fever and oxygen saturation down to 84 to 88 percent. A nebulizer treatment did not improve her respiratory status, and she was promptly sent to the ER. She was admitted and treated for pneumonia. Her G-tube was changed to a GJ-tube on 7/30/10. She initially improved, then deteriorated and died of acute respiratory failure due to aspiration pneumonia, complicated by chest deformities. This case highlights the importance of training the direct support professionals on health status change in the individual. It was possible that there were earlier, more subtle, signs of illness before this individual suddenly developed respiratory distress. A rapid onset might have been caused by severe GERD with reflux. Records did not indicate the reason for the GJ placement, but there might have been significant GERD found while the individual was hospitalized. As noted previously, given her previous hospitalizations, a clinical pathway for treating individuals with histories of aspirations and pneumonia would have been beneficial in determining next steps, and potentially preventing the next hospitalization. In	

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		this case, treatment did not help, and she succumbed to her disease process. ▪ Individual #164 had a complex history of clinical deterioration over the four months prior to his death. This individual had a new onset seizure on 2/17/10. He had a workup including CT of the head, EEG, and neurology clinic visits. On 3/1/10, a second seizure occurred, at which time he was placed on Keppra. He also was hypothermic. On 3/7/10, he was sent to the ER for gross hematuria and found to have cystitis. Back in the Infirmary, he was noticed to have a decline in his gait. PT was ordered, but there was little improvement. He was seen by neurology on 4/19/10, and an MRI was ordered, which incidentally indicated possible mastoiditis and acute sinusitis, for which he was treated. On 5/27/10, an ENT clinic visit was completed, and the specialist found no mastoiditis at that time. On 6/11/10, he had a three-minute seizure and then turned blue and "was cold." The Infirmary nurse went to the residence and EMS was contacted. When the nurse arrived, he was found to have agonal breathing and an oxygen saturation of 78 percent. He was placed on supplemental oxygen with improvement in his oxygen saturation to 94 percent. EMS arrived and intubated and bagged him. He was taken to the hospital. He had another seizure in the ambulance and a third in the ER. He was given Versed in the ambulance and IV Ativan and Fosphenytoin in the ER. He vomited and required intubation. He developed complications of a cardiac arrhythmia, hypotension, and hypothermia, and was found to have extensive hypoxic injury to the brain. When taken off the ventilator, he had no spontaneous breathing. This individual had extensive work-up in a short period of time prior to his demise. The more problematic system concern was the activity when he turned blue. It was not clear how long this individual was blue, cold and on the floor, and what the staff did before, and after, the Infirmary nurse was contacted. There should be training of direct support professionals on what to observe and record when there is a health status change. The quality and depth of training of the direct support professionals concerning expected steps, and a competency-based training approach to handling emergencies should be reviewed by nursing administration. It was not explored with the Medical Director, whether or not direct support professionals are CPR certified for Basic Life Support (BLS). The Infirmary nurse went to the residence to evaluate the individual, but there was no mention of the nursing staff assigned to the residence who may have been closer to the event, and could have taken action sooner. The Infirmary nurse appeared to take the correct steps, and oxygen levels rose, although there was no mention of use of an ambu bag given the history of agonal breathing. Nursing administration should review the emergency drill system in place to ensure all residences and all shifts are included in the training at some point in the calendar year, and that all staff are included in the drills over the year. The	

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		clinical death review had findings focused on the nursing service. <u>Do Not Resuscitate Orders</u> A list of "individuals with DNRs" was submitted. It listed 17 individuals, with dates of orders of DNR dating from 1999 to 2010, with the medical condition. Given changes in condition and treatments over time, it is recommended that each of these individuals be reviewed carefully to ensure compliance with state regulations, as well as related guidance from DADS. Additionally, those individuals with old DNR orders might have conditions and treatments that have changed over time for which the existence of DNR order might no longer be applicable. These should be systematically reviewed and updated.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	There had not been any medical review by a non-Facility physician. This continues to be a recommendation, specifically, the review should be conducted by a physician who is not part of the SSLC system.	Noncompliance
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 of the review, there was no medical quality assurance program in place. As is noted above with regard to Section L.1, there was a database available, but there were issues with regard to comprehensiveness of the information included in it, the accuracy of the information, as well as the ability to produce meaningful reports. There was no evidence that a comprehensive set of clinical indicators had been developed, or that the data available was being used to identify issues requiring the development of corrective action plans. As is discussed in further detail below, while a more comprehensive medical quality improvement system is being developed and implemented, existing data should be utilized to begin to make changes that would positively affect outcomes for individuals. A list of individuals with chronic constipation was submitted. The list included over 120 individuals. Given the frequency and, at times, severity of the problem for the individuals residing at AUSSLC, this would be an opportunity to provide a quality assurance plan that focuses on prn use of medications (suppository or enema), and to reduce their use by providing optimal bowel hygiene. Given the numbers of individuals involved, the effect would be large. It would provide an opportunity for the Medical Director to create a clinical pathway/guideline for describing the steps in treatment of chronic constipation, as well as an expected timeline for any additional work-ups that are indicated. This	Noncompliance

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		would allow standardization across the campus concerning treatment expectations for this diagnosis. The goal would be to reduce the frequency of constipation in these individuals, and the clinical indicator could be a reduction in the need for prn medication. A list of those with GERD was submitted. There were 71 individuals listed. The list did not include the three hospitalized individuals diagnosed with GERD. Given the number of individuals with GERD, and unrecognized GERD, GERD should be an urgent focus for medical quality assurance programs. Creation of a clinical pathway or guideline would be helpful in establishing a standard approach to evaluation and treatment, as well as creating a timeline for taking the next step in the process. From this guideline, there could be a number of clinical indicators identified that would be useful in determining compliance.	
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.	There were no policies submitted by the Medical Department specific to AUSSLC. A copy of the Medical Department policy and procedure manual was submitted. There was one policy, the Texas Department of Aging and Disability Services SSLC Policy: Medical Care policy # 009, dated 7/20/10, attached were the Health Care Guidelines, dated May 2009. Additionally, there were copies of Exhibit B- US Preventive Task Force Guidelines, American Cancer Society Guidelines for Breast Cancer Screening: Update 2003, and American Cancer Society Guidelines for Breast Screening with MRI as an Adjunct to Mammography 2007. There were also three attachments concerning tuberculosis (TB) screening: Targeted Tuberculin Testing Screening Form, Targeted Tuberculin Testing Screening Form Instructions, and Tuberculosis Questionnaire for Children. Additionally, there was a policy for Austin SSLC – Health Services Operational and Policy Manual: Neurological Assessments and Procedures: Vagal Nerve Stimulator Use, dated 3/08, and Neurological Assessments and Procedures: Seizure Management, dated 3/08. These applied to Licensed Vocational Nurses (LVNs) and Registered Nurses (RNs) specifically. The Medical Director should create and implement a number of basic policies as the administrative foundation of the department, as well as clinically focused policies and procedures/protocols/clinical pathways or guidelines based on the Health Care Guidelines. Guidelines should be updated to agree with current recommendations of national health organizations. From the three attachments following the Health Care Guidelines, (one on US Preventive Task Force Guidelines, and two on screening for breast cancer), there seemed to be the beginnings of a review of some of the areas of the Health Care Guidelines to provide updated material. However, this information should be clearly outlined in a policy, procedure, or clinical pathway/guideline, and dated. At periodic intervals, there also should be updates of the clinical pathways/guidelines to	Noncompliance

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		ensure agreement with community and national standards. There should also be evidence of routine in-service education and training of the PCPs to ensure their understanding and expectation of care. As a separate area needing medical policy guideline, there should be an official policy that focuses on providing an updated medical assessment at the time the individual is transitioned into the community. This would be of immense benefit to the receiving PCP and community provider agency.	

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

1. The goal for the caseloads of the PCPs should be lowered to 70 individuals per PCP.
2. The Medical Director should play a leadership role with the Physical and Nutritional Management Team.
3. The Medical Director should not have a clinical caseload of individuals for which he is responsible for providing primary care.
4. The Medical Director should have routine meetings with the Facility Administration to resolve a variety of issues. The Medical Director should play a leadership role and ensure active and effective communication with the Administration to obtain the supports necessary to address the many needs of the Medical Department. The Medical Director should track these issues until there is closure of each concern.
5. A team of respiratory therapists should be hired to provide around-the-clock supports to individuals who need such services.
6. All information should be filed in a timely manner in individuals' records. Assignment of duties should be clear, with timelines established for the acceptable length of time within which a document should be filed correctly. Monitoring should occur to ensure these timelines are met in every residence.
7. The Medical Director should meet with the Facility Administration, and other appropriate department heads, to resolve the problem of clinical information included in Individual Notebooks not being available in a timely manner, and not becoming part of the permanent record.
8. The routing of medical records to the physician should be reviewed, and procedures put in place to ensure that delays in obtaining the medical record do not continue to contribute to inefficient use of time and potential delays in treatment. As noted above with regard to Section L.1 of the SA, there are several options.
9. The Medical Director should meet with Facility Administration to review physician duties and roles. While it is recognized that this will require balance in order to meet the Facility's many requirements, the Facility Administration should assist the Medical Director in determining realistic priorities for the physician job description. Unnecessary duties or assignments should be eliminated, and/or other less time-consuming options to complete necessary duties should be provided. This will require ensuring that the clinical care of the individuals is the first priority, and other responsibilities are balanced to allow such care to be provided.
10. Additional discussion and research should be completed to determine what the requirements are, based on federal or state regulations, related to physicians completing examinations of individuals after allegations of neglect are made, when nurses already have conducted an assessment. The parameters of such reviews also should be discussed, and revised, as appropriate. Specifically, when such a review is requested, the question should be resolved of whether the physician could be provided with a description of the allegation to ensure that an adequate, clinically focused, or in-depth evaluation is conducted, for example, an exam of one part of the body depending on the history provided (e.g., the type of trauma, etc.).
11. The Medical Director should be aware of any delays in equipment requests, and ensure equipment is obtained in a timely manner, or provide a progress report to the medical staff regarding the status of the equipment order.
12. When there are delays in an individual obtaining equipment that impacts his/her health and safety due to lack of insurance reimbursement, the

Medical Director should take this information promptly to the Facility Administration for review. Unless regulatory guidelines indicate otherwise, the Facility should be the guarantor of health and safety, including equipment, and payment should not be dependent on the financial status of the individual.

13. Minutes should be taken of the daily morning medical meeting that incorporate the three sources of information presented, and also record important discussions and business.
14. The morning meetings should be used to address urgent care needs, and to ask critical questions and provide rapid ongoing guidance for clinical issues. Such guidance should help to set standard of care and expectations for medical staff.
15. Nursing administration should be represented at the morning medical meeting.
16. With regard to annual physical exams and medical assessments:
    a. The annual physical exam should be completed by the time of the annual medical assessment.
    b. The Medical Department should develop and implement guidelines, for all PCPs to follow, to ensure the annual physical exam and annual medical assessments are completed within a certain time frame (for instance, no more than seven days apart, with the examination preceding the assessment).
    c. There should be documentation on both the annual physical exam and annual medical assessment regarding the reason for any delay in completing either one of them, or for there being an increased time interval between the two.
    d. There should be a standardized format for the physical examinations across the campus.
17. The Medical Director should explore the reason the osteoporosis and osteopenia lists were inaccurate and incomplete, and take action to ensure that the Facility has an accurate listing of individuals who are at risk due to these two conditions.
18. There should be criteria for re-testing included in a clinical pathway for osteoporosis/osteopenia, and a system created and implemented to ensure that updated testing is completed, at the appropriate intervals, for those who are recommended for a bone densitometry.
19. The Medical Director should explore the reason the fracture list for 2010 was not updated, and take action to ensure that accurate data is maintained.
20. For the colonoscopy database, there should be concise documentation maintained for those that would not benefit from the procedure, and for those in which the risk exceeds the benefit of the procedure.
21. A system should be in place so that the Medical Director is aware of all unanswered pages to the physician on-call to determine any systemic issues that need correcting.
22. The Nursing Department or home manager should ensure that an appropriate inventory of basic and essential medical/nursing equipment is available in the residence at all times, such as thermometers.
23. For individuals with complex medical needs with extensive work-ups and consultations, there should be a concise summary available and updated at intervals so a covering physician does not have to review the complete record.
24. Inadvertent removal of enteral feeding tubes is a common complication with care of the tube. The Medical and Nursing Departments should create a policy and/or procedure to reduce, to the greatest extent possible, inadvertent removal or purposeful removal by the individual. This will require coordination with individuals' teams, and potential approval of the Human Rights Committee, if any restrictive procedures are proposed.
25. When there is an off-site emergency, there should be someone appointed the responsibility for updating the Integrated Progress Notes. When the individual is transported offsite in an emergency, the Facility should ensure and document that a transfer packet is subsequently delivered to the hospital in a timely manner.
26. For dangerous behaviors with potential serious health consequences, the Psychology Department should review the individuals' needs and develop appropriate plans within a short period of time. The Director of Psychology should monitor this to ensure there are no delays.
27. PSTs should quickly and thoroughly address any individual's noncompliance with diets, medication, or other health-related activities, particularly those that lead to worsening health outcomes. Ongoing monitoring should be completed, and changes should be made to strategies that are ineffective. The Integrated Progress Notes should reflect the activities of the psychologist and other members of the PST, including

monitoring activities and results.

28. There should be a system to ensure the psychiatry team is aware of such issues as polydipsia, noncompliance with medication regimens or other health-related activities, as well as assaulting staff and peers. In addition, the psychiatry team should address these issues in their team minutes as well as in the Integrated Progress Notes. High priority should be given to developing interventions and monitoring those individuals who have been hospitalized for behaviors that lead to complications (i.e., severe hyponatremia leading to seizures).
29. There should be adherence to the policy that a physician will contact his/her counterpart at the hospital when individuals are transferred from AUSSLC, as well as a physician note reflecting this conversation. The Medical Director should provide guidelines on the role of the AUSSLC physician for hospital transfers. Indicators related to these requirements should be incorporated into the Quality Assurance system.
30. A formal training program should be developed and implemented specifically for the direct support professionals with focus on: 1) health status change; 2) how to recognize an emergency; and 3) documenting critical events.
31. The Hospital Liaison Nurse should update each hospital admission separately, especially if there are several hospitalizations within a short period of time.
32. As the clinical pathways/guidelines are developed, one area of consideration should be that, for those individuals with G-tube feedings and aspiration pneumonia, the individuals be evaluated for GERD. For those with significant GERD, a gastroscopy might be indicated to determine the presence of Barrett's esophagus. Procedures to reduce GERD should be considered, such as fundoplication and/or J-tube placement, among other surgical procedures.
33. Due to the increased prevalence of dysphagia in the Intellectual Disability/Developmental Disability (ID/DD) population, physicians should respond without delay to concerns about swallowing by consulting a Speech Language Pathologist/Occupational Therapist, or order a swallow study, or both.
34. The Medical Director should explore inconsistencies in lists of those with pica, and ensure a valid and complete list is available.
35. The Medical Director should create a clinical pathway for pica that provides guidance to ensure medical care is standardized, including ordering tests, frequency of repeat tests, and nutritional supplements.
36. Reduction or change of supervision levels for those with pica should require input and agreement from the Medical Department through the interdisciplinary planning process.
37. The Medical Director should review the BSPs and subsequent addendums of those individuals with ongoing pica behavior to ensure knowledge of the type and frequency of pica, and to provide needed medical guidance to the PSTs.
38. Nursing administration should ensure emergency drills are conducted on all residences, on all shifts, and include all staff working at AUSSLC.
39. Each of the DNR orders should be reviewed periodically to ensure compliance with State regulations and guidance from DADS. Focus should be on those with older DNRs, to determine if conditions and treatments have changed, which may make a DNR order no longer applicable. In addition, a review should be conducted to ensure that the family members or guardian information is current for each of these individuals.
40. Medical review by a non-Facility physician from outside the state SSLC system should be completed. Sampling of medical records should be random and approach 20 percent of the population residing at AUSSLC.
41. While a more comprehensive medical quality assurance system is being developed and implemented, existing data should be utilized to begin to make changes that would positively affect outcomes for individuals. Some examples of possible areas of focus are provided above with regard to Section L.3 of the SA.
42. The Medical Director should create and implement a number of basic policies as the administrative foundation of the department, as well as clinically focused policies and procedures/protocols/clinical pathways or guidelines based on the Health Care Guidelines.
43. Policies and guidelines should be updated to agree with current recommendations of national health organizations.
44. At periodic intervals, there also should be updates of the clinical pathways/guidelines to ensure agreement with community and national standards.
45. There should be evidence of routine in-service education and training of the PCPs to ensure their understanding and expectation of care. Such training should be based on the policies and clinical pathways or guidelines referenced above.

46. As a separate area needing medical policy/guidelines, there should be an official policy that focuses on providing an updated medical assessment at the time the individual is transitioned into the community. This would be of immense benefit to the receiving PCP and community provider agency.

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

1. Consideration should be given to providing additional administrative assistant positions/hours to the Medical Department for transcription, as well as database management.
2. Consideration should be given to modifying the system for "as needed" medication, such as Tylenol for pain relief. Provided a nurse had taken the history and examined the individual to rule out significant problems, there would seem to be little purpose to requiring an order from the PCP. There could be a monitoring system in which the PCP was notified the next morning of any pro re nata (PRN, or "as needed") medications, whether it was Tylenol, a laxative, etc. The standing orders could be individualized to meet the needs and safety issues of the individuals.
3. The Medical Director should be involved in supporting the annual influenza vaccine campaign in order to improve the rate of employee vaccination.
4. It would be helpful if the MD notes were dictated, transcribed, and placed in the record in a timely manner. A dictated note summarizing care at the Infirmary, from the time of admission to the Infirmary, to the day of discharge as the individual is transferred back to the residence, would be helpful to the receiving team.
5. The Medical Director should consider development of a post ictal tracking sheet for serial vital signs to determine clinical stability.
6. There should be a place to document when the Hospital Liaison Nurse is unavailable to do weekday rounds, to explain gaps in reporting. This could readily be added to the daily morning medical meeting minutes.

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 AUSSLC's POI; o AUSSLC's Nursing Supplemental POI; o AUSSLC's Nursing Department Presentation Book; o AUSSLC's nursing staffing data; o AUSSLC's Table of Organization; o Proposal for Program Compliance Nurse; o Memo dated 7/14/10 to Vira Benson, Director from Carole Ivy, RN, Nursing Operations Officer and Debra Schroeder, RN, Nurse Manager regarding Nursing Schedules; o Proposed Plan to Facilitate Filling of Open Positions at AUSSLC dated 4/22/10; o Draft policy for Nurse Staffing; o Job description for Nurse Educator; o Job description for additional part-time RN Assistant position for Infection Control; o AUSSLC's Nursing monitoring data since April 2010 including Acute Illness, Acute Injury, Urgent Care, and Hospitalization, Medication Administration and Documentation audits; o AUSSLC's QE monitoring data since April 2010, including monitoring observations at Cardinal, monitoring and collecting data regarding mammograms, maintaining individuals' weight data, audits for QE Monitoring for Wood Hollow, audits for the Plan of Correction for deficiencies found from the Facility's annual survey on 10/30/09, Incident and Complaint Investigation on 10/9/09, and audits for the Plan of Correction for Nursing related to the QE recommendations from mortality reviews since May 2010; o Training curriculum for Nursing Care Plans; o Training curriculum for new employee orientation; o Environmental/Infection Control Surveillance Review for July 2010; o Current Active Nursing Projects and Workgroups provided by the State Office Nurse; o Infection Control Committee meeting minutes dated 3/23/10, and 8/31/10; o AUSSLC's Medical Emergency Drills from 6/10, 7/10, and 9/10; o Competency Training and Development (CTD) Department's schedule for conducting Mock Drill Schedule; o QE Nurse's timeline for Emergency Response System; o AUSSLC's procedure for Emergency Response System; o Training curriculum and training rosters for Emergency Response System; o CTD Department's tracking system for recommendations from conducted drills; o The medical records for the following individuals: Individual #404, Individual #226, Individual #339, Individual #435, Individual #151, Individual #103, Individual #68, Individual #302, Individual #398, Individual #182, Individual #65, Individual #39, Individual #254, Individual #265, Individual # 29, Individual #382, Individual #298, Individual #458, Individual #368, Individual #307, Individual #429, Individual #168, Individual #249, Individual #217, Individual #283, Individual #83, Individual #30,

	Individual #276, Individual #204, Individual #59, Individual #208, Individual #140, Individual #371, Individual #444, Individual #219, Individual #414, Individual #73, Individual #123, Individual #409, Individual #187, Individual #410, Individual #98, Individual #289, Individual #277, Individual #350, Individual #74, Individual #360, Individual #139, Individual #210, Individual #217, Individual #276, Individual #122, Individual #83, Individual #355, Individual #244, Individual #361, Individual #74, Individual #154, Individual #42, Individual #331, Individual #453, Individual #280, Individual #160, Individual #152, Individual #3, Individual #108, Individual #217, Individual #358, Individual #424, Individual #228, Individual #301, Individual #112, Individual #336, Individual #446, Individual #251, Individual #92, Individual #384, Individual #175, Individual #321, Individual #342, Individual #417, Individual #48, Individual #366, Individual #144, Individual #304, Individual #454, Individual #126, Individual #84, Individual #253, Individual #450, Individual #430, Individual #297, Individual #246, Individual #328, Individual #184, Individual #206, Individual #78, Individual #276, Individual #283, Individual #77, Individual #416, Individual #305, Individual #84, Individual #24, Individual #434, Individual #174, Individual #51 Individual #405, Individual #323, Individual #182, Individual #154, Individual #1, Individual #107, Individual #31, Individual #404, Individual #117, Individual #233, Individual #127, Individual #395, and Individual #53; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o AUSSLC's lists of individuals who were seen in the emergency room, and hospital; o AUSSLC's Risk lists for health indicators; o AUSSLC's database for Medication Administration Observations; o AUSSLC's Medication Pass Observations data; o Modified Medication Observation tool; o Pharmacy and Therapeutics (P&T) Committee meeting minutes, dated 2/25/10, and 9/28/10; o Medication Error/Prevention Committee meeting minutes, dated 4/29/10, 9/27/10, and minutes without a date; o AUSSLC's medication variance data; o Nursing Administrative Team Meeting minutes, dated 7/28/10, 8/25/10, and 9/8/10; o Draft policies for MRSA and Multi-Drug Resistant Organisms; o AUSSLC's Trends in Infection Control reports; and o AUSSLC's Infection Control curriculum for new employee orientation. ▪ **Interviews with**: o Priscilla R. Hackett, MSN, MPH, RN, CCM, Chief Nurse Executive (CNE); o Mary LeFebvre, RN, Acting Nurse Operations Officer (NOO); o Kim Sweeney, RN, QE Nurse; o Carla Jones, RN, Health Status Coordinator, Auditor QE;

	○ Kay Cowan, RN, MSN, FNP, BC, Infection Control Nurse IV; ○ Jamie Duggan, RN, Hospital Liaison Nurse; ○ Jennifer Mears, CTD Director; ○ Soledad Reyes-Hernandez, CTD Training Specialist II; and ○ Vanessa Haupt, RN, Nurse Educator. ▪ **Observations of**: ○ Medication Administration in Cardinal and the Infirmary; and ○ Demonstration of the emergency equipment in the Infirmary.
	Facility Self-Assessment: The Facility was revising the POI to provide a description of the steps it was taking to assess compliance with regard to the specific sections of the Settlement Agreement related to nursing care. Although the POI for AUSSLC did not include this component, the POI highlighted the commitment the State and the Facility had to the thoughtful implementation of the processes and systems needed to provide quality services. AUSSLC indicated that it was not in compliance with Section M of the SA, which was consistent with the Monitoring Team's findings. In order to move into a position of substantial compliance, there are a number of foundational systems and competencies in nursing that have to be solidly built before additional needed systems are constructed. This will affect the determination of substantial compliance in many areas. Also, the quality of nursing cares plans, assessments, and the supports being provided, not just completion, is the determining factor in appropriately assessing substantial compliance in most areas. After these foundational systems are built and the monitoring systems include the quality aspect, to substantiate compliance, it will be necessary to provide data validating substantial compliance that includes the total population being reviewed (N), and the sample of that population audited (n) to yield a percent sample that indicates the relevance of the compliance scores. An adequate sample size also needs to be reviewed to ensure that the findings can be applied to the total population. Without this information, the Facility's data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured.
	Summary of Monitor's Assessment: Since the baseline review, AUSSLC had significantly reduced the number of nursing vacancies. At the time of the baseline review, AUSSLC had a total of 124 nursing positions with 25 vacancies. At the time of the most recent review, AUSSLC had only 13 nursing vacancies. Although the number of vacancies had decreased, in order to meet the minimum staffing ratios, the Facility continued to use the services of six agencies. In addition, due to some building closures and restructuring, AUSSLC went from four Units to five Units with the addition of Cardinal (727C), which was previously a part of Castner Estates. Cardinal, a unit for individuals with complex medical issues, was moved from the oversight of residential services and placed under the supervision of the Nursing Department. AUSSLC's QE Nurses and the Nursing Department had begun using some of the new monitoring tools. This system was in the initial stages, and the data generated from the auditing was not yet addressing the quality of the areas audited. Once the Facility has more experience with these tools, instructions should be developed for each monitoring tool. As these are developed, the Facility also should develop and implement a procedure for establishing inter-rater reliability. In addition, the Facility should ensure that

	auditors are competent in the areas that they are auditing, to ensure the data is an accurate reflection of the Facility's practices Consistent with the findings from the baseline review, AUSSLC continued to have a significant number of problematic issues regarding the nursing documentation addressing timely, complete and adequate nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when the individual began showing symptoms of a change in status, and of assessments prior to the transfer to an off-site medical center, as well as upon return to the Facility. Significant problems also were found regarding the competency-based training the Facility was providing at new employee orientation and annually. The QE Nurses were in the very early stages of auditing individuals with acute illness and those requiring hospitalization. They were using the monitoring tools to assess the care and documentation, which should lead to the implementation of plans of correction to address the identified deficiencies. The State Office had approved the use of the Health Care Protocols: A handbook for DD Nurses, and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and Nursing Care Plans. Consistent with the baseline findings, there were significant problems found regarding the quality of the Nursing Assessments and Nursing Care Plans. Since the baseline review, the State Office had modified the Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. At the time of the review, the Facility had implemented the modified Comprehensive Assessment form, and the new Nursing Care Plan templates. However, adequate competency-based training was not provided prior to implementation. Consequently, there was no improvement found in the quality of the assessments or care plans. Since the baseline review, the Nursing Department had begun conducting quarterly medication observations. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection, or via tube. However, competency will have to be confirmed for the auditors to ensure accurate data are generated from the observations. Also, the Facility was beginning to review its system regarding medication variances and ways to generate reliable data. Although many of the systems were not in place to meet substantial compliance with the requirements of the SA, AUSSLC's Nursing Department recognized that it needed to build a strong infrastructure in order to sustain any systems implemented, and demonstrated its commitment to moving forward. The steps that AUSSLC's Nursing Department had taken are described in further detail in the sections that address each of the requirements of Section M of the SA.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report is divided into sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found in the sections addressing Sections M.2 and M.3 of the SA. <u>Staffing</u> Since the baseline review, AUSSLC had significantly reduced the number of nursing vacancies. At the time of the baseline review, AUSSLC had a total of 124 nursing positions with 25 vacancies, including 15 for RNs and 10 for Licensed Vocational Nurses. At the time of the most recent review, AUSSLC had a total of 124 nursing positions with only 13 total vacancies, including seven for RNs and six for LVNs. Although the number of vacancies had decreased, in order to meet the minimum staffing ratios, the Facility continued to use the services of six agencies. From discussions with the CNE, she indicated that the Facility had been approved to double fill positions for nursing. If this is accurate, the Facility would have the potential to have 248 total nursing positions. However, at the time of the review, no documentation could be produced verifying this. The Facility should continue its efforts and strategies to secure a consistent nursing staff to facilitate positive clinical outcomes for the individuals at AUSSLC. Since the baseline review, nursing personnel changes at AUSSLC included the following: ▪ New Chief Nurse Executive (CNE), as of 6/16/10; ▪ New Infirmary Nurse Manager, as of 6/1/10; ▪ New Castner Estates Nurse Manager, as of 7/16/10; ▪ New Cardinal Nurse Manager, as of 9/16/10; ▪ Nurse Recruiter/Schedule Coordinator, as of 10/1/10 (in orientation); ▪ Full-time Nurse Educator position posted, and interviews began in October 2010; and ▪ Part-time RN Assistant position for Infection Control, as of 4/16/2010. At the time of the review, AUSSLC had a census of 376 individuals. Since the baseline review, the Facility's census had decreased by 12, and they were not accepting any new admissions until the staffing issues were stabilized. In addition, the overall structure of the Facility's Units and nursing services had been modified as follows: ▪ AUSSLC went from four Units to five Units with the addition of Cardinal (727C), which was previously a part of Castner Estates; ▪ Residence 772A (Aspen) in the Timber Creek units was closed, and Residence 730 in the Wood Hollow was in the process of closing; ▪ Three of the residences had 24-hour nursing care, specifically Cardinal, Castner	

#	Provision	Assessment of Status	Compliance
		Estates, and the Infirmary; ▪ During the day, nurses were assigned to each unit. During the night shift, the Facility utilized a Campus Nurse who made rounds, and covered the portions of the Facility that did not have 24-hour nursing care; ▪ Cardinal (727C) was moved from under the supervision of residential services, and placed under the supervision of the Nursing Department; ▪ The Chief Nurse Executive continued to supervise directly the Hospital Nurse Liaison, the Nurse Educator, the Infection Control Nurses, the Nurse Operations Officer, and an Administrative Assistant; and ▪ The minimum nursing staffing requirements were based on a fixed number of nursing staff (RN and LVN) per specific Unit, but could be modified based on patient census, patient acuity, and staff workload related to individual or staff activities. Consistent with the findings during the baseline review, the Chief Nurse Executive reported that the orientation training for an agency nurse continued to be significantly abbreviated compared to the orientation training for Facility-hired nurses. The current orientation for agency nurses involved sending a packet to them prior to working at AUSSLC, including a description and introduction to the Facility, and a number of nursing forms. In addition, they were required to complete training for Prevention and Management of Aggressive Behavior (PMAB), and Abuse and Neglect. They were then assigned to a staff nurse for one day of mentoring, and were observed administering medications. As the Monitoring Team's baseline report indicated, this is not an adequate orientation for nurses who are providing nursing supports and services to individuals with complex and challenging medical and behavioral needs. At the time of the most recent review, the training had not yet been modified. From previous discussions with the Stare Office Nurse, a workgroup had been organized to address new employee orientation, including orientation for agency nurses. The CNE reported that this group was scheduled to meet the week following the Monitoring Team's on-site review. However, based on the problematic issues related to the use of agency nurses identified during the baseline review, and findings from this most recent review related to medication errors, and incomplete and inappropriate nursing assessments and nursing documentation, the Facility should implement an improved process for agency nurses' orientation to ensure individuals are provided competent and appropriate nursing services. AUSSLC's Supplemental POI indicated that Facility action would begin after receipt of new/amended policy and direction from the State Office. Due to the critical nature of the problematic issues identified, the Facility cannot wait for the Nursing Workgroup to develop an orientation template. Changes in the orientation, mentoring, and monitoring of agency nurses should be promptly implemented, and then modified in alignment with the recommendations of the Workgroup.	

#	Provision	Assessment of Status	Compliance
		At the time of the review, the Facility did not have a system in place to reconcile the nursing schedules and to accurately reflect whether or not shifts were actually covered, either through the use of overtime, or agency staffing. As a result, it could not be determined whether or not the Facility fell below minimum staffing. Consequently, the nursing schedules the Monitoring Team reviewed did not provide an accurate picture of the Facility's nursing staffing patterns. In response to a request from the Monitoring Team, the Facility produced reconciled nursing staffing data from March through August 2010 that indicated there were a number of days when staffing fell below minimum nursing staffing ratios. AUSSLC's data indicated the following :	

Days per month per Unit below minimum nursing staffing ratios

Unit	March 2010	April 2010	May 2010	June 2010	July 2010	August 2010
Castner	27	13	13	8	17	15
Timbercreek	4	3	4	4	7	4
Woodhollow	11	3	9	11	8	8
Sunrise	7	6	8	7	8	5
Infirmary	4	1	4	7	8	31
Cardinal	*-------	*---------	*---------	*---------	*---------	19

* On 8/2/10, Cardinal became a separate unit, and was placed under the Nursing Department.

Based on discussion with the CNE and the Acting Nurse Operations Officer (NOO), there was no regular review of the nursing staffing data. Consistent with the baseline findings, the Nursing Department did not have a system that tracked the time RNs reported to work and the time they left. In addition, there was no system in place that consistently and accurately identified where nurses (Facility and agency) were assigned, and/or where they actually worked each shift. There was no system in place that indicated specifically which nurses were on campus at any given time, and/or those who were on break (e.g., lunch or dinner) on or off campus. Based on discussions with the Acting NOO, changes made in the schedule were not reconciled on the master schedule, and there was no procedure in place to notify the Facility's Administration regarding incidents of staffing levels falling below minimum. In addition, at the time of the review, the CNE and Acting NOO did not know if the Facility had a policy addressing minimum staffing levels.

Since the baseline review, the Nursing Department became responsible for the staffing and scheduling of the direct support professionals for the Cardinal Unit, which included one residence and the Infirmary. From information the Facility Director provided at the entrance meeting, all direct support professional positions had been filled and the

#	Provision	Assessment of Status	Compliance
		Facility no longer used agency staff to meet minimum staffing ratios for this area. However, direct support professional staffing data, for the areas under nursing, were not provided. Also, for the Cardinal Unit, information was not available regarding the time the direct support professionals reported to work and the time they left, where the direct support professionals were assigned, and where they actually worked, and which direct support professionals were on campus at any given time and those who were on break (e.g., lunch or dinner) on or off campus. The Facility should develop and implement a system to ensure the minimum staffing ratios are maintained at all times for nursing staffing throughout the Facility, and the direct support professional staffing on the Cardinal Unit. When ratios fall below the required minimum, this should be communicated to Facility Administration. Reliable schedules, that accurately identify who and where staff actually worked, and when staff reported to and left their assigned work areas, should be maintained. There should be regular review of staff patterns and issues, with follow-up action on any issues identified. Since the previous review, the Facility added one part-time RN Assistant position to Infection Control, a Nurse Recruiter/Schedule Coordinator, and a full-time Nurse Educator position that had not yet been filled. In addition, the CNE was working on a proposal for the addition of a Program Compliance Nurse, dedicated to the Nursing Department. At the time of the review, the Facility had developed job descriptions and job duties for these additional positions. The Facility should develop or modify policies, procedures and/or protocols addressing the integration of these positions into the Nursing Department. Also, AUSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. <u>Quality Enhancement Efforts</u> Since the baseline review, the QE Nurses and the Nursing Department recently had begun using some of the Monitoring Teams' review/monitoring tools for nursing in the areas of Individuals At Risk, Acute Illness, Acute Injury, Documentation, Health Care Plans, and Urgent Care and Hospitalizations. From review of the data, it was clear that the Facility was in the initial stages of becoming familiar with the monitoring tools. The QE Nurses had developed a draft of instructions for sampling. Continued efforts are needed to develop the processes necessary to generate data that can be accurately interpreted, analyzed, and are reflective of the practices being measured. These include: ▪ Having tool instructions; ▪ Providing the total population being reviewed (N), and the sample of that population audited (n) to yield an adequate percent sample to indicate the relevance of the compliance scores; ▪ Having an adequate sample size, usually 20%; ▪ Ensuring auditors are competent in the areas they review;	

#	Provision	Assessment of Status	Compliance
		▪ Developing and implementing a procedure for establishing inter-rater reliability at 85% or above; and ▪ Assessing for quality, not just presence or timeliness of an item. Although the Facility was in the initial stages of implementing some of the new monitoring instruments, the QE Analysis and QE Recommendations, noted on the completed monitoring tools, indicated that the QE Nurses conducted a thoughtful review. In addition, a number of the recommendations the QE Nurses made regarding the monitoring process itself, such as the need for specific timeframes for record reviews, and where auditors should look for specific documentation, should be addressed with the development of instructions for each of the monitoring tools. Since the baseline review, the QE Nurses had conducted a number of monitoring activities. These included regular monitoring observations at Cardinal; monitoring and collecting data regarding mammograms; maintaining individuals' weight data; conducting audits for QE Monitoring for Wood Hollow; conducting audits for the Plan of Correction for deficiencies found from the Facility's annual survey on 10/30/09, and Incident and Complaint Investigation on 10/9/09; and conducting audits for the Plan of Correction for nursing related to the QE recommendations from mortality reviews since May 2010. These audits needed a consistent structure, larger sample sizes, supporting documentation addressing corrective actions, and an analysis of trends. However, there were a number of valuable clinical findings generated. For example, some of the findings from the QE nurses' monitoring observations at Cardinal included: ▪ Several individuals were found not positioned according to their Physical and Nutritional Management Plans; ▪ There were inconsistent directions included in the PNMPs and from PCPs regarding use of pillows for head positions; ▪ Wash clothes were placed around individuals' tracheotomies; ▪ Some PNMPs were not readily available; ▪ Dried feces was found on bed sheet and stuffed animal, and then not cleaned six hours after it was reported; • Float nurses were unfamiliar with suctioning individuals with tracheotomies; ▪ Feeding pumps were dirty from dried formula; ▪ Record audits for 12 individuals found that 10 had quarterly nursing assessments missing; ▪ Record audits for 12 individuals found that six had no Health Management Plans; and ▪ Record audit for 12 individuals found that five had no progress notes for a month or more. Since the Nursing Department had initiated monitoring with the new tools in September	

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		2010, Corrective Action Plans, addressing any problems identified from the monitoring data, had not yet been developed and implemented. As data is generated, the department should analyze it in a timely manner to identify problematic trends so that timely and appropriate plans of correction can be implemented to remedy problems. These data should be integrated into the Facility's Quality Management and Risk Management systems. As mentioned previously, the QE Nurses were in the beginning stages of implementing the monitoring tool for Urgent Care and Hospitalizations. In order to be able to generate accurate monitoring data, it is recommended that the auditing staff first read the "clinical story" included in the Integrated Progress Notes from the start of the change of status to the individuals' return to their residence, and then score the monitoring tools. This method would help ensure they are giving appropriate attention to the quality of the documentation related to clinical care, and to the completeness and appropriateness of assessments, rather than just looking for the completion of notes. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> As noted above, the Nursing Department and the QE Nurses had conducted some initial audits for individuals who experienced an acute illness and hospitalization. All acknowledged that the monitoring conducted had not yet resulted in any measurable changes regarding clinical outcomes or improvements in documentation. This was consistent with the Monitoring Team's findings for this group. A review of 15 individuals' medical records (Individual #404, Individual #226, Individual #339, Individual #435, Individual #151, Individual #103, Individual #68, Individual #302, Individual #398, Individual #182, Individual #65, Individual #39, Individual #254, Individual #265, and Individual # 29), who had been transferred to a community hospital, or emergency room found that for all 15 individuals reviewed, there continued to be significant problems regarding the nurses' documentation in the following areas: ▪ A lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms; ▪ A lack of assessments in response to changes in vital signs, oxygen saturations, vomiting, or mental status; ▪ Significant gaps in nursing documentation when nurses' notes stated "will monitor"; ▪ The type of temperatures taken was not consistently documented; ▪ Notes did not indicate specifically when incidents of vomiting or diarrhea occurred; ▪ A lack of follow-up from issues noted in previous nurses' progress notes; ▪ A lack of follow-up for symptoms related to the reasons for the hospitalizations; ▪ A lack of specific description, size, and location of injuries, bruises, or rashes; ▪ Administration and follow-up for PRNs, not documented or not adequately	

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		documented; ▪ Inadequate assessments and follow-up addressing pain; ▪ A lack of lung sounds assessed and documented for respiratory issues; ▪ A lack of assessment of bowel sounds and abdomen for individuals with constipation; ▪ Physician/Practitioner not timely notified of change in status due to nurses' inadequate follow-up; ▪ No documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ Frequent refusal of medical procedures not addressed by PSTs; ▪ No documentation of activity level or changes in activity level related to changes in health status; ▪ Lack of specific descriptions of the individuals' behaviors and overall status, assuming that all staff reading the progress notes were familiar with the individuals; ▪ A lack of mental status assessments documented during status changes; ▪ Lack of analysis of contributing problematic issues affecting changes in status; ▪ Several inappropriate abbreviations; ▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to hospital or emergency room; ▪ No documentation indicating that an information 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, especially addressing the same symptoms that precipitated the transfer; ▪ Dates and times not consistently documented for progress notes; ▪ Inconsistent use of format for progress notes [Description, Assessment, and Plan (DAP), Data, Action, Response, and Treatment (DART)]; ▪ The lack of modifications to the Nursing Care Plans when interventions were not effective; ▪ Lack of an adequate updated Nursing Care Plan to reflect changes in status and new interventions in response to acute events; and ▪ Several nursing progress notes and signatures were illegible. Similar to the findings from the baseline review, there were a number of significant problematic issues found regarding complete, timely, and adequate nursing documentation and assessments of symptoms for acute changes in status for individuals. Below is an example of some of the problems found:	

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		▪ In the case of Individual #103, the documentation indicated that she had become lethargic and less responsive, and when hospitalized in June 2010, was found to have had an intracranial hemorrhage. Since that time, there were no complete nursing assessments found documenting her status and level of functioning. Several of the nurses' notes stated: "client at baseline behavior," which provided no description of what her baseline status and behavior actually consisted of to be able to determine if or when changes occurred. One of the progress notes indicated that she appeared to be in pain and discomfort. However, there was no description of what behaviors she was demonstrating that indicated pain, and no vital signs or assessments were documented. According to the note, she was given Tylenol. The following morning the nurse documented that, staff reported that Individual #103 felt warm. The documentation indicated that she had a slight temperature of 99.0 rectally, and was "at baseline behavior." However, no other vital signs or assessments were documented. The notes indicated that she left the Facility to have a mammogram and a Carotid Doppler completed. However, there was no note documenting when she actually left the Facility, and what her status was at that time. In addition, since the time she had experienced the intracranial hemorrhage, there was no documentation found from nursing indicating that her functional status was being assessed. . The Occupational Therapist noted she was eating at a "considerably" slower pace, and that staff had not been transferring her into a dining room chair during meals as they were supposed to, to strengthen her lower extremities. A progress note nine days later, from the OT, indicated that Individual #103 had been sleepy and in bed the previous two days, and thus, the OT was unable to see her. A note from the physician the next day indicated that there was a discussion with the OT, during a meeting about Individual #103, and her decrease in activity level over the past two weeks. The note indicated that the physician asked an RN and an LVN about changes in the individual's status and was told that she was the same as she had been in the Infirmary after the stroke, except for eating slower. The notes indicated that over the next seven days, the OT assessed her pace and functioning while eating and completed detailed notes of her observations. The notes then indicated that Individual #103 was sent to the hospital after being found "slumped over and difficult to arouse." From the time the OT documented a change in Individual #103's pace of eating, to the day she was sent to the hospital, 17 days, there were no notes from nursing found in the record. Even when the physician inquired about possible changes in her status, nursing did not initiate regular assessments to determine if the individual was experiencing changes in status. The record indicated that her symptoms were related to a urinary tract infection found while she was hospitalized. Six weeks prior to this hospitalization, Individual #103 had been hospitalized for similar symptoms resulting from a urinary tract infection. Clearly, there had been no plan in place	

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		to regularly monitor this individual related to the symptoms that precipitated her recent hospitalizations. From the 15 records reviewed, all had significant, problematic issues, indicating deficits in appropriate development of nursing protocols, clinical judgment to guide frequency of assessments and documentation, communication between nurses and other clinical disciplines, reporting protocols addressing when it is necessary to notify the physician of changes in status, an inability to analyze clinical data, and the overall clinical competency of the nursing staff. The Nursing Department should establish appropriate criteria and competency-testing for the entire nursing staff in order to have a meaningful and lasting effect on the clinical outcomes for the individuals at AUSSLC. In addition, a review of the 15 records listed above found that the documentation from the Hospital Liaison Nurse was present in only six of the 15 records (40%). Also, Nursing Care Plans and current Nursing Quarterly Assessments were found in 10 out of the 15 records (67%). However, the Facility provided these missing documents indicating that the Hospital Liaison and Nurse Managers had not printed them and/or they were not timely filed in the medical records. Having these documents available in the records is essential for continuity of care. From an interview with the Nurse Educator, she reported that competency-based training and skill assessments were conducted during new employee orientation, and then nurses were assigned a mentor from the units. As an example, the Nurse Educator was asked how competency-based training was conducted for respiratory assessments, in particular auscultating lung sounds. She reported that the Facility used a manikin with which the nurses demonstrated where they would place the stethoscope to listen to lung sounds. Since there would be no lung sounds actually heard on a manikin, there was no actual competency-based training conducted to determine if nurses could identify the various types of lungs sounds, and/or in which lobe a sound was heard. Although the Nurse Educator indicated that determining competency was also part of the mentor's role, there was no valid documentation indicating that the mentors were clinically competent in this area. A critical review should be completed of competency-based training, and curricula that does not adequately address or measure competency should be revised or new training developed. Since the baseline review, the Nursing Department had acquired the Lippincott Manual of Nurse Practice, 9th Edition, and the Health Care Protocols: A handbook for DD Nurses that was approved by the State to use for nursing policies, protocols, and care plans. From a previous discussion with the State's Nursing Coordinator, she indicated that the Facility's Nursing Departments were to use the books as a reference to develop their policies, procedures, and protocols, but they needed to individualize these materials to	

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		align them with Facility's systems. Based on the number of individuals with medical complexities, who had been admitted to the hospital, Infirmary, or seen in the emergency room, and the significant issues found during the baseline and current reviews regarding acute status changes, this area should be considered a priority for the development, training, and implementation of nursing policies, procedures, and protocols. Although not a requirement of the SA, it would be extremely beneficial to the Nursing Department to modify or develop a separate policy from the State's policy addressing Nursing Peer Review, which is an investigational process rather than an educational process. As defined by the American Nurses Association (ANA) in 1988, peer review "is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice." Again, although not a requirement of the Settlement Agreement, the introductory section of the HCG highlights the value of nursing peer review. The Nursing Department is encouraged to utilize an educational process for regularly reviewing cases focused on the identification of strengths and weaknesses of the Facility's nursing practices, including a critical analyses of nursing practices, identification of problematic trends with plans of correction generated for problematic areas found, and continual monitoring for improved clinical outcomes. These activities will certainly contribute to the Facility's movement toward compliance with Section M of the SA, as well as facilitate a clinical dialogue among nurses and assist with the Facility's efforts with regard to self-assessment. <u>Availability of Pertinent Medical Records</u> Based on information provided at the entrance meeting, as of September 29, 2010, AUSSLC had converted all the records at the Facility to be in alignment with the revised Unified Records Guidelines. However, as was the case during the baseline review, in reviewing records on-site, it was noted that a number of documents were not in the medical records and had to be obtained from the residences. There were several Nursing Quarterly and Annual Assessments, Nursing Care Plans, and Hospital Liaison Nurse's notes that were not found in the records. However, all Integrated Progress Notes were found to be available in the medical records from the Monitoring Team's sample. Interviews with the CNE and QE Nurses indicated that the Facility had "green files" for each individual that contained copies of lab work, consultations, and other types of medical documentation specific to each individual. From discussion with the nurses, this was an informal system that had been in place for a number of years, implemented because of the delay in getting documentation filed timely in the medical records. Having all the appropriate documents timely filed in the medical records is essential to ensure	

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		adequate clinical care. In addition, there were a number of documents maintained on the computers of the Nurse Managers and the Hospital Nurse Liaison that had not been available for filing in the records. The Facility should ensure that documents are filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information to make decisions regarding treatments and health care services. <u>Infection Control (IC)</u> Based on AUSSLC's POI, the Facility reported they were not in substantial compliance with any of the items specific to Infection Control. This was consistent with the Monitoring Teams findings. At the time of the review, the Facility continued to have one full-time Family Nurse Practitioner coordinating the activities for Infection Control. Since the baseline review in April 2010, the Facility had added a part-time assistant RN, with no specific IC experience. She was assigned duties related to employee health issues, such as administering PPDs, Flu vaccines, and Hepatitis B injections to the staff, and maintaining a database for these issues. A job description had been developed for this position. However, there was little documentation indicating that the RN filling this position had demonstrated competency in the area of Infection Control. Validation of clinical competency for staff working in Infection Control is essential to ensure that they are knowledgeable about all facets of infectious and communicable diseases and practices. The IC Nurse should ensure that all IC staff are competent in the area of Infection Control and maintain documentation verifying this competency. Also, there continued to be no clerical employees assigned to the Infection Control staff. At the time of the review, the Facility had generated a list of individuals who had experienced infectious or communicable disease in the areas of Methicillin-resistant Staphylococcus aureus; Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); Human Immunodeficiency Virus; pneumonias; urinary tract infections; and antibiotic use. The IC Nurse reported that the lists were obtained from a number of systems. For example, the antibiotic list was generated from the pharmacy, lab and cultures, and Infection Control logs from the residences. However, consistent with the baseline findings, there was no system in place to ensure that the lists generated were reliable and included all individuals who had either a chronic, or acute issue, related to an infectious or communicable disease process. After the Facility provided the initial lists, a second list regarding individuals who had positive PPDs was requested. A comparison of the two lists found that there were a	

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		number of discrepancies. In addition, while reviewing the records, the Monitoring Team noted that some individuals who were found to have had MRSA, also were not included on the Facility's list. Moreover, the Facility's Trend Analysis for General Disease Events indicated that information for Infection Control was "insufficient and lacking for trending" due to the resignation of a nurse manager for Cardinal, a residence for individuals who had complex medical needs. An interview with the Infection Control Nurse validated that there continued to be no formalized system in place to ensure the reliability of the Facility's IC data. Although the Facility had been using an Infection Control log that residential nurses completed weekly, the Infection Control Nurse candidly reported that she did not consistently receive accurate information from the residences, and used a number of other systems to identify issues related to Infection Control. Consistent with the baseline findings, AUSSLC's Infection Control data was found not to be reliable. Ensuring the reliability of the IC data is a fundamental step to allow the Facility's Infection Control activities to positively impact clinical outcomes on a systems level and at the individual level. It is very concerning that the Facility had not recognized the importance of establishing a system to ensure data reliability in an area that has significant clinical relevance for the individuals, as well as the staff, at AUSSLC. The Facility should develop a procedure outlining the specific process to ensure data reliability for Infection Control, including how discrepancies in the data are reconciled and tracked. The procedures should address specific information, such as when data are collected from each system, how discrepancies between the systems are tracked and reconciled, and how residence reporting falls into the data collection system. Without reliable IC data, the Facility cannot accurately identify trends requiring timely corrective interventions, ensure that treatments and treatment plans are clinically sound, ensure that timely and appropriate training is being provided, or initiate proactive interventions. Also consistent with the baseline findings, the Facility had no comprehensive and accurate database to identify and track individuals with Infection Control issues. The Facility should develop and implement a database system for IC that allows for reliable tracking and monitoring of the Facility's IC data. Since the last review, the IC Nurse reported that she had provided in-service training to staff during a Town Hall meeting regarding issues related to the seasonal flu. However, she had not documented this training. In addition, spot checks for hand washing had been initiated. However, there had been no formal system or structure developed for how frequently these spot checks would occur. Spot check audits have significant potential for generating valuable data regarding hand-washing practices at the Facility. The Facility should formalize a system of regular spot checks in different areas to	

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		generate data regarding hand-washing practices of the staff. This information should then be aggregated and compared with Facility IC trend data to identify possible residences or day programs in need of additional training and monitoring. In addition, the Infection Control staff should consistently document their activities, and any findings from these activities, recommendations, and outcomes. Regarding environmental reviews, the Facility's Supplemental POI indicated that environmental rounds were being conducted. However, from discussions with the IC Nurse, she reported that since the baseline review, only one Environmental/Infection Control Surveillance Review had been conducted in July 2010 for Castner Estates. The Environmental/Infection Control Review conducted identified a number of problematic issues that could significantly affect the health of the individuals as well as the staff in the Unit reviewed. Some of the findings included: ▪ Furniture was not being cleaned; ▪ Blinds were not cleaned; ▪ Staff were not reporting problems or broken items; ▪ Nursing staff reported direct support professionals needed training regarding hand washing and the handling of soiled linen; ▪ Medication rooms were dirty; ▪ Some feeding pumps had dried formula on them and the poles needed cleaning; ▪ Some staff were using vinegar and water, which does not disinfect, to clean shower trolleys in between individuals' use of the equipment; ▪ Staff were not aware they needed to disinfect tables between use; ▪ Air vents in ceilings were dirty; ▪ Staff reported that cockroaches were seen in the mornings; ▪ There were inadequate supplies of hand sanitizer, hand soap, and paper towels; and ▪ Medication room refrigerators were dirty and in need of defrosting. In addition to a narrative report addressing the findings of the Environmental/Infection Control Review, the information was also placed in a format that included sections for: Location/Inspection Date, Location Description, Environmental Findings, Recommendations for Corrective Action, Rationale, Responsible Person, Follow-up Findings, and Due date. The structure of this report clearly outlined the issues and specific actions taken to address most of the problematic issues. Although some of the issues listed did not have documentation indicating that they had not been resolved, the format and structure of the information made it easy to identify issues that warranted follow-up and closure. Training rosters verified that, for the issues requiring retraining, it had been completed. However, the Environmental/Infection Control Review was conducted in July 2010, and the training in response to the problems was not provided	

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		until nearly two months after the review, in September 2010. This was a significant delay, especially when staff were inadequately disinfecting equipment used regularly by the individuals. Supporting information also needed to be obtained for some of the recommendations listed in the Environmental/Infection Control Review. These included, for example, obtaining the schedule for air vent cleaning from Maintenance, and plans of correction from Unit Directors. Of additional concern, the IC Committee minutes dated 3/23/10 indicated that an environmental review of Castner Estates had identified a number of the issues, many of which were identical to those found in July 2010. This illustrated that some significant issues were not adequately resolved over months, and could have impacted the health of the individuals as well as the staff. It also was concerning that the Facility did not implement regular Environmental/Infection Control Reviews after discovering similar findings from the July review. The Facility should implement a regular schedule of Environmental/Infection Control Reviews to identify and correct environmental issues in a timely manner. In order to generate accurate data, the Facility might want to consider rotating the reviewer to bring a "fresh set of eyes" to the process. Once these Environmental/Infection Control Reviews are regularly conducted, the information generated should be analyzed in relation to other IC data to identify possible transmission and/or cross contamination issues. At the time of the review, the Facility had begun the initial process of reviewing the immunization status of the individuals, in accordance with the HCGs. The IC Nurse had developed and initiated a Preventable Disease-Vaccinations Currency Checklist to collect individual data and to evaluate each individual's needs regarding vaccinations and immunizations. Individuals from Cardinal and Castner Estates were chosen as a priority for this evaluation due to the risks associated with their complex medical status. At the time of the review, seven individuals had been reviewed. This was a positive development. The Facility had not developed a schedule outlining timeframes regarding when the remaining individuals were going to be reviewed. The Facility should develop a schedule outlining timeframes for reviews of the individuals' vaccine and immunization status to ensure individuals are appropriately prioritized and that no one is overlooked. At the time of the review, the IC Nurse had not implemented the Infection Control Monitoring tool, and no target date had been assigned. As noted above in relation to all of the monitoring review tools, the Facility should develop instructions for the IC monitoring tools to ensure consistent and reliable data is generated. There were no IC audits being conducted to ensure that appropriate treatment practices were being implemented regarding Infection Control issues. For example, there was no formal monitoring system in place that would ensure that individuals with MRSA were audited regarding treatment with the appropriate antibiotic, in alignment with the culture and	

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		sensitivity results, or individuals with Hepatitis C were screened for their immunization status for Hepatitis A and B, and, if needed, had received them timely. Based on review of the IC Committee Meeting minutes for 3/23/10, and 8/31/10, the committee had not met quarterly. The structure and format of the minutes had been modified, making it easy to identify the issues, corrective actions, persons responsible, and dates for completion. In addition, the Facility Trend Analysis reports included additional sections addressing risk contributors, interventions and strategies, and the surveillance plan. A review of the Urinary Tract Infections and Pneumonia trend reports for Castner Estates included excellent sections regarding risk contributors, interventions, and strategies. However, there was no documentation indicating whether or not the risk contributors identified, and the interventions listed, were actually being addressed. In addition, the surveillance plan for both trend reports stated: "Educate plus provide ongoing review and revision of management strategies, incorporating prevention interventions and surveillance of individuals known to be or suspected of having a risk for UTIs/pneumonia." There was no indication that any surveillance actions listed were being implemented at the residential level to impact clinical outcomes. The Infection Control Committee meeting minutes also included data regarding antibiotic use at the Facility. There was no analysis of the data found in the IC Committee minutes, or the Pharmacy and Therapeutic Committee meeting minutes. The Infection Control Committee meeting minutes should include a comprehensive analysis of trends in the IC data; a description of the inquires made into problematic trends; the corrective actions implemented addressing any problematic trends; and a summary of the monitoring outcomes based on the activities and interventions of the Infection Control Department, in conjunction with the practices in the residences. The Infection Control staff should consider conducting root cause analyses on events such as outbreaks, or post exposures, to provide a framework and structure for completing a comprehensive analysis, and identifying systemic issues that contributed to both positive and negative outcomes. The Facility should continue its efforts in developing a comprehensive trend analysis process for IC issues. Regarding Nursing Care Plans, the Infection Control Nurse reported that she had begun reviewing some of the Nursing Care Plans addressing infectious diseases, but was not formally auditing the care plans using a monitoring tool. She reported she had made some recommendations regarding the Nursing Care Plans, but was not confident that they were appropriately modified. She reported she did not find that the Nursing Care Plans reviewed were adequate, which was consistent with the Monitoring Team's findings. As discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, of 18 Nursing Care Plans reviewed by the Monitoring Team addressing infectious diseases, none (0%) were adequate. In fact, most	

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		of the Nursing Care Plans reviewed did not address the infectious disease issue at all. The Facility submitted Nursing Care Plan for bee stings, the common cold, and boils, in response to a request for the care plans for individuals with MRSA. In other cases, generic Nursing Care Plan templates were submitted. At the time of the review, there were no clinically adequate Nursing Care Plans in place for individuals who experienced acute or chronic infections and communicable diseases. In addition, the Facility had not yet begun to ensure treatment teams were implementing interventions with individuals who refused treatments, such as immunizations or TSTs. The following provides an example of an individual for whom Infection Control issues were not addressed properly: ▪ Individual #117 was in the Infirmary, diagnosed with MRSA, and was placed on Contact Precautions. The Monitoring Team observed a direct support professional, walking in and out of the individual's room with a mask around his neck, no gown, no gloves, and touching the light switch outside the individual's room, as well as the door, and the hallway wall. Based on a discussion with the direct support professional, he reported he had been off work for a few days, and thought that the individual no longer had MRSA. He said he did not think he needed to wear gloves or a gown when entering his room. He reported that no one gave him any report about the individual's status when he came into work, and had been in and out of the individual's room all morning assisting him with personal care activities. When asked if he had received any recent teaching or training since Individual #117 was diagnosed with MRSA, he reported he had not been given any recent instructions regarding MRSA or Contact Precautions. The Nurse Manager confirmed that no additional training had been provided to staff when Individual #117 was diagnosed with MRSA. She stated that the staff should have received that information in new employee orientation (NEO), and she had not seen the need to provide additional training. In addition, she reported there was no monitoring in place to ensure staff were using the correct procedures when working with individuals with infectious or contagious illnesses. At that time, the Monitoring Team recommended that the IC Nurse come to the unit to provide the staff training regarding MRSA and Contact Precautions. Because the direct support professional had not been provided a report of the individual's status; recent training regarding the transmission and prevention of the spread of MRSA, and the appropriate procedures for Contact Precautions; and/or adequate supervision by nursing staff, all individuals and staff members at AUSSLC were placed at significant risk for transmission and cross contamination. Based on this example, there were no systems in place to ensure that individuals with infectious and communicable diseases were receiving appropriate services, or that staff were adequately trained and competent regarding infectious diseases and associated procedures. In addition,	

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		there was no Nursing Care Plan found for Individual #117 addressing MRSA. Moreover, the individual's name was not included on the Facility's list identifying individuals with MRSA. A review of AUSSLC's Infection Control curriculum for NEO and annual classes showed that hand-washing and Standard Precautions were included in the curriculum. However, the content did not include the spread of specific infections, and the post-test did not adequately measure competency regarding Infection Control issues. As mentioned previously, the State had implemented a workgroup to address and standardize the education curriculum for Infection Control issues. However, until the IC curriculum is standardized, the Facility should modify the IC curriculum and post-test so they reflect necessary Infection Control information and to ensure staff is competent in this area. In addition, the lack of adequate Nursing Care Plans addressing infectious and communicable diseases warrants additional and on-going competency-based training for the nursing staff. Since the baseline review, the Facility was in the process of developing draft policies addressing MRSA and Multi-Drug Resistant Organisms. The Facility's Supplemental POI addressing Infection Control policies and procedures indicated that a State Office policy was required and that "Facility action would begin after receipt of new/amended policy and direction from the State." Aside from the two policies that the Facility was developing, there had been no review of the Facility's existing Infection Control policies/procedures. From a previous discussion with the State Office Nurse, a number of workgroups, comprised of staff from the various Facilities had been organized to address the development of standardized processes and procedures in several areas for nursing. In the area of Infection Control, a workgroup was in process of addressing education and monitoring; policy and procedure; data collection and trend analysis; and Infection Control Meetings. The workgroups were scheduled to present drafts of their assigned projects at the CNE meeting in November 2010. The standardization of these areas in Infection Control is a positive development to facilitate movement towards compliance with the SA. It was evident that the IC staff at AUSSLC were invested in moving forward to meet the requirements of the SA. Although some positive steps had been taken since the baseline review, the Facility's Infection Control program and practices had serious deficits. Significant efforts continued to be needed to construct a solid infrastructure, with formal operational procedures, to drive the activities of the Infection Control staff. Having to build a new infrastructure can easily overwhelm and exceed any nurses' expertise and divert clinical energy. Although the Facility's Supplemental POI indicted that "Expertise	

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		from within the system will be utilized to develop and improve IC practices statewide," and that "The current IC department is more than adequate," the findings from the baseline and current review suggest otherwise. Clear direction needs to be provided so that the efforts and actions of the IC staff are not wasted on building systems that are not adequate to produce sustainable compliance. Additional expertise in Infection Control is needed to assist the staff in defining and implementing systems to effectively meet IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. <u>Code Blue Drills</u> At the time of the baseline review, AUSSLC had not been conducting emergency medical drills. The Facility had been using a "6200 system," a code-like procedure which was activated for both minor injuries as well as for emergencies without distinction. Since the baseline review, the Facility had developed a new system for emergency response procedures that included written procedures for non-urgent, urgent, and emergent situations. From discussions with the QE Nurse, the Facility began developing and training Nurse Trainers on this system in May 2010. She had a detailed timeline that described each step of the implementation process, including training for the Unit Directors, Medical Director, and CTD staff. Although the documentation indicated that there had been two incidents where the Nurse Trainer did not show up to provide the training, at the time of the review, all but 46 staff had received the training. Clearly, there was a significant amount of work and effort put forth in developing and implementing this system. Once this system is fully operational, the Facility should develop a monitoring system for the Emergency Response Procedure to ensure that emergency procedures are being appropriately followed and are effective. In June, July, and September 2010, the Competency Training, and Development Department had conducted 27 Medical Emergency Drills. A review of the Medical Emergency Drill reports indicated that drills had not been conducted at all residences or on each shift. However, the CTD Department had developed a tracking system to ensure that drills were provided as required. Information from the drills indicated that a total of 45 staff participated in the drills, and of those, 34 (76%) were recommended to take the Cardiopulmonary Resuscitation (CPR) Refresher Class due to issues executing the appropriate emergency procedures. The CTD Department had a tracking system in place that documented the dates of the drills, and the names of the staff that were recommended for the refresher class. Although the Facility had a separate database that tracked staff training, in order to close the loop, the Facility should consider including the date the staff completed the CPR refresher class to ensure that staff received the needed skills training. In addition, at the time of the review, there was no system in place to analyze the data from the drills to identify problematic trends and implement timely plan of correction.	

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		In addition, interviews with two Training Specialists from the CTD Department revealed that all of the drills conducted consisted of CPR, and scenarios for either seizures or choking. No other scenarios were included in the drills, such as heat stroke, bee stings with anaphylactic shock, head injuries, or scenarios addressing first aid issues. The Facility should expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions in addition to CPR. From discussions with the CNE, the Nurse Educator, and CTD staff, the Facility did not provide training regarding basic First Aid as part of the new employee orientation, or in conjunction with CPR certifications or re-certifications classes. Given that many of the individuals at the Facility are at risk for accidents and injuries, and more individuals will be going off campus with direct support professionals, the Facility should consider adding First Aid training to the NEO and CPR classes. The CTD staff reported that they bring the Automated External Defibrillators (AEDs) to the drill rather than having the staff demonstrate that they know where they are in the residences. In order to adequately assess the Facility's emergency procedures, staff should be responsible for bringing all emergency equipment to the drill, as well as demonstrating its use as they would be during an actual emergency. The CTD staff also noted that overall, nurses were not participating in the drills, and no physicians had participated. The Facility should ensure that the clinical staff participates in the Emergency Medical Drills. As noted from the baseline review, the purpose of conducting regular medical emergency drills is to identify strengths and weaknesses in the Facility's response to emergencies, as well as assessing staff's knowledge and competency in executing emergency procedures. There should be interdisciplinary collaboration with the CTD regarding medical emergency drills and the Facility's emergency systems. It is essential that the nursing and medical staff practice their roles in a medical emergency, know the Facility's emergency systems, and be familiar with the staff's knowledge of emergency procedures. At the time of the review, the Facility did not have AEDs available in every residence. The Facility should evaluate if the current number of AEDs is sufficient, or if more are needed, to ensure that the equipment is readily available throughout the Facility. Although the Facility indicated that 100% of the nurses had successfully completed competency-based training regarding use of emergency equipment, while on-site during the review, the nurse asked to demonstrate the use of the oxygen tank initially could not find the key to turn on the tank. After a few minutes, the key was found in a desk drawer under stacks of paper, and the nurse was able to demonstrate how to turn it on. In an emergency, the time it takes to find a key for the oxygen tank could be crucial to the life of the individual in need of oxygen. In addition, there was no emergency equipment	

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		check sheet, filled out daily, indicating that the tank was being checked to ensure that it had oxygen. Likewise, there was no documentation found indicating the suction machines were being checked to ensure they were in working condition. The Facility should continue to implement the system in which nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment. In addition, all emergency equipment should have documentation showing it is being regularly checked, and it is in working condition.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	In July 2010, the State Office modified the Guidelines and the form for the Comprehensive Nursing Assessment. The CNE reported that the Facility began using the modified assessment forms in August. However, competency-based training was not provided prior to its implementation. AUSSLC's Supplemental POI indicated that competency-based training had begun in September 2010. However, from a review of the training curriculum provided by the Facility, no competency-based curriculum was found for this area. The CNE reported that a workgroup of Nursing Educators from the Facilities were meeting to discuss the overall training needs for the nurses. Developing and maintaining nursing competency regarding nursing assessments is an essential foundational skill. The nursing summary section of the nursing assessment form should provide a clinical analysis of the raw data from the previous sections. This data should be compared to the previous quarter's assessment regarding the individual's progress related to their health and behavioral goals. The competency-based training regarding the Quarterly/Annual Nursing Assessment process should address how to clinically analyze data, write the findings of that analysis, and adequately measure the nurses' competency in producing a quality nursing assessment. The records of 22 individuals who had quarterly or annual nursing assessments completed since the modified guidelines and assessments forms were implemented were reviewed, including: Individual #382, Individual #298, Individual #458, Individual #368, Individual #307, Individual #429, Individual #168, Individual #249, Individual #217, Individual #283, Individual #83, Individual #30, Individual #276, Individual #204, Individual #59, Individual #208, Individual #140, Individual #371, Individual #444, Individual #219, Individual #414, and Individual #73. Consistent with the findings during the baseline review, none (0%) of the 22 quarterly/annual assessments were adequate and all were of very poor quality. The narrative summary section for all of the 22 assessments reviewed continued to lack any assessment and analysis of the individuals' progress related to their health or behavioral issues. In addition, most of the quarterly assessments reviewed included the goals/objectives from the Nursing Care Plans/Health Management Plans. Unfortunately, the quality of the goals/objectives and interventions included in the Nursing Care Plans had not improved	Noncompliance

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		since the baseline review. This is discussed in further detail with regard to Section M.3 of the SA. Thus, merely transferring inadequate information into the summaries of the Nursing Quarterly Assessments renders the assessments meaningless. The few summaries in which comparisons were found between, the current and the previous quarters, only consisted of raw data without an analysis and summary addressing why the individual was doing better, maintaining, or doing worse regarding his/her health and behavior issues. Due to the extremely poor quality, the lack of proactive interventions, inappropriate goals and objectives, and the generic nature of the Nursing Care Plans/Health Management Plans, using them as a template for completing the summary section contained in the Nursing Assessments did not and will not provide an adequate clinical nursing analysis. It was noted that some of the summaries contained in the nursing assessments were lengthier than previous assessments found during the baseline review. However, there was no improvement in the quality of the content, only more historical information, more of the nursing care plan template, and/or more raw data. There was no analysis of the data found in any of the 22 assessments reviewed. There had been no improvement in the Nursing Assessments since the baseline review. The following provides some examples of problems noted in the nursing assessments: ▪ The Quarterly Nursing Assessment Summary dated 8/1/10 for Individual #414 stated the following: *[Individual #414] will have no more than 3 episodes of alterations in skin integrity requiring treatment more than soap and water.* *[Individual #414] had 0 episode(s) of impaired skin integrity requiring more than soap and water treatment during this review period.* *[Individual #414] did have 3 falls this last year so the will be added to his new HMP [Health Management Plan] for the upcoming year.* *[Individual #414] had 0 Episodes of falls this review period.* Clearly, the summary from the nursing assessment provided little information regarding the individual's health status during the quarter. From a review of the Nursing Assessment for this individual, the information noted that the individual had received intravenous anesthesia for a dental procedure during the quarter. However, the type of procedure, oral hygiene ratings, and interventions developed, modified, or currently in place to maintain the	

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		individual's dental health, as well as possibly avoid the future use of anesthesia for dental procedures, were not mentioned. In addition, there was no analysis regarding the falls the individual experienced. For example, there was no analysis of the causes such as potential balance or vision issues, versus issues related to the environment; the risks from the falls such as fractures, especially if the individual has osteoporosis; what assessments were conducted in response to the falls, such as a physical therapy assessment and associated recommendations; and/or what interventions were implemented to prevent further falls. Also, the information included in the assessment indicated that the individual had a Comprehensive Metabolic Panel obtained "for hyperkalemia" (high potassium levels) during the quarter. This blood test helps evaluate kidney and liver function, sugar (glucose) and protein levels in the blood, and electrolyte and fluid balance. Although having an elevated potassium level does not always initially produce symptoms, sometimes individuals can experience nausea, irregular heartbeat, or a weak, slow pulse. Also, fatigue, diarrhea, poor reflexes, restlessness, slurred speech, confusion, and tingling sensations are sometimes signs of a high potassium level. If the disorder has advanced, heart palpitations or muscle paralysis may occur. Because hyperkalemia rarely causes symptoms initially, it is usually discovered during routine blood tests or secondarily from findings from electrocardiograms (EKGs). Severe cases may involve numbness, as well as respiratory or cardiac arrest. Some of the dietary interventions for an elevated potassium level include, avoiding potassium rich foods such as bananas, and nuts, as well as refined foods made with white flour and sugar, cutting back on red meat, and keeping hydrated. Although the assessment indicated that the individual had the blood test, there were no results included indicating if the potassium level was low, normal, or elevated. The documentation in the nursing assessment only indicated that: "All labs are reviewed by MD." ▪ The Quarterly Nursing Assessment Summary for Individual#219 dated 5/21/10, for the months from 5/1/10 through 8/1/10 stated the following: *[Individual #219] will maintain the best possible health as evidenced by-No more than 3 episodes of alterations in skin integrity requiring treatment more than soap and water.* *[Individual #219] had (4) episodes of alterations in skin integrity requiring treatment more than soap and water.*	

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		It was unclear why the date on the Nursing Assessment indicated that it had been completed two months prior to the end of the quarter, however, the nursing assessment noted that the individual had completed a colonoscopy, and was seen at an orthopedic clinic during the quarter. There was no documentation found indicating the results of these appointments. In addition, the assessment stated that the individual had Gastroesophageal reflux (GERD), and had a medication change related to this diagnosis. However, there was no information provided indicating why the medication was changed and/or an analysis of the individual's status since the change in the medication was initiated. In addition, the brief information that was provided in the assessment summary was merely a tally of the episodes of alterations in skin integrity without any analysis of the clinical relevance of the data to the individual's health status. ▪ In another example, the Quarterly Nursing Assessment Summary dated 8/20/10 for Individual #371 stated the following: *[Individual #371] will maintain the best possible health as evidenced by-No more than 3 episodes of alterations in skin integrity requiring treatment more than soap and water.* *[Individual #371] had 0 episode(s) of alterations in skin integrity requiring treatment more than soap and water.* *[Individual #371] will maintain the best possible health as evidenced by maintaining steady weight during the next year within his EDWR [estimated desired weight range] of 119-134.* *[Individual #371] had 0 episode of weight loss and has shown more stability in weight.* This quarterly nursing assessment summary made no mention of the individual's pica behaviors, diagnosis and symptoms of GERD, problems with constipation, an episode of MRSA during the quarter, results of lab work obtained, or multiple episodes of skin infections. Although the assessment indicated that the individual's weight had remained stable, it provided no specific information or analysis regarding what interventions or strategies had been successful in maintaining stability. The assessment provided no information or analysis that indicated how this individual was progressing from the previous quarter. ▪ The Quarterly Nursing Assessment Summary dated 8/20/10 for Individual #204 stated the following:	

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		[Individual #204] will maintain the best possible health as evidenced by- zero interruptions in skin integrity requiring more than soap and water for treatment during the next 12 months. *[Individual #204] had 0 episode(s) of impaired skin integrity during this review period.* *No more than 3 injuries/falls, requiring more than soap and water for treatment during the next 12 months.* *[Individual #204] had 0 injuries/falls during this review period.* This quarterly nursing assessment summary made no mention of the individual's mental health status related to changes in his psychotropic mediations or assessments during the Psychiatric Clinics he attended during the quarter, ambulation issues and use of a gait belt, abnormal movements placing him at risk for falls according to the Nursing Diagnosis, or his seizure activity and results of a neurology consultation. Again, the nursing assessment provided no information or analysis that indicated how this individual was progressing as compared to the previous quarter. It appeared that the nurses at AUSSLC were using the Nursing Care Plans/Health Management Plan templates in place of conducting clinical analyses for the nursing assessment summaries. In addition, implementing the modified Nursing Assessment form and Guidelines before providing the necessary competency based training had clearly resulted in inadequate nursing assessments similar to those found during the baseline review. Without having the appropriate training, the nurses transferred poor nursing practices regarding assessments, onto new forms. The Facility should provide adequate competency-based training to ensure nursing assessments include adequate clinical analysis resulting in an appropriate summary of the individuals' progress regarding their health and behavior status. The records of 18 individuals who were under the age of 21 years old were reviewed, including: Individual #123, Individual #409, Individual #187, Individual #410, Individual #98, Individual #289, Individual #277, Individual #350, Individual #74, Individual #360, Individual #139, Individual #210, Individual #217, Individual #276, Individual #122, Individual #83, Individual #401, Individual #360, and Individual #276. A review of the past two quarterly nursing assessments found that 15 (83%) of the individuals had quarterly nursing assessments that were completed timely. Three of the 18 individuals (Individual #401, Individual #360, and Individual #276) only had one Nursing Quarterly	

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		Assessment included in the document request, indicating that one of the Nursing Quarterly Assessments had not been completed. Consistent with the findings during the baseline review, none (0%) of the 33 most recent Nursing Quarterly Assessments were found to be clinically adequate, and all required significant improvement. The summary narrative section for all of the 33 quarterly assessments reviewed continued to contain either superficial information carried over from each quarterly assessment, inaccurate information not reflective of the issues for the current quarter, or goals/objectives of the Nursing Care Plans/Health Management Plans without any analysis of the raw data regarding the individual's health status related to the interventions included in the plans. Again, since the quality of the goals/objectives and interventions included in the Nursing Care Plans had not improved since the baseline review, the summaries contained some limited raw data, but no analysis of the individuals' status in the current quarter as compared to the past quarter. In addition, there was no mention, in any of the 33 Nursing Assessments reviewed, as to how individuals under 21 years old were progressing regarding age appropriate activities ,such as school performance and socialization issues. For example: ▪ The nursing assessment dated 7/26/10 for Individual #401 stated the following: *[Individual #401] has been healthy over the last quarter. On 5/21/10 she went to the ER to have sutures placed in her lip after being hit by peer. She received Augmentin to prevent infection. [Individual #401] has not had any other medical concerns this quarter. She has been receiving routine care for some time now, however she wanders around the home asking if her sister is coming to get her. [Individual #401] has been visiting group homes in order to have an easy transition to a group home when the time comes.* The Nursing Assessment contained virtually no assessment of this individual's status from the quarter. There was no assessment and analysis addressing her weight, which was 15 pounds over the desired weight range. There was no mention of the mental health issues related to her psychotropic medications and psychiatric reviews. Although the assessment summary indicated that she had visited a group home in preparation for a transition, which would represent a major life change for this individual, there was no summary of her progress towards her transition. In essence, the nursing quarterly assessment provided no information that indicated how this individual was progressing towards her goals. It was evident from the nursing assessments reviewed that nursing at AUSSLC limited its focus to only medical issues. Consequently, if an individual had few medical issues, the nursing assessment did not address the progress regarding mental health issues, behaviors, or any of the individual's functional goals or objectives. In other	

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		words, the healthier the individual, the less nursing was involved in contributing to the promotion of health and independence. ▪ The Quarterly Nursing Assessment Summary for Individual #98 stated the following: *A very healthy and active young man without any major health issues.* Despite the nursing assessment indicating that this individual had issues with self-injurious and aggressive behaviors, a seizure disorder, a history of a head injury, urinary incontinence, and abnormal testosterone and prolactin levels, it appeared that since the individual had not experienced any major acute health event, nursing had not assessed and analyzed anything. In addition, the records of 49 individuals, who were identified by the Facility as being at risk for specific health indicators, were reviewed, including: Individual #355, Individual # 244, Individual #361, Individual #74, and Individual #154 for Diabetes; Individual #42, and Individual #331 for skin integrity; Individual #453, and Individual #280 for constipation; Individual #160, Individual #152, Individual #3, Individual #108, Individual #217, Individual #358, Individual #424, Individual #228, Individual #301, Individual #112, Individual #336, and Individual #446 for weight issues; Individual #251, Individual #92, Individual #384, Individual #175, Individual #321, Individual #342, Individual #417, Individual #48, and Individual #366 for aspiration; Individual #144, Individual #304, Individual #454, Individual #126, and Individual #84 for cardiac issues; Individual #253, Individual #450, Individual #430, Individual #297, Individual #246, and Individual #328 for seizures; Individual #184, and Individual #206 for medical issues; Individual #78, Individual #276, Individual #283, and Individual #77 for behavior issues; and Individual #416 for osteoporosis. A review of the past two quarterly nursing assessments found that 41 (84%) of the individuals had quarterly nursing assessments that were completed timely. Again, consistent with the findings during the baseline review, none of the 98 assessments (0%) were clinically adequate. The problematic issues, found from review of these Quarterly Nursing Assessments, were the same issues found in the review of the above Quarterly Nursing Assessments. Some of the problematic issues included: ▪ A significant lack of assessment and analysis of information regarding the high risk health indicators identified by the Facility for the individuals; ▪ Information found in the comment/summary sections of the nursing assessments had not been addressed in the summary section; ▪ Nursing summaries only included demographic information and listed the health issues for the individual without providing a clinical analysis of the individual's status regarding the health issues;	

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		▪ Frequent clinical contradictions were found in the assessment summaries (i.e., noting that the individual had good health during the quarter and reporting information that did not support the concept of "good health"); ▪ Lack of an analysis of the health and behavioral data indicating if the individual was progressing in their health goals; and ▪ Nursing Care Plans being inserted into the summary section that provided no information regarding the individuals' health status. Also, the record for Individual #305, who was admitted to the Facility since the last Monitoring Team visit, was reviewed. One quarterly nursing assessment dated 4/7/10 was submitted, and the summary included the individual's age, where he was transferred from, a list of his diagnoses, and a statement indicating that he attacked others when feeling anxious. There was no information provided that reflected the individual's current status related to his health and mental health issues. The significant problems found during the baseline and current reviews, regarding the quality of the Nursing Assessments, emphasizes how critical it is for the AUSSLC's Nursing Department to ensure that clinically appropriate, competency-based training is provided regarding Nursing Assessments. In addition, as the Facility develops and implements the monitoring process for this area, the Facility should ensure that staff auditing this area are clinically competent in determining compliance related to the quality of nursing assessments.	
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.	Since the baseline review, the State Office had approved the use of the Health Care Protocols: A handbook for DD Nurses, and the Lippincott Manual of Nursing Practice, 9th Edition as resources for nursing policies, protocols, and Nursing Care Plans. The CNE reported that the Facility had obtained these resource books. However, some of the Nursing Case Managers reported that they had limited access to these resources since they frequently were locked in an office. The Facility should evaluate and implement mechanisms to make these resources available, such as having the resources available on CDs or having the information available on the shared drive. The CNE reported that the new Nursing Care Plans based on the Health Care Protocols: A handbook for DD Nurses had been implemented on 7/1/10. Although the Facility's Supplemental POI indicated that competency-based training for this area had begun in September 2010, a review of the curriculum addressing Nursing Care Plans found it to be inadequate and not competency-based. Consequently, the Nursing Care Plans reviewed were basically the templates from the resource book without any appropriate individualization. At the time of the review, there had been no competency-based training curriculum developed regarding Nursing Care Plans. AUSSLC's Supplemental POI indicated that the Facility was evaluating the development of a Care Plan workshop	Noncompliance

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		for all RNs. The Facility should develop and implement a clinically sound competency-based training curriculum for Nursing Care Plans to ensure nurses are appropriately trained and demonstrate the ability to develop clinically appropriate Nursing Care Plans. The records of five individuals seen by psychiatry and/or prescribed psychotropic medications were reviewed, including: Individual #78, Individual #276, Individual #283, Individual #305, and Individual #77. Consistent with the baseline findings, none of the Nursing Care Plans addressed the individuals' mental health diagnoses or behavioral issues, including interventions included in behavior plans and/or other strategies used, or issues related to the psychotropic medications prescribed for the individuals. Some of the individuals had Nursing Care Plans addressing risks of injuries related to their challenging behaviors. However, these were essentially templates that contained little to no individualization, and did not include interventions addressing the prevention of injuries, but only what to do when an injury occurred. For example: ▪ Individual #305 was noted to have self-injurious and aggressive behaviors with attacks on others which often precipitated when he was anxious. There was no Nursing Care Plan found addressing the risks related to his behaviors or the use of psychotropic medications. In addition, the Nursing Care Plan was a generic template with no individualized interventions. In addition, the Nursing Care Plans from the records of 49 individuals who were identified by the Facility as being at risk for specific health indicators were reviewed, including: Individual #355, Individual # 244, Individual #361, Individual #74, and Individual #154 for Diabetes; Individual #42, and Individual #331 for skin integrity; Individual #453, and Individual #280 for constipation; Individual #160, Individual #152, Individual #3, Individual #108, Individual #217, Individual #358, Individual #424, Individual #228, Individual #301, Individual #112, Individual #336, and Individual #446 for weight issues; Individual #251, Individual #92, Individual #384, Individual #175, Individual #321, Individual #342, Individual #417, Individual #48, and Individual #366 for aspiration; Individual #144, Individual #304, Individual #454, Individual #126, and Individual #84 for cardiac issues; Individual #253, Individual #450, Individual #430, Individual #297, Individual #246, and Individual #328 for seizures; Individual #184, and Individual #206 for medical issues; Individual #78, Individual #276, Individual #283, and Individual #77 for behavior issues; and Individual #416 for osteoporosis. Consistent with the baseline findings, none of the 49 Nursing Care Plans (0%) was adequate. The Nursing Care Plans consisted of a combination of the old format, as well as some of the new templates. As noted during the baseline review, the interventions contained in the old Nursing Care Plans consisted of service provisions, such as "administer medication as ordered," and "monitor vital signs." The new Nursing Care Plans were exact copies of the protocol templates, with the individual's name inserted. The lack of individual-specific interventions contained in the Nursing Care Plans	

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		reviewed, provided little to no direction for caring for individuals who were identified by the Facility as being at risk for specific health indicators. In addition, most of the goals and objectives listed in the Nursing Care Plans were not appropriate to measure individuals' progress related to the health issue. Consistent with the baseline findings, the interventions contained in the Nursing Care Plans did not address any preventative interventions or interventions that would minimize the individual's identified health risks. The Health Care Protocols: A handbook for DD Nurses resource book that the Facility was using consisted of nursing protocols, not Nursing Care Plans. In order to develop appropriate Nursing Care Plans, the information from the protocols needed to be individualized to address the specific needs of the individual. Merely using generic templates as Nursing Care Plans renders them meaningless in providing appropriate direction to staff caring for the individual. Nursing Care Plans should accurately reflect what nursing is doing for prevention, health maintenance, and health promotion for the individuals. In order for them to be quality Nursing Health Care Plans, the new Nursing Care Plans, which are actually Health Care Protocols, should be modified and individualized to include appropriate goals/objectives, and specific interventions, including proactive interventions. An additional sample of 18 individuals, who were diagnosed with a variety of infections and infectious diseases, were reviewed to determine if these issues were appropriately addressed in the Nursing Care Plans. These individuals included: Individual #84, Individual #24, Individual #434, Individual #174, Individual #51, Individual #405, Individual #323, Individual #182, Individual #154, Individual #1, Individual #107, Individual #31, Individual #404, Individual #117, Individual #233, Individual #127, Individual #395, and Individual #53. Of the 18 individuals, six had positive PPDs, but no Nursing Care Plans addressing this issue. Of the ten individuals who had MRSA, nine had no Nursing Care Plans addressing MRSA, and the one plan that did address MRSA was not adequate. Of the two individuals who had Hepatitis C, none of the Nursing Care Plans were adequate. Thus, from a review of 18 individuals who had infectious diseases, none (0%) had appropriate and adequate Nursing Care Plans. Although the Infection Control Nurse reported that she had begun reviewing the Nursing Care Plans for individuals with infectious issues, and had submitted nine that were reviewed by Infection Control, none of the care plans were found to be adequate by the Monitoring Team. As discussed in detail with regard to Section M.1 of the SA, this area requires significant attention due to the clinical relevance of infectious and communicable diseases, and the health risks associated with these diseases. Consistent with the findings during the baseline review, there was no system in place that ensured that individuals with infectious diseases were actually being provided the appropriate Infection Control	

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		measures, or that clinically appropriate interventions to prevent the spread of infection were being consistently implemented. A Nursing Care Plan should be a blueprint for guiding staff to provide needed care and supports for the individuals they serve. They should be documents that nurses review regularly to plan and prioritize the activities they need to complete. However, as was demonstrated with the Nursing Assessments, implementing new Nursing Care Plans, without first providing adequate competency-based training to the staff, resulted in a poor quality product. Consequently, the Nursing Care Plans continued to be seen as a task to complete rather than a valuable clinical guide for providing care. As required by Section G and F of the SA, the Nursing Department should collaborate with other disciplines regarding care so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans. The State and the Facilities might want to consider pursuing the use of integrated care plans that would incorporate all clinical disciplines' interventions into one treatment plan. This process facilitates collaboration with other disciplines regarding care plans so that an interdisciplinary team approach is used consistently. Regardless of what system is preferred, the consistent problems since the baseline review found in the Nursing Care Plans demonstrate that it is essential for the Nursing Department to provide clinically appropriate, competency-based training regarding Nursing Care Plans. In addition, as the Facility develops and implements the monitoring process for this area, the Facility should ensure that the staff auditing Nursing Care Plans are clinically competent in determining compliance related to the quality of the plans.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	As mentioned previously, the State Office had approved the use of the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols. This reference does not include a set of policies, and the Facilities would need to develop and/or amend existing policies to be in alignment with the procedures and protocols contained in the Manual, as well as with State and Facility practice, the Health Care Guidelines, and SA. For example, there might be procedures included in the Lippincott Manual that would not be allowed at AUSSLC due to its licensing, or only certain staff might be able to perform specific duties due to their credentialing or State regulations. At the time of the review, the Facility had obtained this resource, but had not yet developed Facility-specific policies. Consequently, no training had been provided to staff regarding changes in policies or procedures. At the time of the review, the Facility did not have a plan for when policies, procedures, or protocols would be updated, and/or when training would be conducted for newly developed policies, procedures, or protocols. Using the Lippincott Manual as a resource, the Facility should develop and/or	Noncompliance

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		modify nursing policies, procedures, and protocols to be consistent with the manual, State and Facility practice, and the SA, and Health Care Guidelines. As is discussed in detail above with regard to Sections M.2 and M.3 of the SA, at the time of the review, the Facility did not have adequate assessment processes or reporting protocols in place, nor did it develop appropriate Nursing Care Plans. As a result, AUSSLC was failing to adequately address the health care needs of the individuals it served.	
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.	At the time of the review, the State was in the process of reviewing and revising the system addressing indicators of risk. However, since this system was not yet revised, AUSSLC continued using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. As noted from the previous review, this tool was 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. Since the baseline review, the Facility had modified this system so that individuals were no longer given an overall score for risk, but were assigned a risk score for each of the health indicator categories. Although the HST meetings were being held, the health indicators were discussed and assigned a risk level at the individuals' PSP meetings. The risk levels included the following: Level 1 was the highest risk, Level 2 represented moderate risk, and Level 3 was low risk. Consistent with the baseline review findings, the risk tools used were not adequate, and the assignment of risk levels did not result in the appropriate identification of individuals at clinical risk. By the next review, there should be a new process in place to identify individuals at risk with the appropriate associated policies and procedures. Once this system is adequately implemented, and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop plans to address identified areas of risk. AUSSLC and the State Office recognized that they were not in compliance with this requirement of the SA, which was consistent with the Monitoring Team's findings.	Noncompliance
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	Since the baseline review, the Medication Observation tool had been appropriately revised to include all the basic elements of medication administration orally, by injection, or via tube. A review of the Facility's Medication Pass Observation forms verified that the Facility had implemented the new forms and had begun conducting quarterly medication observations. This was a positive development. However, the following issues were noted: ▪ There were a number of Medication Observation forms that had pages missing,	Noncompliance

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	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.	or had the same dates for the same nurse being observed. In most of these cases, the forms were not duplicates, because the auditing data were different on each form. ▪ AUSSLC's Medication Observation Assessment tools indicated that for initial observations, the auditors were only observing the nurse administer medications to a few individuals, and were not observing the entire process to evaluate adequately the practices and procedures regarding medication administration. Conducting observations of medication administration for a few individuals is appropriate for random or spot checks, but not for the quarterly medication observations that are conducted to ensure that nurses are using the proper procedures for safe medication practices. The Facility should ensure that the auditors are observing the entire process during the quarterly medication observations. The Facility should ensure that policies, procedures, and protocols are updated to reflect the updated medication observation tool, the increase in the medication observation frequency, and the specific procedures to be conducted for the different types of observations. In addition, the Facility had implemented a database to track the medication observations to ensure all nurses were being observed every quarter. The database had sections addressing the problems identified, recommendations, Corrective Action Plans (CAPs), dates the CAPs were completed, and additional follow-up needed. The format of this database was very comprehensive, and provided a structure to easily identify problematic trends and outcomes. However, the database had not been updated since May 2010. Consequently, very few recommendations had associated CAPs, dates of completion, or additional follow-up documented. The Facility should keep the Medication Administration Observation database updated to ensure that problematic trends are quickly identified, corrective action plans are timely implemented, and clinical outcomes are improved, whenever possible. Auditors for medication observations must be competent in the medication administration procedures so that data generated from the observations are an accurate reflection of Nursing Department practices. From review of the issues noted on the Medication Observation forms from 1/10 through 6/10, there were very few issues found regarding the nurses' medication administration practices. Although very important to the process, most of the problems identified were related to technical or environmental issues, such as problems with the medication carts not locking, missing pictures of individuals in the medication administration records, insufficient lighting in the medication rooms, and direct support professionals not able or willing to assist the	

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		medication nurse. There were essentially no problems identified with regard to checking the PNMP for proper positioning prior to medication administration, assessing individuals demonstrating symptoms such as coughing or wheezing before and/or after medication administration, providing privacy during medication administration, providing education to individuals regarding their medications, pouring liquids at eye level, the appropriate use of gloves and hand washing practices, and pre- or post-initialing the MARs, rather than initialing right after the individual took the medications. The lack of procedural findings from the Facility's data regarding medication administration observations did not comport with the Monitoring Team's findings from both the baseline and current reviews, as is discussed in further detail below. From conversations with the CNE, the auditors for Medication Observations had not been tested for competency in this area, and inter-rater reliability studies had not been completed. As the medication observation monitoring system continues to be developed, the department should establish inter-rater reliability among auditors. This is important to produce reliable data to accurately identify areas of strength and weakness in the system, and to be able to implement targeted plans of correction for deficient areas. At the time of the review, there was no formal system in place that summarized the issues found during the medication observations that had been conducted. From review of the Medication Error/Prevention Committee meeting minutes dated 4/29/10, 9/27/10, and one meeting that was not dated, and the Pharmacy and Therapeutics Committee meeting minutes dated 2/25/10, and 9/28/10, there was no information contained in the minutes addressing issues found from the medication observation data. Once the Facility develops a system to update the Medication Administration Observation database, this data should be formally analyzed for trends, and the information integrated into the Medication Error/Prevention Committee meetings, and the Pharmacy and Therapeutics Committee meetings, as appropriate. Due to the lack of structure of the Medication Error Committee meeting minutes, it was very difficult to identify the issues and outcomes. There was no structured format for capturing the information discussed during the meetings. These minutes should be restructured to include sections that address the identification of the issues; an analysis of the issue; plan(s) of correction, including who is responsible for implementation and expected dates of completion; anticipated outcomes; and the plan for further monitoring. This would provide focus to the meetings, and a method to document the information discussed. From review of the minutes, the Facility had included two LVNs at the meeting dated 9/27/10. This was a positive step since the LVNs are usually the nurses who administer medications and can provide valuable information about the strengths	

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		and weaknesses of the Facility's medication administration systems. The minutes indicated that there was little discussion and no analysis regarding the Facility's medication errors/variances. It was evident from the dates of the meetings that the committee did not regularly meet from April to September 2010. The CNE reported that she was now keeping the data regarding medication errors, but for the month of March 2010, no data had been provided. From discussions with the CNE, and review of the Pharmacy and Therapeutics Committee meeting minutes dated 9/28/10, the Facility recognized that medication errors/variances were underreported, which was consistent with the Monitoring Team's findings. Discussions with the CNE, and review of the Medication Error/Prevention Committee minutes and the Nursing Administrative Team Meeting minutes, indicated that the Facility was in the very beginning stages of discussing medication variances, and some of the system issues that could contribute to errors such as distractions during medication administration, and having only one nurse giving several individuals their medications. At the time of the review, there was no indication that any interventions actually had been implemented to address these issues. At the time of the review, it was impossible to determine, with any reliability, the number and type of medication variances that had occurred at AUSSLC. A review of the minutes of the Medication Error Committee meetings and medication variance data the CNE provided, showed there were discrepancies and some missing data. These discrepancies are discussed in further detail with regard to Section N.8 of the SA. The minutes of the Pharmacy and Therapeutics Committee meeting minutes, dated 2/25/10, indicated that because the previous CNE was not able to attend the meeting, no discussion of medication errors occurred. Consequently, no data addressing medication errors was included in the minutes. The Pharmacy and Therapeutics Committee meeting minutes, dated 9/28/10, indicated that the CNE, Nurse Managers, Pharmacy, and the Medical Director would be involved in the Medication Error Committee Meetings to provide more structure to the medication error reporting procedures. However, a review of these minutes found that the Pharmacy and Medical Director did not attend these meetings. Although the CNE had some variance data for August and September 2010, including the number of variances by category and by residence, she candidly reported that the data was not accurate or reliable, which comports with the Monitoring Teams findings. Overall, the Facility had made little progress in this area since the baseline review. Consistent with the baseline findings, the Facility's medication variance system lacked reliability. Although the Facility had increased the frequency of the medication administration observations, the data generated from these audits did not comport with the findings and observations of the Monitoring Team, indicating that the competency of the auditors for this area needed to be assessed. As noted from the baseline review,	

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		AUSSLC should critically review its entire medication system, and develop and implement systems that will ensure adherence to appropriate medication administration practices. As also stated in the baseline report, the Facility should give consideration to using a medication variance system that would significantly expand the scope of the review of the Facility's medication system, and would be consistent with the requirements in Section N.8 of the SA. The medication error system the Facility currently had in place only addressed actual errors related to the wrong patient, wrong time, wrong dose, wrong route, wrong drug, wrong technique, documentation errors, and omitted medications. There are many more system issues that can contribute to medication variances than just breaches in one of the "six rights" for medication administration. Only using these limited indicators as measures of the Facility variances limits the analysis of the system, and excludes proactive reviews that identify areas for potential variances so that interventions can be implemented before variances occur. When observing medication administration, while on site, for individuals living in Cardinal and in the Infirmary, the following significant issues were identified, most of which placed the individuals involved at risk. Specifically, the nurse did not: ▪ Check the PNMP to ensure individuals were in the proper positioning prior to medication administration; ▪ Conduct assessments for individuals demonstrating symptoms such as coughing or wheezing before and/or after medication administration; ▪ Intervene when staff laid Individual #50, who is enterally fed flat on her bed, and the individual began having wet respirations; ▪ Recognize the need to assess Individual #50 rather than proceeding with medication administration; ▪ Know the individuals in the residence who were at risk for aspiration; ▪ Understand why appropriate positioning was crucial for individuals at risk for aspiration; ▪ Provide privacy during medication administration; ▪ Speak or provide education to individuals regarding their medications; ▪ Pour liquids at eye level to ensure the correct dosage; ▪ Wash her hands consistently between individuals receiving medication; and ▪ Have a stethoscope available on the medication cart to listen to lung sounds for individuals coughing before or after receiving medications; and ▪ Consistently use gloves when manipulating tubes. The following provide examples of concerns noted during medication administration: ▪ During the medication administration observation in Cardinal, one of the	

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		residences designated for individuals with complex medical needs, Individual #50 was sitting in her wheelchair and began coughing with much congestion that could be heard from across the room. Neither the medication nurse nor the Facility nurse conducting a medication observation audit initiated an assessment of the individual until the Monitoring Team recommended it. In fact, while the staff was transferring the individual to her bed to obtain her temperature, the medication nurse approached the individual preparing to administer her medications through her G-Tube without assessing the individual's status to determine if it was safe to proceed with administering her medications. As noted above, within a minute after the direct support professionals transferred the individual from her wheelchair and placed her flat in her bed, her respirations became wet and loud. Again, neither the medication nurse nor the Facility nurse conducting a medication observation audit intervened to have the staff reposition the individual or to assess her in response to the changes in her breathing. The individual's PNMP was not in the MAR binder and had to be found. A review of the individual's PNMP indicated she was not to be laid flat. However, neither the medication nurse, the Facility nurse, nor the direct support professionals recognized that she was in an inappropriate position, and did not react to the audible changes in her respiratory status. When the Monitoring Team recommended that the individual's lung sounds be assessed, the medication nurse reported that she did not have a stethoscope on the medication cart. This clearly indicated that medication nurses were not regularly conducting respiratory assessments for individuals at risk for aspiration in a residence serving individuals with medical complications. Once an assessment was conducted, the individual was found to have an elevated temperature and was wheezing upon auscultation. In spite of these findings, the medication nurse again approached the individual in preparation to administer her medications, until the Monitoring Team recommended that she not proceed, and the CNE intervened to direct the staff member not to proceed. Clearly, the medication nurse did not recognize the need to address the individual's clinical signs of distress as a priority over the completion of the medication pass. ▪ While reviewing emergency equipment in Cardinal two days later, Individual #402 was heard coughing with wet respirations in the bathing room. Staff had him lying flat on a shower trolley while a medication nurse was preparing to administer his medications through his G-tube. Again, there were no attempts made to conduct an assessment until the Monitoring Team recommended it. When asked what position the PNMP indicated he should be in for showers, the staff had to find the plan to determine that there was no direction provided for positioning during showers. When the individual's position was changed from being flat on the trolley, the nurse auscultating his lungs sounds noted that they	

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		were clear with the change in positioning. Again, the medication nurse had to be prompted three times to not proceed in administering his medications until his status was assessed and he was deemed stable. The lack of a response to these situations by AUSSLC staff indicated that the staff had become desensitized to clinical symptoms and viewed them as something the individual "always does." Consequently, this resulted in not only a lack of timely and appropriate clinical assessments, but also the lack of timely reporting of symptoms. The significant lack of understanding regarding issues related to dysphagia, the risk of aspiration, the importance of the PNMP, and the inability to recognize that significant clinical symptoms warrant timely nursing assessments places the individuals at AUSSLC at significant risk of harm. As is discussed in greater detail with regard to Section O of the SA, the Facility should provide competency-based training and on-going oversight related to physical nutritional management issues to ensure that nurses and direct support professionals are consistently following safe and appropriate procedures aimed at minimizing the individuals' health risks. In addition, the Nursing Department should collaborate with the PNMTs to build systems that support and integrate physical and nutritional management principles into nursing practices.	

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

1. AUSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement.
2. Until the Nursing Workgroup has developed an orientation template, the Facility should implement changes in the orientation, mentoring, and monitoring of agency nurses, and then modify these in alignment with the recommendations of the Workgroup once they are completed.
3. With regard to nursing staffing, and staffing on the Cardinal Unit:
    a. The Facility should develop and implement a system to ensure the minimum staffing ratios are maintained at all times for nursing staffing throughout the Facility, and the direct support professional staffing on the Cardinal Unit.
    b. When ratios fall below the required minimum, this should be communicated to Facility Administration.
    c. Reliable schedules that accurately identify who and where staff actually worked, when staff reported to and left their assigned work areas should be maintained.
    d. There should be regular review of staff patterns and issues, with follow-up action on any issues identified.
4. The Facility should develop or modify policies, procedures, and/or protocols addressing the integration of the new nursing positions into the Nursing Department.
5. The Facility should continue its efforts to develop and implement the processes necessary for generating data that can be accurately interpreted, analyzed, and are reflective of the practices being measured. These include:
    a. Developing review tool instructions. The Facility in conjunction with the State Office should develop instructions for each monitoring tool to ensure that all auditors are using the same documentation and criteria to determine compliance with each item, which will assist in establishing inter-rater reliability;
    b. Providing the total of the population being reviewed (N) and the sample of that population audited (n) to yield an adequate percent

sample to indicate the relevance of the compliance scores;
   c. Establishing and reviewing an adequate sample size;
   d. Developing and implementing a procedure for establishing inter-rater reliability at 85% or above;
   e. Ensuring that all staff conducting monitoring activities are clinically competent in the areas they monitor; and
   f. Ensuring that audits consist of a critical review of nursing practices, focused on the quality of nursing services and documentation, not just the completion of the required documentation.
6. Data generated from the monitoring tools should be reviewed regularly, addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems. Corrective Action Plans should be developed and implemented to address identified issues.
7. The Nursing Department should establish appropriate criteria and testing for competency for the entire nursing staff in order to have meaningful and lasting effect on the clinical outcomes for the individuals at AUSSLC.
8. A critical review should be completed of competency-based training, and curricula that does not adequately address or measure competency should be revised or new training developed.
9. Acute changes in status should be considered a priority for the development, training, and implementation of nursing policies, procedures, and protocols.
10. The Facility should ensure documents are filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information to make decisions regarding treatments and health care services.
11. To generate accurate data regarding acute illness and urgent care, the auditing staff should first read the "story" included in the progress notes from the start of the change of status to the individuals' return to their residence, and then score the tools. This method would help to ensure recognition of the quality issues related to clinical care and the completeness and appropriateness of assessments, rather than just the completion of notes.
12. The Facility should develop and implement a schedule for training on newly developed nursing care protocols, based on priority of need, as well as when implementation will occur.
13. The IC Nurse should ensure that all IC staff is competent in the area of Infection Control and maintain documentation for verification. Validation of clinical competency for staff working in a specialized area such as Infection Control is essential to ensure that they are knowledgeable about all facets of infectious and communicable diseases and practices.
14. The Facility should develop a procedure outlining the specific process to ensure data reliability for Infection Control, including how discrepancies in the data are reconciled and tracked. The procedures should address specific information, such as when data are collected from each system, how discrepancies between the systems are tracked and reconciled, and where does residence reporting fall into the data collection system.
15. The Facility should develop and implement a database system for IC that allows for reliable tracking and monitoring of the Facility's IC data.
16. The Facility should formalize a system of regular spot checks in different areas to generate data regarding hand-washing practices of the staff. This information should then be aggregated and compared with Facility IC trend data to identify possible residences or day programs in need of additional training and monitoring.
17. The Infection Control staff should consistently document their activities, any findings from these activities, recommendations, and outcomes.
18. The Facility should implement a regular schedule of Environmental/Infection Control Reviews to identify and correct environmental issues in a timely manner. In order to generate accurate data, the Facility might want to consider rotating the reviewer to bring a "fresh set of eyes" to the process.
19. Once these Environmental/Infection Control Reviews are regularly conducted, the information generated should be analyzed in relation to other IC data to identify possible transmission and/or cross contamination issues.
20. The Facility should develop and implement a schedule outlining timeframes for reviews of the individuals' vaccine and immunization status to ensure individuals are appropriately prioritized and that no one is overlooked.

21. The Monitoring Team continues to recommend that the State consider securing the services of an expert in the areas of Infection Control and Nursing to provide consultation and on-site assistance to the State and Facilities.
22. The Facility should continue its efforts in developing a comprehensive trend analysis process for IC issues.
23. The Infection Control staff should consider conducting root cause analyses on events, such as outbreaks or post exposures, to provide a framework and structure for completing a comprehensive analysis, and identifying systemic issues that contributed to both positive and negative outcomes.
24. The Facility should ensure that individuals with infectious and communicable diseases are receiving appropriate services, and that staff are adequately trained and competent regarding infectious diseases
25. The Facility should develop and implement a monitoring system to ensure that appropriate and clinically sound Nursing Care Plans are timely developed for individuals with infectious and communicable diseases.
26. Until the IC curriculum is standardized, the Facility should modify the IC curriculum and post-test so they reflect necessary Infection Control information and to ensure staff is competent in this area.
27. Additional and on-going competency-based training should be provided to the nursing staff addressing infectious and communicable diseases in Nursing Care Plans.
28. Until the statewide workgroup finalizes standardized policies and procedures on IC, the Facility should maintain appropriate and adequate policies and procedures regarding Infection Control.
29. The Facility should develop a monitoring and review system for the Emergency Response Procedure to ensure that emergency procedures are being appropriately followed and are effective. This system should include an analysis of the data from the drills to identify problematic trends and timely implement plan of correction.
30. In order to adequately assess the Facility's emergency procedures, staff should be responsible for bringing all emergency equipment to the drill as well as demonstrating its use, as they would be during an actual emergency.
31. The Facility should expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions in addition to CPR.
32. The Facility's clinical staff, including physicians and nurses, should participate in the Medical Emergency drills in order to be familiar with their roles in a medical emergency, know the Facility's emergency systems, and be familiar with the staff's knowledge of emergency procedures.
33. The Facility should evaluate if the current number of AEDs is sufficient, or if more are needed to ensure that the equipment is readily available throughout the Facility.
34. The Facility should continue to implement the system in which nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment.
35. All emergency equipment should have documentation showing it is being regularly checked, and it is in working condition.
36. Facility should provide adequate competency-based training regarding nursing assessments and Nursing Care Plans to ensure nurses are competent in conducting assessments, and developing, and implementing appropriate Nursing Care Plans. The competency-based training regarding the Quarterly/Annual Nursing Assessment process, at a minimum, should address how to clinically analyze data, write the findings of that analysis, and adequately measure the nurses' competency in producing a quality nursing assessment.
37. The Facility should evaluate and implement mechanisms to make the Facility's resources (the Health Care Protocols: A handbook for DD Nurses, and the Lippincott Manual of Nursing Practice, 9th Edition) available to nurses, such as having the resources available on CDs or having the information available on the shared drive.
38. In order for them to be quality Nursing Health Care Plans, the new Nursing Care Plans, which are actually Health Care Protocols, should be modified and individualized to include appropriate goals/objectives, and specific interventions, including proactive interventions.
39. As required by Section G and F of the SA, the Nursing Department should collaborate with other disciplines regarding care so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans. The State and the Facilities might want to consider pursuing the use of integrated care plans that would incorporate all clinical disciplines' interventions

into one treatment plan. This process facilitates collaboration with other disciplines regarding care plans so that an interdisciplinary team approach is used consistently.

40. Using the Lippincott Manual as a resource, the Facility should develop and/or modify nursing policies, procedures, and protocols to be consistent with the manual, State and Facility practice, and the SA and Health Care Guidelines. Once policies are developed, nursing staff should be provided with competency-based training on their implementation.
41. The Facility should ensure that the auditors are observing the entire medication administration process during the quarterly medication observations to adequate review the medication administration system.
42. The Facility should ensure that policies, procedures, and protocols are updated to reflect the updated medication observation tool, the increase in the medication observation frequency, and the specific procedures to be conducted for the different types of observations.
43. The Facility should keep the Medication Administration Observation database updated to ensure that problematic trends are quickly identified, corrective action plans are timely implemented, and clinical outcomes are improved, whenever possible.
44. Once the Facility updates the Medication Administration Observation database, these data need to be formally analyzed for trends, and the information integrated into the Medication Error/Prevention Committee meetings and the Pharmacy and Therapeutics Committee meeting as appropriate.
45. AUSSLC should critically review its entire medication system, and develop and implement systems that will ensure adherence to appropriate medication administration practices.
46. The Facility should give consideration to using a medication variance system that would significantly expand the scope of the review of the Facility's medication system.
47. The Facility should provide competency-based training and on-going oversight related to Physical Nutritional Management issues to ensure that nurses and direct support professionals are consistently following safe and appropriate procedures aimed at minimizing the individuals' health risks.
48. The Nursing Department should collaborate with the PNMTs to build systems that support and integrate physical and nutritional management principles into nursing practices.

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

1. Although not required by the SA or HCG, the Facility is encouraged to implement the peer review process in alignment with the American Nurses Association definition that states: peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. Such efforts should substantially assist the Facility in meeting other requirement of the SA, as well as meeting the goal of adequate self-assessment.
2. The Facility should consider including the date staff completed the CPR refresher class on the CTD drill reports to ensure that staff received the needed skills training.
3. Given that many of the individuals at the Facility are at risk for accidents and injuries, and more individuals will be going off campus with direct support professionals, the Facility should consider adding First Aid training to the NEO and CRP classes.
4. The minutes for the Medication Error Committee should be restructured to include sections that address the identification of the issues; an analysis of the issue; plan(s) of correction, including who is responsible for implementation and expected dates of completion; anticipated outcomes; and the plan for further monitoring. This would provide focus to the meetings, and a method to document the information discussed.

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 Dyskinesia Identification System: Condensed User Scale (DISCUS) evaluations on the following individuals: Individual #442, dated 6/26/10 and 9/24/10; Individual #7, dated 6/26/10 and 9/24/10; Individual #130, dated 6/26/10 and 9/24/10; Individual #82, dated 6/26/10 and 9/24/10; Individual #146, dated 6/25/10 and 9/30/10; Individual #336, dated 6/26/10 and 9/24/10; Individual #135, dated 5/7/10 and 8/13/10; Individual #59, dated 6/29/10 and 8/13/10; Individual #204, dated 5/4/10 and 8/13/10; Individual #210, dated 7/1/10 and 9/9/10; Individual #401, dated 6/16/10 and 9/9/10; Individual #350, dated 7/8/10 and 9/16/10; Individual #199, dated 6/3/10 and 9/24/10; Individual #16, dated 6/4/10 and 9/3/10; Individual #143, dated 5/12/10 and 8/16/10; Individual #341, dated 5/12/10 and 8/16/10; Individual #43, dated 6/4/10 and 9/3/10; Individual #8, dated 5/27/10 and 8/17/10; Individual #428, dated 6/18/10 and 9/9/10; Individual #71, dated 6/26/10 and 9/9/10; Individual #23, dated 6/2/10 and 9/9/10; Individual #409, dated 6/18/10 and 9/10/10; Individual #410, dated 6/26/10 and 9/10/10; and Individual #126, dated 6/26/10 and 9/9/10; o Monitoring of Side Effects Scale (MOSES) evaluations on the following individuals: Individual #442, dated 6/26/10 and 9/24/10; Individual #7, dated 6/26/10 and 9/24/10; Individual #130, dated 6/26/10 and 9/24/10; Individual #82, dated 6/26/10 and 9/24/10; Individual #146, dated 6/25/10 and 9/30/10; Individual #336, dated 6/26/10 and 9/24/10; Individual #108, dated 6/24/10 and 9/23/10; Individual #276, dated 6/10/10 and 9/9/10; Individual #83, dated 6/15/10 and 9/16/10; Individual #210, dated 7/1/10 and 9/9/10; Individual #401, dated 6/16/10 and 9/9/10; Individual #350, dated 7/8/10 and 9/16/10; Individual #424, dated 5/24/10 and 8/12/10; Individual #175, dated 6/4/10 and 8/12/10; Individual #151, undated and 9/3/10; Individual #14, dated 6/3/10 and 9/24/10; Individual #351, dated 6/4/10 and 9/3/10; Individual #32, dated 5/17/10 and 8/12/10; Individual #404, dated 6/10/10 and 9/13/10; Individual #42, dated 6/16/10 and 9/13/10; Individual #180, dated 6/2/10 and 9/8/10; Individual #98, dated 6/26/10 and 9/10/10; Individual #154, dated 6/2/10 and 9/9/10; and Individual #271, dated 6/18/10 and 9/9/10; o Medication Administration Observation Update – Updated 05/03/10; o AUSSLC Medication Errors by Unit/Home, dated 2010; o AUSSLC Medication Errors by type of Error, dated 2010; o Medication Errors by Unit/Home – 2010; o Medication Errors by Type of Error – 2010; o Medication errors; o Documented communication between pharmacy and nursing leadership in regards to medication errors/variances and adverse drug reaction (ADR) reporting; o Email dated 8/31/10 from Donnie Lane to Priscilla Hackett;

	○ Texas Department of Aging and Disability Services: State Supported Living Centers Procedure: Medication Errors/Incidents, dated 11/09; ○ Texas Department of Aging and Disability Services: State Supported Living Centers Policy: Pharmacy Services and Safe Medication Practices: Policy #011, dated 8/31/09; ○ Drug Utilization Review (DUE): Austin State Supported Living Center: ▪ Drug Evaluated: Levothyroxine, on 11/25/09; ▪ Drug Evaluated: Clozapine, on 2/24/10; and ▪ Drug Evaluated: Clopidogrel on 2/24/10; ○ Austin State Supported Living Center Drug Utilization Evaluation Program: Dipvalproex sodium/Valproic Acid, dated October 2010; ○ Adverse Drug Reaction (ADR) Monitoring Policy and Procedure: Austin Stated Supported Living Center; ○ Quarterly Drug Regimen Reviews (QDRRs) for the following individuals: Individual #32, dated 9/30/10; Individual #220, dated 10/5/10; Individual #243, dated 10/5/10; Individual #457, dated 8/31/10; Individual #93, dated 9/7/10; Individual #253, dated 9/7/10; Individual #4, dated 9/7/10; Individual #230, dated 9/7/10; Individual #173, dated 9/7/10; Individual #352, dated 9/7/10; Individual #367, dated 9/7/10; Individual #266, dated 8/23/10; Individual #94, dated 8/23/10; Individual #364, dated 8/24/10; Individual #201, dated 8/23/10; Individual #153, dated 8/23/10; Individual #379, dated 8/23/10; Individual #308, dated 8/23/10; Individual #229, dated 8/24/10; Individual #448, dated 8/24/10; Individual #80, dated 8/24/10; Individual #337, dated 9/7/10; Individual #167, dated 7/1/10; Individual #401, dated 9/9/10; Individual #421, dated 9/9/10; Individual #278, dated 8/24/10; Individual #339, dated 8/12/10; Individual #157 9/30/10; Individual #292 9/29/10; Individual #169 9/29/10; Individual #68, dated 7/28/10; Individual #72, dated 7/27/10; Individual #105, dated 9/30/10; Individual #56, dated 9/30/10; Individual #332, dated 9/13/10; Individual #417, dated 9/30/10; and Individual #125, dated 9/15/10; ○ Notes Extracts , dated 8/6 to 10/6/10; ○ WORx "Interventions," 8/16/10-9/17/10; ○ Process for routing Chemical Restraint Consult forms (drafted 8/30/10, implemented 9/21/10); ○ Administration of Chemical Restraint Consult for the following individuals: Individual #2, dated 8/26/10; Individual #1, dated 9/21/10; Individual #77, dated 10/4/10; Individual #425, dated 8/22/10; Individual #425, dated 9/10/10; Individual #267, dated 8/18/10; Individual #19, dated 8/14/10; and Individual #210, dated 9/15/10; and ○ AUSSLC Department of Psychiatry Polypharmacy Report, minute meetings for 4/8/10, 5/13/10, 6/10/10, 7/8/10, 8/19/10, and 9/16/10. ▪ **Interviews with**: ○ Kenda Pittman, Pharm D, Pharmacy Director; and ○ Donnie Lane, Pharm D, Clinical Pharmacist.
	Facility Self-Assessment: According to the POI, the Facility's self-assessment identified noncompliance in

	all areas of Section Q of the SA. A new Director of Pharmacy and a new Clinical Pharmacist had been hired recently. They had begun to develop responses to the many areas of the SA for which they were responsible. Considerable progress had been made in most areas, including for example, DUE development, the QDRR process, and communication and documentation of intervention with physicians prior to filling orders. They had a vision for how to change their system, and they were beginning to take steps to effectuate needed modifications. They had made impressive progress in a short time period.
	Summary of Monitor's Assessment: The Pharmacy Department was at the early stages of developing processes and systems to resolve outstanding areas of concern. The QDRR has been redesigned, and, at the time of the review, was undergoing further change to streamline the process, provide important details, and address the various components of the SA. Attention to detail in completing the many parts of the QDRRs, as well as in monitoring DISCUS and MOSES evaluations, will lead to improved processes. In reviewing the different processes created, forms developed, and initial results, it was evident there was still much work to do in reaching compliance. For example, DUEs had begun to be completed, but had not entered the implementation phase. A successful Adverse Drug Reaction (ADR) program will require much training and assistance from the Pharmacy Department. There should be improved communication and collaboration with the Nursing Department in order to improve the medication error rate and the tracking system for errors/variances. A system should be created to ensure all medications administered on campus are approved and tracked through the Pharmacy Department.

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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	At the time of the review, the Pharmacy Department currently had a new Pharmacy Director. There has been an important decision made to have a peer from another SSLC mentor her. This has allowed her to assume the many duties of her multifaceted job quickly. The Clinical Pharmacist position also had been filled recently. The newly staffed Pharmacy Department already had made substantial progress toward meeting the many requirements of the SA. Through the WORx software program, each new order was reviewed for allergies, and drug reactions and interactions with the drug regimen already prescribed to the individual, as well as to ensure the dosage order was consistent with current drug dosage recommendations. Because the Avatar system contained the lab database, but was not linked to the WORx system, lab information was not readily available for review with each new order. Communication with the PCP was documented in the WORx system through an "Interventions" document. There were several entries within a date range of 8/16/10 to 9/17/10. There were six interventions recorded with subcategories documented as: dose adjustment (medication changed from TID to BID), preventing an allergic reaction	Noncompliance

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	dosage is not consistent with Facility policy or current drug literature.	(nurse notified to call PCP for new order), initiated antibiotic therapy (duplicate antibiotic therapy found and discussion with PCP documented), non-stock to stock item (medication not available and PCP notified and given therapeutic options), drug allergy notification (discussed with PCP), and drug allergy notification (PCP notified and order changed). However, in the same document, there were four other entries for patient interventions that were left blank, suggesting an intervention was made, but there was no entry into the system to document this communication. Additionally, there was one entry labeled patient ADE, which could have meant adverse drug event, but there was no entry into the system to document the communication related to this issue. It is recommended that the pharmacy ensure that communication to the PCP be documented in the WORx system, as proof of communication with the PCP, as well as compliance with this section of the SA. For six of the 11 entries (55%) of which communication with the PCP was required, there was documentation of the pharmacist contacting the PCP. Additionally, the pharmacy submitted a separate document entitled "notes extract," dated from 8/6/10 to 10/6/10, providing further information for one of the communications listed above concerning drug allergy notification. Additionally, there were five other entries highlighted documenting communication for the following: providing direction to a nurse about not crushing a Depakote tablet, proper labeling of a record and MAR and medication tray for guardian/parent refusing consent for flu vaccination, as well as three consultation requests from PCPs and psychiatry for best options on medication choices and dosages for specific individuals. These latter consultations were interventions provided prior to the prescription of a new medication. Advice to nursing and labeling of records was not communication to the PCP, although it provided valuable guidance in administration of medication and proper use of pharmacy expertise. These note entries should continue to be completed. They provide documentation of the pharmacists' advice regarding medications. As a potential next step in sharing information prior to dispensing a new antibiotic order, the pharmacy was able to receive lab results for antibiotic resistance and sensitivity for infections that had been cultured. The pharmacy had the ability to share, with the PCP, this information in guiding the choice of antibiotic to avoid resistance and failure to resolve the infection. This has significant implications for treating the population, and should be explored further by the Pharmacy Department.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as	Thirty-seven QDRRs were submitted for review (40 were submitted in response to the Monitoring Team's request, but three were found to be duplicates). There was some variation in the completion of the forms, and this might be due to attempts at creating one form to meet many objectives included in the SA. The most striking and concerning	Noncompliance

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	appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	difference from form to form, was the presence or absence of important lab results. For some of the completed forms, although there might have been a recommendation for a glucose or other test, there was no evidence the pharmacist reviewed the results available at the time of the review. Other forms had a significant amount of detailed lab results. Actual lab values, important to the medications prescribed, should be part of the data included on the form for physician review and reference, but laboratory data that would have little impact on the physician recommendations, or the pharmacist's review, should be excluded. As an example of important lab values to include in the QDRR, a number of individuals were prescribed thyroid replacement medication, yet there were many QDRRs in which there was no Thyroid Stimulating Hormone (TSH) or other thyroid tests recorded, and/or when the tests were last completed. Those tests most likely to affect a clinical decision to maintain the same dosage or change the dosage would be valuable to include in the document. For the atypical antipsychotics, it would be important to record the last glucose level, and not just recommend the testing frequency. As lipid metabolism might also be affected, it is recommended that lipid values be available, as well as glucose values, in reviewing for endocrine and metabolic effects of medications having impact on these physiologic parameters. The following 15 QDRRs out of 37 reviewed (41%) had appropriate lab values on the record, or lab values were not necessary based on the medication profile of the individual: Individual #32, dated 9/30/10; Individual #220, dated 10/5/10; Individual #243, dated 10/5/10; Individual #266, dated 8/23/10; Individual #229, dated 8/24/10; Individual #448, dated 8/24/10; Individual #339, dated 8/12/10; Individual #157, dated 9/30/10; Individual #292, dated 9/29/10; Individual #169, dated 9/29/10; Individual #105, dated 9/30/10; Individual #56, dated 9/30/10; Individual #332, dated 9/13/10; Individual #417, dated 9/30/10; and Individual #125, dated 9/15/10. The following 22 QDRRs did not list the results of relevant laboratory tests, or the Pharmacist's interpretation based on clinical review of the laboratory results and the medication regimen of the individual: ▪ For Individual #457, the QDRR dated 8/31/10, indicated she was prescribed Lovastatin, but there were no lipid profile results for review or interpretation. ▪ Individual #93's QDRR, dated 9/7/10, indicated Atorvastatin, Olanzapine, and Levothyroxine were prescribed, but there were no lab values concerning lipid profiles, or TSH for review or interpretation. ▪ Individual #253's QDRR, dated 9/7/10, indicated Ferrous sulfate and Levothyroxine were prescribed, but there were no lab values concerning a recent CBC (or other tests such as serum Fe, depending on the needs of the individual) or TSH for review or interpretation. ▪ Individual #4's QDRR, dated 9/7/10, indicated the individual was prescribed Levothyroxine, but there were no lab values concerning a TSH for review or	

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		interpretation. ▪ Individual #230's QDRR, dated 9/7/10, indicated Levothyroxine was prescribed, but there were no lab values concerning a TSH for review of interpretation. ▪ Individual #173's QDRR, dated 9/7/10, indicated Ferrous sulfate, Levothyroxine and Cholestyramine/aspartame were prescribed, but there were no lab values concerning a recent CBC (or serum Fe, etc.), lipid profile, or TSH for review or interpretation. ▪ Individual #352's QDRR, dated 9/7/10, indicated Atorvastatin was prescribed, but there were no lab values concerning a lipid panel for review or interpretation, or if outdated, none was recommended. ▪ Individual #367's QDRR, dated 9/7/10, indicated Levothyroxine and Metformin were prescribed, but there were no lab values concerning TSH or blood glucose for review or interpretation. ▪ Individual #94's QDRR, dated 8/23/10, indicated Divalproex ER was prescribed, but there were no lab values monitoring potential adverse effects (platelet count, etc.). ▪ Individual #364's QDRR, dated 8/24/10 indicated Divalproex ER was prescribed, but there were no periodic lab values monitoring potential adverse effects listed on the form. ▪ Individual #201's QDRR, dated 8/23/10, indicated Aripiprazole was prescribed, but there were no lab values monitoring for antipsychotics such as lipid levels or glucose levels. ▪ Individual #153 QDRR, dated 8/23/10 indicated Divalproex ER was prescribed, but there were no periodic lab values monitoring potential adverse effects listed on the form. ▪ Individual #379's QDRR, dated 8/23/10, indicated Atorvastatin had been prescribed, but there were no lab values concerning a lipid panel for review or interpretation. ▪ Individual #308's QDRR, dated 8/23/10, indicated Levothyroxine had been prescribed, but there were no lab values for TSH for review or interpretation. ▪ Individual #80's QDRR, dated 8/24/10, indicated Divalproex ER had been prescribed, but there were no lab values monitoring potential adverse effects listed on the form. ▪ Individual #337's QDRR, dated 9/7/10, indicated Hydrochlorothiazide had been prescribed, but there was no K level for review or interpretation. She also had a diagnosis of hypercholesterolemia and was prescribed Cholestyramine/ aspartame, but there was no lipid profile for review or interpretation. ▪ Individual #167's QDRR, dated 7/1/10, indicated Levothyroxine had been prescribed, but there was no TSH for review or interpretation. Olanzepine was prescribed, and the pharmacist indicated there was no lipid panel on the record for the past year. For the next QDRR, any results should be in the report.	

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		▪ Individual #401 was prescribed Divalproex and Paloperidone, but there were no periodic lab values monitoring potential adverse effects listed on the form. The pharmacist did recommend a fasting blood glucose (FBG) every three months. ▪ Individual #421's QDRR, dated 9/9/10, indicated Clozapine and Divalproex had been prescribed, but there were no periodic lab values monitoring potential adverse effects listed on the form (e.g., platelets, glucose, lipid profile, etc.). ▪ Individual #278's QDRR, dated 8/24/10, indicated Divalproex EC had been prescribed, but there were no periodic lab values monitoring potential adverse effects listed on the form. ▪ Individual #68's QDRR, dated 7/28/10, indicated Allopurinol had been prescribed, but there was no lab value for uric acid on the record for review or interpretation.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	A routing form was used by the pharmacy to ensure all chemical restraints were consistently documented and reviewed by the pharmacist and the psychiatrist. The Process for routing Chemical Restraint Consult forms, drafted 8/30/10, implemented 9/21/10, outlined four steps: 1) the unit or on-call psychologist completed the Chemical Restraint Consultation; 2) the original form was sent to the Director of Behavioral Services and routed to the pharmacist; 3) after the Pharmacist completed the appropriate section, it was forwarded to the psychiatrist for comment; and 4) then, it was routed to the Director of Behavioral Services, and eventually back to the unit psychologist. There were eight chemical restraint forms submitted. For five of these forms (63%), the pharmacist and psychiatrist addressed the essential aspects of evaluating the chemical restraint. The following provides a summary: ▪ Individual #2's 8/26/10 form included an entry by pharmacy discussing clinical justification and risk of the medication in combination with the daily drug regimen the individual was already taking. There was also a psychiatry comment. ▪ Individual # 1's 9/21/10 form included an entry by pharmacy reviewing clinical justification, the risk of over sedation based on medication profile, and need for monitoring. There was also a psychiatry entry. ▪ On Individual #77's 10/4/10 form, clinical justification, current medication profile, risks, and reduction of dosage were reviewed. Psychiatry also commented. ▪ Individual #425 had two events, on 8/22/10 and 9/22/10, both with pharmacy comments concerning clinical justification, review of medication profile, and risks, with a comment that the chemical restraint was not being used as a substitute for long-term treatment. Psychiatry also provided comments. ▪ There were three forms that were incomplete, with the written comment that	Noncompliance

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		they had never been received by the pharmacist or psychiatrist. These included Individual #267, dated 8/18/10; Individual #19, dated 8/14/10; and Individual #210, dated 9/15/10. It was not clear at what point in time these three chemical restraint forms were discovered as being incomplete. This is a new system, and clearly requires some monitoring and further communication between departments. This is necessary to ensure the system accomplishes the multiple goals of tracking chemical restraint usage, with focus on ensuring clinical justification; determining viability of use of alternative approaches; review of associated risks; review for drug interactions with the current medication profile of the individual; review of the history of success or non-success with prior medications and dosages if applicable; review of choice, dosage, and route of medication actually given; and review to determine that the chemical restraint was not used as a substitute for long-term treatment. For all 37 QDRRs listed above with regard to Section L.2 of the SA, all medications had a specific diagnosis listed. This ensured all medications were used in a clinically justifiable manner in monitoring for all drug classes (including benzodiazepines, anticholinergics, and in reviewing poly-pharmacy). For benzodiazepines, of the 37 QDRRs reviewed, there were only two individuals prescribed a benzodiazepine as a routine daily medication. Diastat was only prescribed as needed to stop seizure activity. These two individuals were Individual #93, QDRR, dated 9/7/10; and Individual #253, QDRR, dated 9/7/10. The others were not on a routine benzodiazepine. For two of the two records reviewed (100%), there was clinical justification provided for the use of the benzodiazepine. Anticholinergic risk and drug load were reviewed for 22 individuals in whom medication prescribed had this potential side effect. These were Individual #32, QDRR dated 9/30/10; Individual #220, QDRR dated 10/5/10; Individual #457, QDRR dated 8/31/10; Individual #93, QDRR dated 9/7/10; Individual #167, QDRR dated 7/1/10; Individual #253, QDRR dated 9/7/10; Individual #4, QDRR dated 9/7/10; Individual #230, QDRR dated 9/7/10; Individual #352, QDRR dated 9/7/10; Individual #201, QDRR dated 8/23/10; Individual #153, QDRR dated 8/23/10; Individual #80, QDRR dated 8/24/10; Individual #337, QDRR dated 9/7/10; Individual #401, QDRR dated 9/9/10; Individual #421, QDRR dated 9/9/10; Individual #292, QDRR dated 9/29/10; Individual #169 QDRR, dated 9/29/10; Individual #105, QDRR dated 9/30/10; Individual #56, QDRR dated 9/30/10; Individual #332, QDRR dated 9/13/10; Individual #417, QDRR dated 9/30/10, and Individual #125, QDRR dated 9/15/10. The other 15 individuals were not on medication necessitating a review for anticholinergic side effects. Of the 22 reviewed, all 22 (100%) had a comment about the degree of risk of anticholinergic activity.	

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		Poly-pharmacy was reviewed in the submitted QDRRs for the 37 individuals. Sixteen individuals did not have poly-pharmacy. Twenty-one individuals had poly-pharmacy from a variety of categories of medications. For all 21 (100%), there were comments and suggestions, with focus on risk. For one individual, Individual #153, the QDRR, dated 8/23/10, indicated the poly-pharmacy was for constipation, which was not accurate, and suggested a need to review of content before sending these to the physicians. In this case, the poly-pharmacy was for seizure medication, including Zonegran, Topamax, and Depakote. As a separate route for tracking poly-pharmacy, psychiatric poly-pharmacy was also reviewed through the monthly psychiatry poly-pharmacy review. Each month, the psychiatry department, with pharmacy and medical staff attendance, reviewed every individual meeting the criteria for poly-pharmacy. There were three categories of poly-pharmacy definitions, including: (A) two or more psychotropic medications from the same general class regardless of indication; (B) three or more psychotropic medications regardless of class or indication; and (A)(B) both of these categories. Also included were the total number of individuals on poly-pharmacy, and the total number of individuals receiving psychotropic medication. From the minutes of the 6/10/10 meeting, in April 2010, there were 60 individuals on poly-pharmacy, and in May 2010, there were 58 individuals on poly-pharmacy. The total number of individuals receiving psychotropic medication in March 2010 was 192, in April 2010 the number was 189, and in May 2010 the number was 188. From the meeting minutes of the 9/16/10 meeting, in June 2010, there were 53 individuals on poly-pharmacy, and in both July and August 2010 there were 50 individuals on poly-pharmacy. For the total number of individuals receiving psychotropic medication, in June 2010, the number was 186, and in both July and August 2010, the number was 184. Overall, there was a gradual decline in poly-pharmacy use through June 2010, and the reduction has leveled off. The challenge to the committee is to continue with this reduction, as clinically appropriate. Over recent months, the meeting minutes reflected increasing attention to rationale for medication reduction, in the comments section of the table distributed as part of the meeting minutes. This provided evidence of careful thought given to each medication in the drug regimen within the context of current information related to behaviors and signs and symptoms of mental health diagnoses. The 37 QDRRs were reviewed for indications of tracking metabolic and endocrine effects of atypical/new generation antipsychotic medication. Eleven of the 37 individuals were prescribed this drug category. Six QDRRs were in compliance out of eleven QDRRs. This	

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		was a compliance rate of 55%. Indicators used to determine if the pharmacy reviewed the tracking for metabolic and endocrine effects included lab values that tested for glucose intolerance (fasting blood glucose, Hgb A-1-C, etc.) and lipid abnormalities (lipid panel). Those individuals who were prescribed atypical/new generation antipsychotic medication and included these lab values as evidence of monitoring included: Individual #32, QDRR dated 9/30/10; Individual #220, QDRR dated 10/5/10; Individual #292, QDRR dated 9/29/10; Individual #105, QDRR dated 9/30/10; Individual #56, QDRR dated 9/30/10; and Individual #417, QDRR dated 9/30/10. Those on atypical antipsychotic medication for which appropriate lab values were not listed for monitoring included: ▪ Individual #93's QDRR dated 9/7/10; Individual #167's QDRR, dated 7/1/10; and Individual #401's QDRR, dated 9/9/10, included recommendations for FBGs every three months, but there were no values from prior testing, nor any lipid testing results available on the QDRRs. ▪ Individual #201's QDRR, dated 8/23/10; and Individual #421's QDRR, dated 9/9/10, included no information regarding such testing.	
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.	The QDRRs also were used as a vehicle for pharmacy recommendations to be provided to and reviewed by the PCP, with entries made regarding the PCPs agreement with the recommendation, or, if the PCP disagreed, documentation of the PCP's rationale. The following QDRRs had recommendations for which there was agreement by the PCP: Individual #4, dated 9/7/10; Individual #230, dated 9/7/10; Individual #173, dated 9/7/10; Individual #352, dated 9/7/10; Individual #367, dated 9/7/10; Individual #364, dated 8/24/10; Individual #448, dated 8/24/10; Individual #80, dated 8/24/10; Individual #421, dated 9/9/10; Individual #278, dated 8/24/10; Individual #169, dated 9/29/10; Individual #68, dated 7/28/10; Individual #72, dated 7/27/10, and Individual #417, dated 9/30/10. The following QDRRs had no recommendations: Individual #32, dated 9/30/10; Individual #339, dated 8/12/10; Individual #169, dated 9/29/10; Individual #105, dated 9/30/10; Individual #292, dated 9/29/10; Individual #157, dated 9/30/10; Individual #229, dated 8/24/10; Individual #308, dated 8/23/10; Individual #379, dated 8/23/10; Individual #153, dated 8/23/10; Individual #94, dated 8/23/10; Individual #266, dated 8/23/10; Individual #457, dated 8/31/10; and Individual #220, dated 10/5/10. QDRRs in which the PCP agreed with some of the recommendations included: Individual #93, dated 9/7/10; Individual #253, dated 9/7/10; Individual #337, dated 9/7/10; Individual #167, dated 7/1/10; Individual #401, dated 9/9/10; Individual #332, dated	Noncompliance

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		9/13/10; and Individual #125, dated 9/15/10. When the PCP agreed with a recommendation, evidence that the recommendation was carried out was requested. Pharmacy entries of orders/lab results reflecting completion of one or more of the recommendations were provided for the following QDRRs: Individual #4, dated 9/7/10; Individual #230, dated 9/7/10; Individual #173, dated 9/7/10; Individual #352, dated 9/7/10; Individual #367, dated 9/7/10; Individual #364, dated 8/24/10; Individual #448, dated 8/24/10; Individual #80, dated 8/24/10; Individual #421, dated 9/9/10; Individual #278, dated 8/24/10; Individual #72, dated 7/27/10; Individual #93, dated 9/7/10; Individual #253, dated 9/7/10; Individual #337, dated 9/7/10; Individual #332, dated 9/13/10; and Individual #125, dated 9/15/10. This information should be obtained for each recommendation, as applicable, to ensure that the necessary action is taken to modify the treatment provided to the individuals. The issues that are not addressed should be communicated to the Medical Director for follow-up, and/or discussed at a medical staff meeting. For some QDRRs, there was disagreement in one or more of the recommendations. The following QDRRs included the PCPs written rationale documenting disagreement with recommendation(s): Individual #93, dated 9/7/10, Individual #253, dated 9/7/10, Individual #201, dated 8/23/10, Individual #337, dated 9/7/10, Individual #167, dated 7/1/10, Individual #401, dated 9/9/10, Individual #332, dated 9/13/10, and Individual #125, dated 9/15/10. For some QDRRs, there was disagreement with one or more recommendations, but the PCP had not documented a rationale. These included: Individual #167, dated 7/1/10; Individual #401, dated 9/9/10; Individual #332, dated 9/13/10; and Individual #243, dated 10/5/10. Fourteen out of 37 QDRRs had no recommendations. For the remaining 23 QDRRs, 19 (83%) were compliant with recommendations or justification when there was disagreement.	
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.	DISCUS rating instruments for individuals requiring monitoring for dyskinesia were submitted for review. The DISCUS forms were reviewed for completeness and timeliness, and compared to the last completed form. DISCUS ratings were submitted for the following individuals, with the dates of the two most recent dates of rating and dates of review by prescriber: Individual #442, rated on 6/26/10 with prescriber review on 6/29/10, rated on 9/24/10, with prescriber review on 9/29/10; Individual #7, rated on 6/26/10 with prescriber review on 6/29/10, rated on 9/24/10 with prescriber review on 9/29/10; Individual #130, rated on 6/26/10 with prescriber review on 6/29/10, rated on 9/24/10 with prescriber review on 9/29/10; Individual #82, rated on 6/26/10	Noncompliance

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		with prescriber review on 6/29/10, rated on 9/24/10 with prescriber review on 9/29/10; Individual #146, rated on 6/25/10 with prescriber review on 6/29/10, rated on 9/30/10 with no prescriber review; Individual #336, rated on 6/26/10 with prescriber review on 6/29/10, rated on 9/24/10 with prescriber review on 9/29/10; Individual #135, rated on 5/7/10 with prescriber review 5/27/10, rated on 8/13/10 with prescriber review on 8/19/10; Individual #59, rated on 6/29/10 with prescriber review on 7/2/10, rated on 8/13/10 with prescriber review on 8/19/10, Individual #204, rated on 5/4/10 with prescriber review on 5/4/10, rated on 8/13/10 with prescriber review on 8/19/10; Individual #210, rated on 7/1/10 with prescriber review on 8/12/10, rated on 9/9/10 with prescriber review on 9/30/10; Individual #401, rated on 6/16/10 with prescriber review 7/1/10, rated 9/9/10 with prescriber review 9/30/10; Individual #350, rated on 7/8/10 with prescriber review 8/12/10, rated on 9/16/10 with prescriber review on 9/30/10; Individual #199, rated on 6/3/10 with prescriber review on 6/8/10, rated on 9/24/10 with prescriber review on 9/29/10; Individual #16, rated on 6/4/10 with prescriber review on 6/8/10, rated on 9/3/10 with prescriber review on 9/29/10; Individual #143, rated on 5/12/10 with prescriber review on 5/27/10, rated on 8/16/10 with prescriber review on 9/13/10; Individual #341, rated on 5/12/10 with prescriber review on 6/8/10, rated 8/16/10 with prescriber review on 9/16/10; Individual #43, rated on 6/4/10 with prescriber review on 6/8/10, rated on 9/3/10 with prescriber review on 9/29/10; Individual #8, rated 5/27/10 with prescriber review on 5/27/10, rated on 8/17/10 with prescriber review on 9/13/10; Individual #428, rated on 6/18/10 with prescriber review on 6/24/10, rated on 9/9/10 with prescriber review on 9/10/10; Individual #71, rated on 6/26/10 with prescriber review on 6/29/10, rated on 9/9/10 with prescriber review on 9/16/10; Individual #23, rated on 6/2/10 with prescriber review on 6/2/10, rated on 9/9/10 with prescriber review on 9/16/10; Individual #409, rated on 6/18/10 with prescriber review on 6/29/10, rated on 9/10/10 with prescriber review on 9/16/10; Individual #410, rated on 6/26/10 with prescriber review on 7/1/10, rated on 9/10/10 with prescriber review on 9/16/10; and Individual #126, rated on 6/26/10 with prescriber review on 6/29/10, rated on 9/9/10 with prescriber review on 9/16/10. There were a number of irregularities noted with the completion of the DISCUS evaluations. Specifically: ▪ For one individual, Individual #146, dated 9/30/10, there was no prescriber signature. ▪ Additionally, for 13 of the DISCUS forms completed out of 48 forms reviewed (27%), there was more than a 14-day gap between the rater evaluation and the prescriber review. The longest gap was 42 days. The prescriber should review the ratings in a timely manner, as side effect profiles can change, and it would also keep the prescriber reviews within an approximate 90-day window at each review. For purposes of this review, a 14-day window was chosen. The Facility	

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		should create a policy identifying an acceptable time period in which the DISCUS scores should be reviewed. Compliance with DISCUS scoring was 71% (34/48), with focus of this review on review by the prescriber within 14 days of the rater evaluation. Additionally, a review of the tracking system might be needed. For one individual, Individual #59, although the DISCUS form indicated a frequency rating of every three months, the two forms reviewed were only six weeks apart, placing an extra burden on the individual to cooperate, and resulting in an inefficient use of time for the rater and prescriber. MOSES rating instruments for individuals requiring monitoring for side effects associated with certain drug categories (psychopharmacologic, etc.) were submitted for review. The MOSES forms were reviewed for completeness and timeliness compared to the last completed form. MOSES ratings were submitted for the following individuals with the dates of the two most recent dates of examination and dates of review by prescriber: Individual #442, examination date of 6/26/10 and prescriber review on 6/29/10, examination date of 9/24/10 and prescriber review on 9/29/10; Individual #7, examination date of 6/26/10 and prescriber review on 6/29/10, examination date of 9/24/10 and prescriber review on 9/29/10; Individual #130, examination date of 6/26/10 and prescriber review on 6/29/10, examination date of 9/24/10 and prescriber review on 9/29/10; Individual #82, examination date of 6/26/10 and prescriber review on 6/29/10, examination date of 9/24/10 and prescriber review on 9/29/10; Individual #146, examination date of 6/25/10 and prescriber review on 6/29/10, examination date of 9/30/10 and no evidence of prescriber review; Individual #336, examination date of 6/26/10 and prescriber review on 6/29/10, examination date of 9/24/10 and prescriber review on 9/29/10; Individual #108, examination date of 6/24/10 and prescriber review of 7/1/10, examination date of 9/23/10 and prescriber review of 9/30/10; Individual #276, examination date of 6/10/10 and prescriber review on 7/1/10, examination date of 9/9/10 and prescriber review on 9/30/10; Individual #83, examination date of 6/15/10 and prescriber review on 7/1/10, examination date of 9/16/10 and prescriber review on 9/30/10; Individual #210, examination date of 7/1/10 and prescriber review on 8/12/10, examination date of 9/9/10 and prescriber review on 9/30/10; Individual #401, examination date of 6/16/10 and prescriber review on 7/1/10, examination date of 9/9/10 and prescriber review on 9/30/10; Individual #350, examination date of 7/8/10 and prescriber review of 8/12/10, examination date of 9/16/10 and prescriber review of 9/30/10; Individual #424, examination date of 5/24/10 and prescriber review of 5/27/10, examination date of 8/12/10 and prescriber review of 8/18/10; Individual #175, examination date of 6/4/10 and prescriber review on 6/8/10, examination date of 8/12/10 and prescriber review on 8/18/10; Individual #151, examination undated and prescriber review undated, examination date of 9/3/10 and prescriber review on 9/29/10; Individual #14,	

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		examination date of 6/3/10 and prescriber review on 6/8/10, examination date of 9/24/10 and prescriber review on 9/29/10; Individual #351, examination date of 6/4/10 and prescriber review on 6/8/10, examination date of 9/3/10 and prescriber review on 9/29/10; Individual #32, examination date of 5/17/10 and prescriber review on 6/1/10, examination date of 8/15/10 and prescriber review on 8/17/10; Individual #404, examination date of 6/10/10 and prescriber review on 6/11/10, examination date of 9/13/10 and prescriber review of 9/14/10; Individual #42, examination date of 6/16/10 and prescriber review of 6/16/10, examination date of 9/13/10 and prescriber review on 9/14/10; Individual #180, examination date of 6/2/10 and prescriber review on 6/2/10, examination date of 9/8/10 and prescriber review on 9/9/10; Individual #98, examination date of 6/26/10 and prescriber review on 7/1/10, examination date of 9/10/10 and prescriber review on 9/16/10; Individual #154, examination date of 6/2/10 and prescriber review on 6/2/10, examination date of 9/9/10, and prescriber review on 9/13/10; and Individual #271, examination date of 6/18/10 and prescriber review on 6/29/10, examination date of 9/9/10 and prescriber review on 9/16/10. There were a few irregularities noted with the MOSES. Specifically: ▪ For Individual #146, dated 9/30/10, there was no prescriber review. ▪ For Individual #151, there was a form submitted that had no rater or prescriber review signatures, and probably was completed for the June 2010 three-month review. ▪ Additionally, for 11 MOSES ratings, the prescriber review occurred more than 14 days after the rating was completed. Timeliness is important in reviewing these scores. Any findings of concern should be promptly noted, and if necessary, a change in medication or dosage should be ordered in a timely manner. Delays in review could result in unnecessary delays in medication change. For the MOSES forms reviewed, the longest delay in prescriber review, from the date of rating, was 42 days. For compliance reflecting efficient and timely review of the MOSES forms, a 14-day window was chosen. Compliance was 73% for timeliness of prescriber review within 14 days of the rater evaluation. The QDRR was also used as a monitoring tool for timely completion of DISCUS and MOSES instruments. The SA and the pharmacy manual indicated a quarterly review (or more frequently as indicated) is expected. The HCG recommends a quarterly DISCUS and a MOSES every six months. Since the pharmacy was monitoring the completion of these tools for side effects of psychotropics, the standard of care set in the pharmacy manual, as well as the SA requirements, was used as the expectation for this review. The following QDRRs met the compliance threshold of the SA and the pharmacy manual:	

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		▪ Individual #32's QDRR, dated 9/30/10, had a DISCUS recorded as completed in 5/17/10 and 8/12/10. The MOSES was completed 5/17/10 and 8/12/10. ▪ Individual #243's QDRR, dated 10/5/10, had a MOSES 6/25/10 and 7/19/10, and there was no indication for the DISCUS. ▪ Individual #253's QDRR indicated a DISCUS on 8/13/10 (there was no current use of an antipsychotic with this individual) ▪ On Individual #157's QDRR, dated 9/30/10, no DISCUS (recorded as not indicated by current medications), and MOSES on 2/25/10 and 8/25/10. ▪ Individual #292's QDRR, dated 9/29/10, listed a DISCUS on 6/29/10 and 8/30/10, and MOSES 6/29/10 and 8/30/10. ▪ Individual #169's QDRR, dated 9/29/10, listed a DISCUS on 5/21/10 and 7/29/10, and MOSES on 5/21/10 and 7/29/10. The pharmacy review included monitoring by DISCUS and MOSES at quarterly intervals, and recommended improvements to meet the SA requirements in the following QDRR reviews: ▪ Individual #401's QDRR, dated 9/9/10, DISCUS recorded as 3/18/10 and MOSES as 12/22/09, with recommendation "ensure that MOSES and DISCUS are performed on a minimum quarterly basis;" ▪ Individual #421's QDRR, dated 9/9/10, DISCUS 4/1/10, MOSES 11/11/09 with recommendation "ensure that MOSES and DISCUS are performed on a minimum quarterly basis." The following QDRRs did not reflect compliance and were not followed by a pharmacy comment or recommendation: ▪ Individual #220's QDRR, dated 10/5/10 had a DISCUS recorded for 5/12/10 and 7/7/10. The MOSES was completed on 2/12/10 and 7/7/10. There were approximately five months between MOSES ratings, but no comment from the pharmacist. ▪ Individual #93's QDRR, dated 9/7/10, had a DISCUS recorded for 8/13/10. There was no prior date of DISCUS or MOSES completion to suggest pharmacy tracked these evaluations despite the fact that the individual was taking Olanzapine. ▪ Individual #201's QDRR, dated 8/23/10, only listed DISCUS on 7/16/10, and no prior value nor any MOSES despite the administration of Aripiprazole. ▪ Individual #167's QDRR, dated 7/1/10, only listed DISCUS on 4/15/10, and no prior DISCUS or any MOSES scores, despite being prescribed Olanzapine, ▪ Individual #105's QDRR, dated 9/30/10, listed DISCUS on 5/31/10 and 9/16/10 (more than 90 days/3months), and MOSES on 5/31/10 and 9/16/10 (more than 90 days/3 months) ▪ Individual #56's QDRR, dated 9/30/10, listed DISCUS on 5/31/10 and 9/16/10	

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		(more than 90 days/ 3 months), and MOSES on 5/31/10 and 9/16/10 (more than 90 days/3 months). ▪ Individual #417's QDRR, dated 9/30/10, listed DISCUS on 3/5/10 and 6/29/10 (more than 90 days/3 months), and MOSES 12/7/09 and 6/29/10 (more than 90 days/ 3 months). With regard to monitoring, six QDRRs were in compliance, with two additional records showing monitoring with appropriate recommendations. This resulted in a total of eight out of 15 being compliant (53%).	
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.	The pharmacy had a policy for adverse drug reaction monitoring, entitled "Adverse Drug Reaction (ADR) Monitoring Policy and Procedure, Austin State Supported Living Center." The pharmacy also used the U.S. Department of Health and Human Services (USDHHS) MedWatch program [the Food and Drug Administration (FDA) Safety Information Adverse Event Reporting Program], and used the MedWatch form for voluntary reporting of adverse events, product problems, and product use errors. There were no reports of adverse drug reactions submitted. The Clinical Pharmacist emailed nursing administration on 8/31/10, requesting copies of any and all adverse drug reaction reports completed in the prior six months. According to the previous Director of Pharmacy, the nursing staff completed the ADR reports and copies were to be sent to the Clinical Pharmacist. However, this has not occurred since the new Clinical Pharmacist started working at AUSSLC. At the time of the review, there had been no response from nursing. The current system did not appear to be functioning. It is recommended that one of the priorities for pharmacy be to increase communication with the Nursing Department to create and implement a process for ADR reporting and tracking. Additionally, the Director of Pharmacy and the Clinical Pharmacist were both unaware of other areas of the campus utilizing medications. A physiatrist had a clinic on campus, and Botox injections were given. The Habilitation Therapies had commented that there were two adverse reactions to Botox, given for treatment of sialorrhea, but as a side effect or adverse effect created dysphagia. Neither of these was reported to the pharmacy to determine if they met criteria for reporting as an adverse reaction. Additionally, the Director of Pharmacy and the Clinical Pharmacist were not aware that IV sedation was given in the Dental Department. Although there were no reports of adverse reactions, the pharmacy should be aware of all departments and programs on campus that use medications, as they are responsible for monitoring and reporting adverse drug reactions. It is recommended that they meet with each of the clinical departments to determine	Noncompliance

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		what medications are administered, and by what professional. Additionally, the pharmacy should create a monitoring system to ensure any potential adverse reactions are reported in a timely manner. Clinical departments using medications should provide a log of activity and use to the pharmacy on a routine basis (daily, weekly, monthly, etc.), depending on the medication and frequency of use/application.	
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.	Three drug utilization evaluations were submitted for review. A DUE evaluation was completed on November 25, 2009, for Levothyroxine use from the period of 10/1/09 to 11/12/09. Medication profiles were reviewed to determine concomitant use of calcium or iron containing preparations and antacids, and to verify administration times. Eighty-eight individuals were identified as receiving Levothyroxine during this time, and 79 individuals received calcium or iron containing products or scheduled antacid preparations. The percentage of individuals receiving Levothyroxine, separated by four hours from calcium or iron containing products, or scheduled antacid preparations, was 27.8 percent. This information was to be shared with the medical staff, and the recommendation was that Levothyroxine should be administered at least four hours apart from antacids, calcium supplements, and iron containing preparations. Also, monitoring of thyroid function tests was recommended. There was no follow-up monitoring submitted to suggest that any of this valuable information was acted upon to improve the care at AUSSLC. A program of DUE development and implementation also requires evaluation and action steps based on findings.. Each DUE should have a corrective action plan, with due dates in the following calendar quarter, and ongoing results reported to the medical staff. On 2/24/10, a drug utilization evaluation was completed for Clozapine. Nine individuals were identified as being prescribed Clozapine, and the study reviewed the monthly or every two-week requirement of white blood cell count and absolute neutrophil count completed. There was 100 percent compliance. The recommendation was that this was a baseline DUE. Additional recommendations concerning Clozapine had little to do with the study results of blood counts. As is explained further below, the review included review of basal metabolic index, fasting plasma glucose, hemoglobin A-1-C, and lipid screening. These were not reported further in the study, but a recommendation included discussion that atypical antipsychotics were associated with significant weight gain, and that fasting plasma glucose levels or hemoglobin A-1-C, and lipid panel screenings were indicated more frequently for those receiving Clozapine, and who meet or exceed the risk criteria for metabolic syndrome. However, this drug utilization evaluation reflected two separate issues. The tracking of blood counts was one area. This was problematic as a topic for a DUE, because the standard of care nationally is that medication refills for Clozapine are not	Noncompliance

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		dispensed by the pharmacy until the lab testing for hematological parameters is received, and the parameters are within an agreed upon acceptable range. This should not require a DUE, and there should have been ongoing information available in the pharmacy before Clozapine was dispensed. Separately, the relationship between metabolic syndrome and Clozapine is an important one. There was an initial data review concerning measurable tools (fasting blood glucose, lipid levels, etc.), but this did not then proceed into review of the data and recommendations at AUSSLC. Further, this was considered a baseline DUE for Clozapine. The pharmacy had not followed up with further review or action. The impact of Clozapine on lipid levels and fasting blood glucose would be an important DUE as a next step. On 2/24/10, a DUE was completed on Clopidogrel, and the drug interaction with proton pump inhibitors. Specifically, Omeprazole decreased the anti-platelet effect of Clopidogrel. Four individuals were identified as taking Clopidogrel and none were on Omeprazole, although one individual was prescribed a different proton pump inhibitor. The recommendation was that the combination of Clopidogrel and proton pump inhibitors should be avoided, with consideration for use in high-risk individuals. There was no additional follow-up of this study to determine if those on Clopidogrel continued not to be prescribed proton pump inhibitors, or that use was limited to high-risk individuals. More problematic was that DUEs should focus on medications prescribed to a greater number of individuals. It is suggested that the pharmacy determine the 25 most commonly prescribed medications, and begin to develop DUE programs for some of these medications. The impact on the individuals at AUSSLC will be far greater than selecting medications that are only used with a few individuals. Considering the small number of individuals on Clopidogrel, follow-up on this study would be relatively easy, but would not have much impact, due to the small cluster of individuals living at AUSSLC who are prescribed this medication. The pharmacy should focus its energy and attention on medications commonly prescribed at AUSSLC. Guidance was provided in the Pharmacy Policy #011, dated 8/31/09, and outlined medications that should be given priority in the DUE process. An additional DUE was "currently in the process of being completed." It had not been through the Pharmacy and Therapeutics (P&T) Committee at the time of Monitoring Team's review. Divalproex sodium/valproic acid was chosen as the medication to be reviewed. The purpose was wide-ranging, and included: evaluation of indications for use, presence of absolute or relative contraindications, presence of significant drug-drug interactions, development of treatment of emergent adverse events, and appropriateness	

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		of monitoring. Data collection was to be extensive, and a work sheet had been developed. Twenty residents were to be reviewed. This was a highly ambitious study, and was actually several DUEs wrapped into one study. It likely should be reduced greatly, and should focus on just one or two areas related to this medication. Additionally, given that this medication was commonly prescribed, it was not clear why 20 individuals were considered as the sample to be reviewed. It is recommended that the size of the study be increased to a substantial percentage of those taking this medication, but that the number of parameters being studied be reduced greatly. The parameters not reviewed initially could be used as additional DUEs in the future. No calendar of future DUEs for the next four quarters was submitted.	
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.	Policies in the Pharmacy Department that provide direction for medication errors and medication variances include: Texas Department of Aging and Disability Services: State Supported Living Centers Policy: Pharmacy Services and Safe Medication Practices, Policy Number 011, dated 8/31/09; and Texas Department of Aging and Disability Services State Supported Living Centers Procedure: Medication errors/Incidents, dated November 2009. As part of surveillance, the Pharmacy Department completed a monthly inspection of all medication rooms. The MAR was reviewed, and the visits were unannounced. Three tables of information were provided concerning medication variances/errors. One was entitled "Medication Errors by Type of Error - 2010." Data entry began in August 2010, and only two months had been entered. A second table labeled "Medication Errors" listed monthly data from 4/1/10 onward. Unfortunately, the two tables did not agree, so the accuracy of information is questionable. For August 2010, the first table mentioned 28 errors of omission, and the second table documented three errors of omission. For the wrong individual, the first table documented six errors, and the second table documented one error. For the wrong time, the first document indicated 17 errors, and the second table indicates no errors. The second table did not list dispensing errors. The first table documented dispensing errors in August 2010 as 29 errors, and in September 2010, the entry was 16 errors. Pharmacy should develop corrective actions to ensure that dispensing errors do not occur. There were a number of checks in place, so this should not occur. Further, pharmacy was only receiving information on medication errors that were	Noncompliance

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		considered dispensing errors. They were not receiving information from the Nursing Department regarding all types of errors, although their role was to monitor all medication errors. The pharmacy cannot generate accurate reports, or begin to introduce systems improvements, without complete information. It is recommended that the pharmacy review the two tables mentioned above, to determine the reason(s) for the discrepancies. Generating one table, with complete and accurate information, is recommended to reduce confusion and ensure everyone is reading the same information. Additionally, there was a table submitted entitled "Medication Errors by Unit/Home – 2010." From the third quarter, which was the only quarter with information entered, there was great variation in the number of errors reported. The number of medication errors per residence ranged from one to 123. Pharmacy, in conjunction with the Nursing Department, should review this information to determine the reason(s) for these errors and the variations in reporting, and begin to develop actions to address issues identified. Additionally, there were two tables submitted entitled "AUSSLC Medication Errors by type of Error 2010," which displayed data per month, and "AUSSLC Medication Errors by Unit/Home 2010," which displayed data per quarter. Unfortunately, this was difficult to read, as the bars were in shades of gray (probably in color in the original graph). From the "Medication Errors by type of error" record, it appeared there was no data from the first half of the year, and from the "Medication Errors by Unit/Home" record, only one residence reported data from the second quarter. The "Medication Errors by type of Error" record did demonstrate the main types of medication errors: omission errors, wrong time, MAR not initialed, and dispensing error. The "Medication Errors by Unit/Home" did indicate that seven residences had the most errors: Castner 732-M, Castner 779-H, Castner 732-D, SR 791, SR 792, SR 795, and WH 787. This should provide focus for both the Nursing and Pharmacy Departments in resolving and preventing medication errors. Another working document that provided valuable information in steps to resolve medication errors was entitled "Medication Administration Observation Update – Updated 05/03/10." This several page document listed the observations monitored at each medication pass, and included information such as: date, time, unit, residence, name of nurse, full-time staff, agency staff, problem identified, recommendation, corrective action plan, and date Corrective Action Plan completed. Several valuable entries were recorded, on 2/10/10, an RNII recorded "immediate teaching was done," and "verbalized P&P to RN." For two of the three problems identified at that medication pass, "correction was done at the time of med observation." However, some documented concerns that could readily have been resolved, but which	

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		had no further information, such as date CAP completed, included the following: "MAR does not have current resident photos, NOO working on updating photos," "residential staff not assisting during medication administration," "med cart does not lock," "Missing picture and swallowing and feeding instructions," "many liquids do not have date opened or initials," "meds not administered within 59 minute time frame," "no SAMs (Self-Administration of Medication) programs performed," "O2 only checked twice this month per daily O2 check sheet" [date of observation 4/14/10], "suction machine missing tubing," 'juice pitcher is dirty," "not enough light in med room," "not all meds brought from residence – very time consuming to replace from pharmacy," and "RN did not know how to test O2 tank." Many of these did not have a date of completion. This document, although providing much information, was from 5/3/10. No further information was provided by the Pharmacy since that date to indicate the number, or quality of medication pass reviews, their findings, nor their steps taken to resolve the problems identified. This may reflect the current difficulty that the Pharmacy Department has had in obtaining medication error information and medication pass information from the Nursing Department. It is recommended that there be dedicated time set aside for the Director of Pharmacy to meet with the Director of Nursing on a routine basis to review medication error data and reports. According to the SA, the Pharmacy Department has significant responsibility to ensure regular documentation, reporting, analysis, and ongoing follow up, until resolution of medication errors and variances, both actual, and potential. This also is outlined as a responsibility for nursing in Section M of the SA. Compliance will not occur if there is not a close working relationship between the two departments.	

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

1. The Pharmacy Department should ensure communication with the PCP is documented in the WORx system as proof of communication with the PCP.
2. Actual lab values important to the medications prescribed should be part of the data included on the form for physician review and reference. However, laboratory data that would have little impact on the physician recommendations or the pharmacist's review should be excluded. For example:
    a. For individuals on thyroid replacement, lab values for TSH or other thyroid profile tests would be important to document.
    b. For the atypical antipsychotics, the actual last glucose value would be helpful to the PCP, as well as lipid panel results.
3. In the QDRR, there should be evidence of pharmacy analysis of lab results, including listing test results, and documented interpretation as to whether the results are within normal limits, or low, or high.
4. When monitoring for adverse drug effects or serious side effects, serial lab values with dates should be provided in order to ensure there are no trends suggesting negative impact (elevated liver enzymes, etc.)
5. For lipid lowering agents, serial lipid panel results should be included (if available) and be part of the document to determine the impact of the medication.

6. The process for completion of the Chemical Restraint Consult form should be reviewed to determine the reasons for the successful documentation when it occurred, but also determine the reasons that the established procedure did not work. Increased cooperation and communication between departments, and increased monitoring for completion and effectiveness, will be essential to make the program successful.
7. To reduce inaccuracies, the content of the QDRR should be reviewed before sending the completed reports to the physicians.
8. For proof that the PCP agrees with a pharmacy recommendation, there should be a meaningful response through orders and lab testing, which should be documented in the medical record. The pharmacy should collect evidence of such orders and tests to ensure that the pharmacy recommendations have been implemented.
9. Recommendations that remain unaddressed should be communicated, in writing, to the Medical Director and/or discussed at a medical staff meeting.
10. Rationale for PCPs disagreement with the Pharmacist's recommendations should be documented on the QDRR or in the Integrated Progress Notes.
11. The prescribers should review DISCUS and MOSES ratings in a timely manner, as side effect profiles can change, and the prescriber review should occur within an approximate 90-day window of each previous review. The Medical Director should create a policy defining the acceptable time period for a prescriber to review the rater evaluations
12. A campus-wide tracking system should be developed to ensure timely completion of rating evaluations and prescriber reviews.
13. The Pharmacy Department should work with the Nursing Department to create and implement a process for ADR reporting and tracking.
14. There should be training of direct support professionals and nursing staff concerning the definition of an ADR, and signs and symptoms for which they should be alert, and which they should report.
15. The Pharmacy Department should create a campus-wide system, in which every medication that is administered is reviewed by the Pharmacy Department before being used. The Pharmacy also should also be responsible for creating a database of these medications, including the individual involved, the medication given, dosage, route, etc. and effect, as well as diagnosis for which it is prescribed.
16. Clinical departments using/administering medications should provide a log of activity to the pharmacy on a routine basis depending on the medication and frequency of use/application.
17. Each DUE should have a corrective action plan, with due dates in the following calendar quarter, and ongoing results reported to the medical staff as a continuous improvement mechanism.
18. The Pharmacy Department should take the next step and create a DUE program concerning the metabolic impact of Clozapine.
19. As outlined in the Pharmacy Policy #009, DUEs should be selected and completed for medications that are prescribed to many individuals at AUSSLC. The Pharmacy Department should determine the 25 most commonly prescribed medications and begin to develop DUE program based on some of these medications in order to have a wider impact on the population residing at AUSSLC.
20. The DUEs should review a greater number of records, with fewer questions, in order to have more valid results, and focus on specific areas of concern.
21. The Pharmacy Department should create a calendar for the next four quarters for DUE programs.
22. Dispensing errors should be reviewed intensively, and systems approaches developed and implemented to prevent such errors from occurring. Internal corrective action reports should reflect the depth of research, the findings, and the systems change that was implemented, as well as a monitoring process to determine effectiveness.
23. The Pharmacy Department should be provided information on all medication errors and variances in order to compile a complete, accurate, and timely database. The Pharmacy Department should meet on an ongoing basis with the Nursing Department to resolve this issue of database management, as well as create a collaborative effort in reducing and eliminating medication errors.
24. The Pharmacy Department should review current tables and records related to medication errors/variances to determine accuracy and resolve any apparent discrepancies in the information.
25. The Pharmacy Department, in conjunction with the Nursing Department, should focus attention on the residences, and other areas of campus,

with the most medication errors based on current data, with demonstrable initiatives taken to reduce the rate of errors.

26. The many problems identified on the 5/3/10 "Medication Administration Observation Update" document should be pursued to closure, with written documentation of progress until closure.

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

1. The Pharmacy Department should review and keep current data on antibiotic resistance, and share this information with the PCP when a new antibiotic order is written, in order to maximize success in treatment and avoid potential problems of inadequate response to infections that might demonstrate resistance.
2. To ensure documentation of breadth of services, the "notes extract" section should continue to be completed. For those that provide more information concerning a "single patient intervention" entry, notation that this extract note exists or providing it as an attachment to the communication log system, would add value.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section O; o The following documents: Occupational Therapy (OT)/ Physical Therapy (PT)/Speech Language Pathology (SLP) Assessments, PNMT Comprehensive Assessment, Nursing Care Plan, OT/PT/SLP consultations for the last year, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan (PNMP) with pictures, Nutritional Management Team (NMT) Individual Record with recommendations, PNMP person-specific monitoring for the past year, PNMP Clinic Notes, competency-based training for staff for PNMPs, and dining plan for the following individuals: Individual #39, Individual #182, Individual #426, Individual #452, Individual #327, Individual #74, Individual #54, Individual #372, Individual #159, Individual #355, Individual #413, Individual #422, Individual #50, and Individual #435; o The following documents: Occupational Therapy/ Physical Therapy/Speech Language Pathology Assessments, PNMT Comprehensive Assessment, Nursing Care Plan, OT/PT/SLP consultations for the last year, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan with pictures, Nutritional Management Team Individual Record with recommendations, PNMP person-specific monitoring for the past year, PNMP Clinic Notes, competency-based training for staff for PNMPs, and dining plan for the following individuals: Individual #344, Individual #199, Individual #403, Individual #251, Individual #416, Individual #42, and Individual #331; o The following documents: Occupational Therapy/ Physical Therapy/Speech Language Pathology Assessments, OT/PT/SLP consultations for the last year, Nutrition Assessment, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan with pictures, and pleasure/therapeutic feeding program/plan for the following individuals: Individual #50, Individual #456, Individual #107, Individual #34, Individual #310, Individual #189, Individual #286, Individual #121, and Individual #22; o The following documents: Occupational Therapy/ Physical Therapy/Speech Language Pathology Assessments, OT/PT/SLP consultations for the last year, NMT Individual Record, PNMP with pictures and dining plan for the following individuals: Individual #44, Individual #27, and Individual #136; o PNMPs and dining plans for the following individuals: Individual #115, Individual #453, Individual #356, Individual #319, Individual #2, Individual #79, Individual #147, Individual #323, Individual #113, Individual #398, Individual #22, Individual #182, Individual #448, Individual #396, Individual #50, Individual #72, Individual #251, Individual #92, Individual #100, and Individual #115; o Budgeted Positions versus Actually Filled/Staffed, dated 8/28/10; o Schedule for Ongoing In-Service Staff Training, from 4/10 through 9/10;

	o Risk Assessment and Management Systems (draft), dated 9/10; o PNMT Evaluations for Multiple Individuals, from 8/10 and 9/10; o PNMT Management Core Team Training (draft), undated; o Monitoring Tools Utilized by QE Department, revised 8/9/10; o Unusual Incident Log, FY 2010; o Risk Factors for Multiple Individuals, from 10/09 through 8/10; o List of Pneumonia Counts, from 1/10 through 8/10; o List of Individuals Admitted to Hospital, from 1/10 through 8/10; o List of Individuals Admitted to Infirmary, from 1/10 through 9/10; o List of Individuals Served by Residence/Home, undated; o PNMP Coordinator Training Schedules, from 5/10 through 9/10; o Competency-Based Training Documents for PNMP Coordinators, from 1/10 through 9/10; o Orientation and Pre-Service Training Schedule, revised 6/10; o PNMP Supports, undated; o List of Top 10 Serious Injuries, undated; o List of Top 10 Peer Aggression, undated; o PSPs for Multiple Individuals, from 7/10 through 9/10; o List of Therapists, undated; o Curriculum Vitae (CVs) for PNMT Members; o PNM Policy (draft), undated; o List of Continuing Education Courses, from 7/10 through 9/10; o PNMT Planning, undated; o PNMT Evaluation/Updates (blank), 8/10; o Health Status Team Meeting Notes, from 2/10 through 8/10; o NMT Meetings, 1/10 through 8/10; o Aspiration/Choking - Health Risk Assessment Tool, revised 12/7/09; o List of Physical Nutritional Management (PNM) Assessments and Updates, 8/10; o PNMP Master List - by residence, dated 9/27/10; o PNMT Evaluations for Multiple Individuals, from 8/10 through 9/10; o PNMPs for Multiple Individuals, from 1/10 through 10/10; o Monthly PNMPs for each residence, from 7/10 through 9/10; o NMT Database for Documentation, undated; o Dining Plan Template, undated; o Competency-Based Training Sheets for Dining Plans/Training Rosters, from 5/10 through 7/10; o PNMP Master Lists - by residence, dated 9/23/10; o List of Individuals with Body Mass Index (BMI) less than or equal to (≤) 20, dated 9/10; o List of Individuals with BMI greater than or equal to (≥) 30, dated 9/10; o List of Individuals with Modified Diets/Thickened Liquids, dated 9/13/10; o List of Individuals who had Unplanned Weight Loss greater than 10%, from 2/10 through 8/10; o List of Individuals with Choking Incidents, from 12/09 through 7/10;

	o List of Individuals with Skin Breakdown, from 8/09 through 8/10; o List of Individuals with Fecal Impaction, from 9/09 through 9/10; o List of Individuals with Falls, undated; o List of Individuals diagnosed with Pneumonia, from 11/09 through 8/10; o List of Individuals with Poor Oral Hygiene, undated; o List of Individuals who receive Nutrition through Non-Oral Methods, undated; o List of Videofluoroscopies, Modified Barium Swallow Studies (MBSS), and other Swallowing Evaluations, from 10/09 through 7/10; o Scheduled Meal Hours by residence, revised 9/8/10; o PNM Staff Training Curricula, undated; o Tools/Checklists used to provide Competency-Based Training, undated; and o Competency-Based Training Sessions, from 9/09 through 9/10. ▪ **Interviews with**: o Karen Hardwick, State Coordinator of Habilitation Therapies; o Sarah Reves, AUSSLC Lead Occupational Therapist and Back-up to Department Head, PNMT Core Member; o Mace Welch, AUSSLC Interim Department Head, PNMT Core Member; and o Kim Ingram, Lead Speech Language Pathologist, PNMT Core Member. ▪ **Observations of**: o Residences 732-D, 732-E, 732-M, 779-R, 779-F, 779-H, Infirmary, 727-C, 795, 794, 793, 792, 791, 501, 796, and 797; o PNMT Meetings, on 10/5/10 and 10/7/10; o PIC Meeting, on 10/6/10; and o PNMP Coordinator Meeting, on 10/6/10.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps it had taken to assess compliance. Although the POI reviewed for AUSSLC did not include this component, the POI for Section O identified compliance and/or non-compliance with identified indicators. Based on the Monitoring Team's review, the Facility was not in compliance with some of the components of the SA with which the Facility indicated it was in compliance. Examples of indicators that were rated in compliance, but noncompliance was found by the Monitoring Team included: ▪ The POI for Section O.1.1 documented compliance with the following indicator: "100% of records show that the PNM team consists of qualified SLP, OT, PT, RD and RN and ancillary members [e.g., MD, PA (Physician Assistant), RNP (Registered Nurse Practitioner)] as needed. At the time of the on-site review, there was not a RN core team member. ▪ The POI for Section O.2.8 documented compliance with the following indicator: "100% of records reviewed show that updates are provided at least annually and as needed for all individuals with PNM supports." The comment section stated: "there is no formal tracking for this; however, this is the policy, and in informal tracking of this we have found no errors." The Monitoring Team's review of records identified individuals with no current annual update. ▪ The POI for Section O.3.1 documented compliance with the following indicator: "100% of records reviewed show that all individuals identified as being at risk (requiring PNM supports) are

	provided with a comprehensive PNM Plan (PNMP)." The POI comment section stated: "PNMPs are provided for all individuals who need one, however they are provided based on clinical judgment of risk rather than official risk levels. Awaiting new SO (State Office) risk policy." The Monitoring Team did not concur with the Facility's finding of compliance for this indicator, because PNMPs did not incorporate all components required by the SA. ▪ The POI for Section O.3.10 documented compliance with the following indicator: "100% of records reviewed show that PNMPs are reviewed annually at the PSP meeting and update as needed." The Monitoring Team did not concur with the Facility's finding of compliance for this indicator, because PNMPs were not integrated into the PSPs, and in multiple instances, therapists were not in attendance at the annual PSP meeting. ▪ The POI for Section O.3.13 documented compliance with the following indicator: "100% of records reviewed show that there is congruency between strategies, interventions, and recommendations contained in the PNMP and the concerns identified in the comprehensive assessment." The Monitoring Team did not concur with the Facility's finding of compliance for this indicator, because comprehensive assessments were not being completed, and PNMPs did not incorporate all components required by the SA. ▪ The POI for Section O.3.14 documented compliance with the following indicator: "100% of records reviewed show that all PNM supports and techniques should be based on the assessment and should be clinically justifiable and appropriate for the individual." The Monitoring Team did not agree with Facility's finding of compliance for this indicator, because assessments and PNMPs did not incorporate all components as required by the SA. ▪ The POI for Section O.7.4 documented compliance with the following indicator: "100% of records reviewed show that the individual's PNM status is reviewed annually at the PSP and all PNMPs are updated as needed." The Monitoring Team did not agree with the Facility's finding of compliance for this indicator, because PNMPs were not integrated into the PSP, and in multiple instances, therapists were not in attendance at the annual PSP. ▪ The POI for Section O.8.1, O.8.2 and O.8.3 documented compliance for individuals who were fed by a tube. The Monitoring Team did not concur with compliance status for these indicators as is discussed below with regard to Section O.8 of the SA. During the entrance conference, the AUSSLC Habilitation Therapies (HT) Interim Director indicated that the Habilitation Therapy Department had implemented the following activities related to Section O of the SA following the initial baseline review: ▪ Core and supplemental PNMT members had been identified; ▪ Six PNMT meetings had occurred, and three people were discussed; ▪ While awaiting clear criteria for individuals at high risk from State Office (SO), the PNMT had begun assessing individuals that were clinically judged to be at higher risk; and ▪ Habilitation therapists had started monitoring, along side the PNMP Coordinators, to assess their skill level, and to provide validation of skills. This continued to be in process.
	Summary of Monitor's Assessment: At the time of the review, the PNMT had some dedicated or core members as required by the SA, including a SLP, OT, and PT. In its response to the Monitoring Team's draft

	report, the State indicated that there was a nurse assigned as a core member of the PNMT. This was inconsistent with information provided to the Monitoring Team during the on-site review. At that time, the Monitoring Team was told that there had been a nurse assigned, but she was no longer a core member of the team. A number of positive training initiatives were underway with regard to physical and nutritional supports. The State Office had developed a set of training modules that was designed to provide PNMT members with information about the expectations for the PNMT, as well as technical knowledge and skills. In addition, based on interview, the State Coordinator for Habilitation Therapies was planning to implement an educational case study process in which a PNMT would present an individual case to multiple PNMTs through a Webinar. The goal was to provide ongoing opportunities for peer review and clinical instruction through the observation of the assessment process of another PNMT. The reconstituted PNMT had conducted its first assessment in August 2010, as well as one other review. However, in reviewing the PNMT Evaluations and Action plans that had been developed, as well as the documentation of the PNMT's follow-up with regard to these evaluations and plans, some concerns were noted. More specifically: ▪ The evaluations did not consistently follow the required format. As a result, key information was missing, and not included in the analysis. ▪ Lengthy timeframes for the completion of action steps were included in some instances. The PNMT should be mindful of not including elongated timeframes for the completion of recommendations, because the PNMT should be working with individuals with the most complex health, physical, and nutritional needs. This should generate a sense of urgency to complete all recommendations leading the individual to improved health and wellness. ▪ When recommendations were made, they were not always implemented timely. When the PNMT identified that recommendations had not been completed, they did not reassign a due date, or take action to ensure the recommendations were followed. ▪ It did not appear that the PNMT had consistently reviewed existing PNMPs to determine their continued appropriateness. During a comprehensive PNMT evaluation, the PNMT should be critical in their review of a current PNMP to determine what must be revised and/or monitored to minimize identified health risk indicators. ▪ It did not appear that the PNMT had met with the PSTs to develop Personal Support Plan Addenda to incorporate the PNMT Evaluation with recommendations into the PSPs. Continued mealtime and positioning errors observed by the Monitoring Team placed individuals at risk. Although PNMP Coordinators had undergone training covering a variety of relevant topics, and a competency-based checklist had been developed, the Monitoring Team's observations revealed that PNMP Coordinators were not consistently intervening to correct errors and coach staff on the proper implementation of PNMPs. The competency-based checklist needed to be revised to require an actual demonstration of competence in many areas. The implementation of competency-based, individual-specific PNMP training for all staff in the Infirmary

	and Cardinal should be a high priority. During multiple observations by the Monitoring Team, staff were not following individuals' PNMPs, which placed individuals at risk of harm. PNMPs should be integrated into Nursing Care Plans to minimize identified risk factors for individuals. The consistent implementation of PNMPs is important to ensure the health and safety of these individual at highest risk. Habilitation Therapies staff were completing monitoring, but it did not appear that this was resulting in improved outcomes for the individuals AUSSLC served. Non-compliance findings, with monitoring indicators within residences, were not being analyzed, summarized, and/or addressed. Compliance with PNMPs and dining plans should be the joint responsibility of Habilitation Therapies and all staff responsible for the provision of supports to individuals, including, but not limited to, residential staff, day program and vocational staff, nurses, the Dental Department, etc. Facility Administration, in collaboration with Habilitation Therapies staff and Quality Assurance staff should analyze monitoring results and implement strategies to support staff compliance with individuals' PNMPs. Using a matrix, the Habilitation Therapies Department had assigned individuals to the level of assistance they required during mealtimes. This was used to determine the appropriate staffing ratios for mealtimes. Based on interview, this analysis had been presented to Facility Administration for their review. The Habilitation Therapies Department was to be commended for completing this analysis, which was designed to assist Facility Administration in developing and implementing strategies to provide appropriate staffing ratios to support mealtime safety. A review of Facility reports, including those from Quality Assurance/Quality Enhancement, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis. This is an important aspect of reporting that would ensure identification and the provision of supports to individuals with the most complex physical and nutritional support needs. For example, data was available with regard to Emergency Room visits and hospitalization, but this was not being used to identify individuals in need of supports. The PNMT should establish thresholds that would trigger further evaluation based on degree of, and/or frequency of, certain types of incidents, and/or key health care indicators. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems. Seven individuals died within the time period from January to August 2010. Five of these individuals' deaths were attributed to acute respiratory failure, chronic respiratory failure, pneumonia, and aspiration pneumonia, which indicated these individuals had physical and nutritional support needs. Based on review of a sample of three of these individuals, the Nutritional Management Team and Health Status Team had reviewed these individuals multiple times prior to their deaths, but as stated in the baseline report, the NMT reviews consisted of a chart review leading to recommendations that did not support an aggressive approach to minimize identified health risk indicators, such as aspiration pneumonia. The PNMT did not provide an intensive, interdisciplinary problem-solving approach for these individuals, resulting in a timely and proactive comprehensive assessment, including the development of outcomes for which strategies would be implemented.

	Furthermore, an extensive, critical review of events leading up these individuals' deaths would be an important learning strategy to identify future individual-specific strategies, and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs, most importantly, for individuals at the highest health risk levels. It did not appear that the PNMT was involved in such a critical review.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, 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	Due to the multiple requirements included in this provision of the SA, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the SA, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The assessment and planning processes in which the team is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the SA. The PNM team consists of qualified Speech Language Pathologist, Occupational Therapist, Physical Therapist, Registered Dietician (RD), and, as needed, ancillary members (e.g., MD, Physician's Assistant, Registered Nurse Practitioner). The AUSSLC PNMT initiated the first PNMT comprehensive assessment for Individual #426 on 8/5/10. The signature page for the PNMT Evaluation documented the following attendees: Lead OT (Core member), Lead PT (Core member), Home OT, Lead SLP (Core member), Home SLP, Hospital Liaison Nurse (Core member at the time of this individual's review, but was no longer a Core member), RN Case Manager (CM), Dietitian, and Home PT. An additional individual had been assessed by the PNMT, Individual #39, but this evaluation did not have a signature page attached. Based on interview, the PNMT had dedicated or core members, including a SLP, OT, PT, and RD. The Hospital Liaison nurse had been a core PNMT member, but this changed during the week of the on-site review. In its response to the Monitoring Team's draft report, the State indicated that there was a nurse assigned as a core member of the PNMT. This was inconsistent with information provided to the Monitoring Team during the on-site review. At that time, the Monitoring Team was told that there had been a nurse assigned, but she was no longer a core member of the team. At the time of the review, there were two RDs supporting 376 individuals living at AUSSLC. As a result, if the census of AUSSLC was divided evenly between the two, each RD would be supporting approximately 193 individuals. The assignment of a RD as a dedicated PNMT member would significantly impact the workload of the remaining RD.	Noncompliance

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	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.	Even without this added responsibility, the current caseloads were not allowing the RDs to be active members of individuals' PSTs. With regard to the qualifications of the PNMT members, review of curriculum vitae submitted for the dedicated PNMT members (SLP, OT, PT and RD) documented that each had five years of experience within their respective fields. The Texas license numbers and license expiration dates for the PNMT SLP, OT, and PT showed these therapists were licensed to practice in the state of Texas and that their licenses were current. During the next on-site review, the curriculum vita of the nurse assigned to be a core member will be reviewed. During the on-site review week, the Assistant Director of Programs (ADOP) and the new Habilitation Therapies (HT) Director from Corpus Christi State Supported Living Center (CCSSLC) were present to learn about the compliance review process. The ADOP and HT Director shared their experiences reorganizing the PNMT, and identifying, and obtaining supports to enable the PNMT to function proficiently. The State Coordinator for Habilitation Therapies requested a meeting with members of the AUSSLC Management Team (Director, Assistant Directors, Medical Director, and Interim HT Director), Core PNMT members, the Quality Enhancement Director, QMRP Coordinator, Finance Director, and Chief Nursing Executive, to discuss the process that CCSSLC implemented to eliminate barriers and to enable the PNMT to efficiently assess individuals with complex medical, physical and nutritional supports needs. Members of the Monitoring Team and the State Settlement Agreement Coordinator also attended. This appeared to be a beneficial process in assisting staff at AUSSLC to identify next steps. The core PNMT members discussed with the AUSSLC Management Team the following needed supports to assist the PNMT to function successfully: ▪ Training regarding physical and nutritional supports for the Director, Assistant Directors, Unit Directors, RN Case Managers, QMRP Coordinator, and Quality Enhancement, Psychology, and Active Treatment staff; ▪ Dedicated room for meeting with table and chairs; ▪ Supplies, including a laptop with a large screen or rear-projection screen, easel and flip charts; ▪ Clerical support to assist with the development of a schedule; forwarding invitations, notices, and reminders; and completing transcription and minutes for PNMT meetings; ▪ Access database for tracking PNMT recommendations and strategies; ▪ Assignment of dedicated nurse and a facilitator; and ▪ Strategies to ensure PST follow-through of PNMT recommendations and strategies.	

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		As the Facility develops a well-functioning PNMT, the impact upon the current staffing will need to be taken into consideration, including: ▪ Time commitments of core members and backups for core members; ▪ At the time of the review, there were only two dieticians for entire campus, yet one of them will be required to participate in every meeting; and ▪ Habilitation Therapists had caseloads in excess of 80 individuals. Clinical instruction documentation for the core PNMT members (SLP, PT, OT and RD) included the Nutritional Management Team/PNMP/Equipment Webinar, and Seating and Positioning for Dysphagia. Per interview, core PNMT members had attended Section I of the Physical Nutritional Management Core Team Training, but no documentation to confirm this was submitted for this training. Because a dedicated nurse had not been assigned, documentation of clinical instruction within the last 12 months related to physical and nutritional supports could not be reviewed for this position on the PNMT. The State Office had developed a set of training modules that was designed to provide PNMT members with information about the expectations for the PNMT, as well as technical knowledge and skills. In reviewing the information provided, the Monitoring Team supports this initial, comprehensive training for PNMT members. As documented on the training agenda for core PNMT members entitled Draft Physical Nutritional Management Core Team Training (undated), clinical instruction for the PNMT members was expected to include: **Section I: Physical Nutritional Management Team** ▪ Settlement Agreement Section O (PNMP); ▪ Draft PNMT Policy; ▪ Draft evaluation form from Health Care Guidelines; and ▪ Roles of PNMT members. **Section II: Nutritional Management/GI Issues** ▪ Dysphagia definition; ▪ Dysphagia risk factors; ▪ Clinical implications; ▪ Triggers for investigation: o Signs and symptoms; ▪ Evaluation: o History and physical exam; o X-ray; o Lab; o CBC, blood chemistries, hemoccult, gastroccult; o Consultation with gastroenterologists; o Procedures: • Manometry;	

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		• pH (acidity measure) probe; • Scintigraphy; • Esophagogastroduodenoscopy (EGD); • Occupational therapy assessment; • Speech assessment; • Swallowing therapy assessment; and • Mealtime evaluation; ▪ Aspiration pneumonia; ▪ Gastrointestinal (GI) problems: o Esophageal disorders; ▪ Anatomical Problems: o Hiatal hernia; o Esophageal stricture; o Esophageal webs; o Zenker's Diverticulum; o Schatzki's ring; o Dysphagia Lusoria; o Barrett's Esophagus; and o Sandifer Syndrome; ▪ Esophageal dysmotility: o Achalasia; ▪ Gastroesophageal (GE) reflux; ▪ Esophageal clearance; ▪ Treatment of Nutritional Management Issues/Dysphagia: o Gastrostomy Tube (G-tube); o Positioning; o Avoiding predisposing factors; o Medication; o Esophageal dilation; and o Surgical intervention; ▪ Important factors with dealing with the developmental disabilities population: o Be proactive; o Monitor weight/intervene early; o Educate staff; o Follow PNMP; o Reassess interventions; and o Watch for trends. **Section III: Clinical Assessment Technologies** ▪ Doppler Ultrasound;	

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		▪ Ankle Brachial Index (ABI); ▪ Rubor of Dependency; ▪ Pulse Oximetry; ▪ Pressure Mapping; and ▪ Videofluoroscopy. **Section IV: Seating and Positioning for Dysphagia** ▪ Clinical implications; ▪ Physical factors in dysphagia; ▪ Indicators for types of seating; ▪ Dining furniture; ▪ Positioning for eating/digestion; ▪ Oral eating; and ▪ Enteral eating. **Section V: Evaluation of Seating and Positioning** ▪ Principles of seating; ▪ Evaluation process; ▪ Impact of developmental disabilities; and ▪ Principles of design and fit: o Appropriate design/fit; o Choice of frame/mobility base; o Contoured versus planar design: • Correction versus accommodation; o Methods of contouring: • Simulator; • Direct foam in place; • Sculpted foam; o Multiple positions in space: • Frontal plane lateral tilt; • Neutral position; • Sagittal plane: o Recline; o Forward tilt; o Minimalist principle. **Section VI: Wound Investigation Protocol** ▪ Pressure wounds; ▪ Shear; ▪ Maceration; ▪ Fungal infection; ▪ Skin tear; ▪ Skin approximation; and	

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		▪ Circulation. **Section VII: Communication Issues/Strategies** ▪ Audiology: o Anatomy of the ear/hearing: • Care of the ear/supports; ▪ Communication Assessment: o Assessment; o Alternative/augmentative communication; and o Behavioral/active treatment supports. **Section VIII: Nursing Issues in PNMP** ▪ Enteral eating; ▪ Pneumonia/respiratory problems; ▪ Dehydration; ▪ Hypothermia; ▪ Seizures; and ▪ Urinary tract. **Section IX: Dietary Issues in PNMP** ▪ Tube feeding/formula; ▪ Calories; and ▪ Preparation/textures. Based on interview, the State Coordinator for Habilitation Therapies was planning to implement an educational case study process by having a PNMT present an individual's case to multiple PNMTs through a Webinar. This would provide ongoing opportunities for peer review and clinical instruction. The State Coordinator for Habilitation Therapies would lead this process. All of this training was helpful training for PNMT members to have, and the Facility and State are encouraged to continue to offer such training opportunities to PNMT core team members, as well as ancillary members of the PNMT, and other therapists. All PNMT dedicated members (not just therapists) and ancillary members should attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of supports for individuals with the most complex physical and nutritional supports needs. <u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> Based on a review of 14 individual records (Individual #39, Individual #182, Individual #426, Individual #452, Individual #327, Individual #74, Individual #54, Individual #372, Individual #159, Individual #355, Individual #413, Individual #422, Individual #50, and Individual #435), for two (Individual #426 and Individual #39) of the 14 individuals	

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		(14%), documentation supported that the PNM Team had met regularly to address changes in status, complete a comprehensive assessment, implement recommendations and strategies, and review clinical data and monitoring results. The individual record sample was drawn from lists of individuals at risk based on the following criteria: ▪ Individuals who had Emergency Room visits; ▪ Individuals who had hospitalizations; ▪ PNM (NMT) Team meeting minutes; ▪ Individuals with an active pressure ulcer within the last six months; ▪ Individuals with severe dysphagia; ▪ Individuals with chronic constipation or who experienced fecal impaction within the last six months; ▪ Individuals with unexplained weight loss or BMI ≤ 20; ▪ Individuals with BMI ≥ of 30; ▪ Individuals who experienced a choking incident that required the abdominal thrust within the last six months; ▪ Individuals with a diagnosis of aspiration pneumonia; ▪ Individuals who had experienced significant falls related to transfers and/or ambulation; ▪ Individuals with chronic respiratory infections; ▪ Individuals with chronic dehydration; ▪ Individuals with a diagnosis of osteoporosis and/or osteopenia; ▪ Individuals who experienced a fracture; and ▪ Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care, and functional communication. A Physical and Nutritional Management Team Evaluation was completed for Individual #426, PNMT Evaluation dated 8/5/10, and Individual #39, PNMT Evaluation, dated 9/16/10, but these evaluations did not consistently follow the PNMT comprehensive Evaluation outline format. For example: ▪ The Monitoring Team reviewed Individual #426's PNMT Evaluation, dated 8/5/10, and the draft Physical Nutritional Management Team Evaluation format and identified the following issues: o The Medical Problems section, Section #2 of the PNMT evaluation format, did not reflect a comprehensive review of his medical problems. The assessment risk factors identified medical conditions that were not included under medical problems, such as history of aspiration pneumonia, and a long history of emesis. The medical problems section did not discuss his status of chronic upper respiratory congestion, noisy respiration, hoarseness upon phonation, etc.; medical conditions that	

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		alter intake or nutrient requirements; enteral nutrition tubes; and any alternation in lab values. o There was no discussion of respiratory status. Section #9 and #10 of the PNMT evaluation format were supposed to reflect that his respiratory problems had been monitored and promptly reported to healthcare staff, and respiratory problems had been evaluated promptly and treated aggressively. The risk factor section of the assessment documented "these factors affect [his] breathing, digestion and respiratory health." o There was no discussion of an assessment of his enteral tube. Section #12 of the PNMT evaluation format indicated that individuals were to be evaluated annually, and more often as needed, regarding type of enteral feeding and/or resumption of oral nutritional intake. The PNMT analysis stated: "By report, he ate orally as long as possible - he is not a candidate for returning to oral intake. Historically, he has had issues with nausea and emesis, which continue to be problematic for him." The analysis commented: "his feeding schedule needs to be reassessed to decrease overall feeding time if possible." The PNMT recommendation stated: "consider decreasing feeding time if test results indicate that possibility." As required by the SA, the PNMT will need to continue to assess the medical necessity of the tube and, if possible, determine if there are opportunities for potential pathways to by mouth (PO) status. o Treatment options for individuals with dysphagia and/or aspiration (Sections #14 through #17 of the PNMT evaluation format) had not been completed. o Treatment options for individuals with GERD (gastroesophageal reflux disease) (Sections #18 through #19) had not been completed. o Individual #426's recommendations should have identified the person responsible for implementing the recommendation with an identified timeframe, but did not. o The measurable outcomes should have identified person(s) responsible for completion, but did not. o In addition, the strategies developed by the PNMT to be implemented should have identified baseline objective clinical data, and required the continued documentation of the clinical data to enable analysis of the data to determine the efficacy of the interventions. The Team should review the status of identified strategies at every meeting until the individual is discharged from the PNMT. PNMT Action Plans for Individual #39 and Individual #182 were presented during the	

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		week of the on-site review. The action plan format documented the following fields: objective, action step, frequency, person responsible, timeline, and comments, which should provide a manageable working document for the PNMT and PST members. In reviewing the PNMT Evaluations and Action plans that had been developed, as well as the documentation of the PNMT's follow-up with regard to these evaluations and plans, some concerns were noted. More specifically: ▪ Lengthy timeframes for the completion of action steps were included in some instances. The PNMT should be mindful of not including elongated timeframes for the completion of recommendations, because the PNMT should be working with individuals with the most complex health, physical, and nutritional needs. This should generate a sense of urgency to complete all recommendations leading the individual to improved health and wellness. ▪ When recommendations were made, they were not always implemented timely. When the PNMT identified that recommendation(s) had not been completed, they did not reassign a due date, or take action to ensure the recommendations were followed. ▪ It did not appear that the PNMT had consistently reviewed existing PNMPs to determine their continued appropriateness. During a comprehensive PNMT evaluation, the PNMT should be critical in their review of a current PNMP to determine what must be revised and/or monitored to minimize identified health risk indicators. ▪ It did not appear that the PNMT had met with the PST to develop Personal Support Plan Addenda to incorporate the PNMT Evaluations with recommendations into the PSPs. Examples of these issues were as follows: ▪ In Individual #426's PNMT evaluation, there was an action step that he would have "fair oral hygiene by 2/1/11." This set a low expectation and elongated the timeframe for improved oral health. Another action step read: "environmental infection control plans will be in place by 11/1/10," but it was not stated when these plans would be implemented for Individual #426 who had been hospitalized five times for respiratory distress and pneumonia. In addition, concerns were noted with regard to when recommendations actually were completed for Individual #426. A measurable outcome stated: "PNMP will reflect range of elevation for safety during ADLs, including bathing, changing, resting and feeding in bed by 9/1/10." Individual #426's PNMP, revised 9/30/10, was revised 29 days after the recommended completion date. Moreover, the PNMP stated: "provide all nutrition, liquids and medication by G-	

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		tube while in most upright position in bed and any position in wheelchair." The PNMP did not provide staff with adequate detailed instructions for positioning him in his wheelchair as he was receiving enteral nutrition and/or medication through his gastrostomy tube. Nursing staff may interpret "any position in wheelchair" to be in a reclined position during administration of medication and/or enteral feeding, which would place Individual #426 at risk. PNMPs for individuals with complex medical, physical, and nutritional support needs should be sufficiently detailed to ensure staff are providing supports in the safest manner. During a comprehensive PNMT evaluation, the PNMT should be critical in their review of a current PNMP to determine what must be revised and/or monitored to minimize identified health risk indicators. The PNMT recommendations did not identify monitoring to be conducted by the PNMT. Until Individual #426 was discharged from the PNM Team, the PNMT should provide monitoring oversight on a daily and/or weekly basis depending on the importance of the strategy being implemented to minimize risk. The PNMT should track the status of individual recommendations, as well as identify individual triggers that would alert staff of immediate concerns. The PNMT Evaluation follow-up, dated 8/17/10, for Individual #426 documented the status of six recommendations as pending without a reassignment of a completion due date. Again, the PNMT must work with a sense of urgency to implement recommendations for individuals who have been identified at highest risk. Individual #426 was hospitalized again on 8/22/10 for increased respiratory distress, and continued to be hospitalized during the week of the on-site review. Individual examples of where the PNM Team did not regularly address changes in status, review clinical data, develop comprehensive assessments, and/or monitor the efficacy of strategy results included: ▪ Individual #452 experienced a choking incident on 5/15/10. In addition, Individual #452 was hospitalized on the following dates: o On 6/11/10, she was admitted for unstable vital signs, respiratory distress, and coffee ground emesis, with a discharge diagnosis of community acquired pneumonia. Treatment included intravenous (IV) antibiotics and percutaneous endoscopic gastrostomy (PEG) tube placed on 6/17/10. o On 1/16/10, she was admitted for coffee ground emesis, with discharge diagnosis of coffee ground emesis. An EGD showed mild gastritis. She had no further emesis, developed mild bronchospasms, and received IV antibiotics. o On 1/16/10, she was admitted for repeated coffee ground emesis with	

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		no discharge diagnosis and/or treatment. The PNMT did not complete a timely and proactive comprehensive assessment following the choking incident or placement of her PEG tube to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #435's Body Mass Index was 17.9 which placed her in the underweight category. The Nutritional Management Team Report, dated 7/21/10, documented: "[Individual #435] has been reviewed by NMT 16 times due to low weight for more than 2 years." Individual #435 was admitted to the infirmary twice, once on 8/28/10, and once with no date listed, for dehydration. She had a Health Maintenance Plan (High Risk), implementation date 9/16/10, for being underweight. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #74's BMI was 50.75. A BMI score over 50 placed her in the "super obesity" category, and placed her at extremely high health risk. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #50's BMI was 16.53, which placed her in the underweight category. Her OT/PT Update, dated 10/27/09, documented: "[Individual #50] had been reviewed extensively by NMT for pneumonia and dysphagia. [Individual #50] was last reviewed by the NMT in 10/08 as a one-year review prior to staffing. It was determined that she was stable and was placed on PRN by NMT at that time." The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ On 7/10/10, Individual #327 experienced a choking incident, but the PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #422's NMT Report, dated 7/21/10, documented: "7/10 review to follow up hospitalizations 6/14/10 for pneumonia, UTI and subsequent G-tube placement." The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #355 was hospitalized on 4/23/10 for a small bowel obstruction and poor oral intake, and readmitted on 5/22/10, for anorexia, abdominal distension and discomfort with suspicion of partial small bowel obstruction. The PNMT did	

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		not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. The following chart represents a very basic analysis of the number of admissions to the Infirmary and hospitalizations per residence from January to September 2010. As illustrated below, there were residences with higher levels of Infirmary admissions and hospitalizations in contrast to other residences. Such an analysis could be expanded to include reasons for Infirmary admissions and hospitalization, individuals involved, etc. The Facility should conduct an analysis of this type of information to begin the process of initially identifying individuals who are in need of physical and nutritional supports, and developing thresholds using objective data to trigger further evaluation. The purpose of such an analysis should be to determine if there were causal factors leading to an increase in emergency room visits, Infirmary admissions, and/or hospitalizations. The Facility Incident Management and/or Investigation departments could conduct such an analysis to determine if there were systemic issues that required resolution. Actions taken to address issues identified might decrease the number of Infirmary admissions and/or hospitalizations. The PNMT should play an integral role in this process. The PNMT should be responsible for determining, not only the efficacy of the individual-specific outcomes for those individuals at highest risk and with the most complex health, physical, and nutritional needs, but also should be responsible for providing an analysis, on a systemic level, and developing and monitoring thresholds/triggers for integration into the Facility Risk Management and Quality Assurance Systems. Infirmary visits for preparation/observation for mammograms, colonoscopy, shunt placement, cystoscopy, bone density exams, and renal ultrasound, as well as dental observation/extraction, were not included in the following chart. However, there were 76 Infirmary admissions, with no reason noted that were included in the following chart:	

Residence	Number of Infirmary Visits	Hospital Admissions	Total
727-C	59	36	95
732-D	19	8	27
732-E	12	1	13
732-M	10	2	12
779-F	26	9	35
779-H	28	18	46

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<tr><td>779-R</td><td>30</td><td>9</td><td>39</td></tr>
<tr><td>788</td><td>3</td><td>2</td><td>5</td></tr>
<tr><td>789</td><td>4</td><td>2</td><td>6</td></tr>
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<tr><td>O2</td><td>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</td><td><u>A process is in place that identifies individuals with PNM concerns.</u>
Based on policy review (State and Facility) and record review of 14 individuals (Individual #39, Individual #182, Individual #426, Individual #452, Individual #327, Individual #74, Individual #54, Individual #372, Individual #159, Individual #355, Individual #413, Individual #422, Individual #50, and Individual #435), a process that identified individuals with PNM concerns was not defined sufficiently, as illustrated by:
▪ In zero of the 14 records reviewed (0%), there was documentation of risk identification levels based upon physical and nutritional history and current status, including specific criteria for guiding placement of individuals in specific risk levels.
▪ In one of the 14 records reviewed (Individual #426) (7%), there was documentation of a comprehensive assessment process for individuals at highest risk, which included analysis of discipline-specific assessments (OT, PT, SLP, nursing, medical, nutrition, and psychology), PNMP Clinic results, PNM (NMT) Meeting Summaries, and individual-specific consultations, leading to the development of measurable, functional outcomes to minimize and/or reduce the identified health risk.</td><td>Noncompliance</td></tr>
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	nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	▪ In one of the 14 records reviewed (7%), there was documentation of development of implementation strategies. ▪ In zero of the 14 records reviewed (0%), there was documentation of competency-based training for individual strategies. ▪ In zero of the 14 records reviewed (0%), there was documentation of a monitoring schedule for individuals at highest risk. ▪ In zero of the 14 records reviewed (0%), there was documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. As illustrated in the individual examples provided above with regard to Section O.1 of the SA, except for Individual #426 and Individual #39, the PNMT had not yet conducted the necessary screenings and assessments to address the needs of the individuals in the sample. The Facility did not have a policy that set forth an adequate screening process to identify individuals at risk. The At-Risk Individuals and Physical Nutritional Management policies were being revised by State Office, but had not been finalized. <u>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.</u> A review of seven records of individuals who had been identified by the Facility at highest risk (Individual #344, Individual #199, Individual #403, Individual #251, Individual #416, Individual #42, and Individual #331) revealed the following:. ▪ In zero of the seven records reviewed (0%), there was documentation of PNMT review/analysis of the findings of relevant documents, including but not limited to discipline-specific assessment(s), PNMP Clinic results, PNMPs, and relevant consultation(s) leading to the development of a comprehensive summary. The summary should have addressed: o Physical health status; o Nutritional health status; o Oral care; o Medication administration; o Mealtime strategies; o Proper alignment; and o Positioning during the course of the day and nutritional intake. ▪ In zero of the seven records reviewed (0%), measurable, functional outcomes were identified. ▪ In zero of the seven records reviewed (0%), there was documentation of PNMPs	

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		developed with input from the PNM (NMT) for those individuals at highest risk. ▪ In zero of the seven records reviewed (0%), there was congruency between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. ▪ In zero of the seven records reviewed (0%), comprehensive summary results were integrated into the design of the appropriate PNM support plans. ▪ In zero of the seven records reviewed (0%), PNMT updates were provided as needed until the individual was discharged from the PNMT. Examples of where the PNMT had not: 1) reviewed the individuals identified by the Facility at highest risk; 2) provided individuals a comprehensive assessment; 3) integrated the results of the comprehensive assessment into the PNMP; 4) implemented strategies; and 5) provided updates, were as follows: ▪ Individual #199 was identified by the Facility as being at high risk for respiratory concerns. Individual #199 was admitted to the Infirmary on 1/13/10, with no reason documented; on 2/24/10, with no reason documented, on 3/11/10, for hyperthermia, and on 3/31/10, for aspiration pneumonia. He was admitted to the hospital for pneumonia on 1/2, 2/17, 3/26, and 4/30/10. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #416 was identified by the Facility as being at high risk for osteoporosis. She was admitted to the Infirmary for a dislocated right shoulder, on 6/14/10. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #251 was identified by the Facility as being at high risk for constipation, and her BMI was 16.84, which placed her in the underweight category. The PNMT did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #344 was identified by the Facility as being at high risk for weight. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #403 was identified by the Facility as being at high risk for dehydration. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #42 was identified by the Facility as being at high risk for skin integrity. The PNMT did not complete a timely and proactive comprehensive	

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		assessment to address her ongoing health risks, as well as identified complex physical and nutritional support needs. ▪ Individual #331 was identified by the Facility as being at high risk for medical concerns. The PNMT did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified complex physical and nutritional support needs.	
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.	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> Based on a review of a sample of 21 individual records (Individual #39, Individual #182, Individual #426, Individual #452, Individual #327, Individual #74, Individual #54, Individual #372, Individual #159, Individual #355, Individual #413, Individual #422, Individual #50, Individual #435, Individual #344, Individual #199, Individual #403, Individual #251, Individual #416, Individual #42, and Individual #331), individuals were not provided consistently with a comprehensive PNMP. Although a number of the components of a comprehensive PNMP were present for many individuals, there were a number of components missing. More specifically: ▪ In 21 of 21 records reviewed (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 21 of 21 records reviewed (100%), transfer instructions were included. ▪ In 21 of 21 records reviewed (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks and/or addressed receiving nutrition through a feeding tube. ▪ In 21 of 21 records reviewed (100%), the mealtime/dining plan included food/fluid textures and/or addressed receiving nutrition through a feeding tube. ▪ In 21 of 21 records reviewed (100%), the mealtime/dining plan included behavioral concerns related to intake and/or addressed receiving nutrition through a feeding tube. ▪ In zero of 21 records reviewed (0%), strategies for medication administration were included. ▪ In zero of 21 records reviewed (0%), strategies for oral hygiene were included. ▪ In 21 of 21 records reviewed (100%), individual adaptive equipment was included. ▪ In 21 of 21 records reviewed (100%), bathing/showering positioning and related instructions were included. ▪ In 21 of 21 records reviewed (100%), personal care instructions were included. ▪ In 21 of 21 records reviewed (100%), communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included: ▪ Per the SA, PNMPs need to incorporate strategies for medication administration and oral care for those individuals identified at risk. In addition, these PNMP	Noncompliance

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		strategies need to be integrated within an individual's nursing care plan. As noted above, such strategies were not included in the PNMPs reviewed. Based on observations, the following additional concerns were noted with regard to individuals' PNMPs: ▪ Individual #323 coughed multiple times throughout the meal. His dining plan, dated 10/5/10, did not identify this as an individual trigger, which would place him at risk during mealtime. ▪ Individual #115 was holding her plate with her right hand close to her mouth, and eating rapidly with her left hand. Her dining plan instructions did not prompt staff to slow her eating pace, and staff did not prompt her throughout the meal to slow her pace. She required more direct supervision during the meal to ensure her safety. ▪ Individual #2's dining plan, dated 5/10/10, did not recommend a dycem mat. His plate consistently moved around the table as he was attempting to scoop food. ▪ Individual #356's dining plan, dated 5/7/10, his wheelchair position did not support good head alignment. His mealtime position needed to be reevaluated. ▪ Individual #319 consistently cleared his throat and burped during the meal. An updated mealtime assessment was needed to reassess his mealtime oral motor skills. ▪ Individual #92 was observed in her residence during a meal. Her BMI was 15.31, which placed her in the underweight category. She was in need of an updated mealtime and nutrition assessment to review the efficacy of the current mealtime seclusion strategy, because she continued to remain underweight which placed her at risk nutritionally and medically. <u>PNM plans were incorporated into individuals' Personal Support Plans.</u> In 19 records reviewed (Individual #39, Individual #182, Individual #426, Individual #452, Individual #327, Individual #74, Individual #54, Individual #372, Individual #159, Individual #355, Individual #413, Individual #422, Individual #50, Individual #435, Individual #199, Individual #403, Individual #251, Individual #416, and Individual #331), none of the PNMPs (0%) were incorporated into individual Personal Support Plans. Information from PNMP should have been integrated within the PSP, not simply referenced and/or listed. In addition, relevant PSP recommendations should be integrated into PNMPs. Examples of where individual PNMPs were not incorporated in PSPs included: ▪ Individual #42 and Individual #344 did not have a PSP provided in response to the document request. ▪ Individual #452's PNMP, revised 3/5/10, discontinued the use of his abdominal	

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		binder and added: "use of any position in wheelchair for feedings, medications and tooth brushing." These changes were not integrated into his PSP, nor were the changes integrated in Nursing Care Plans. Again, as noted above, his positioning in his wheelchair for these activities should have been better defined. ▪ Individual #251's PNMP, revised 6/24/10, discontinued "assisting on her right side and walking with two staff holding gait belt if she lifts her right leg or use transport wheelchair." Offering her six ounces of liquids at meals, snacks, and in the evening was discontinued. Additions to her PNMP were "use of a recliner, stand pivot transfer with one staff holding gait belt, moves freely in bed and stop feeding her if she falls asleep." Her PSP did not discuss the rationale for these changes, nor were these changes integrated into her PSP. ▪ Individual #159's PNMP, reviewed 8/5/10, added the use of a good grip coated youth spoon, angled to the right, and thicken liquids to honey consistency. Her PSP, dated 12/8/09, did not incorporate her PNMP, nor were there PSP Addendums to provide the rationale for these changes and integration of her revised PNMP into her PSP. <u>PNMPs are developed with input from the PST, home staff, medical and nursing staff.</u> In 19 records reviewed (Individual #39, Individual #182, Individual #426, Individual #452, Individual #327, Individual #74, Individual #54, Individual #372, Individual #159, Individual #355, Individual #413, Individual #422, Individual #50, Individual #435, Individual #199, Individual #403, Individual #251, Individual #416, and Individual #331), none (0%) of the PNMPs were developed with input from the PST with an emphasis on direct support professionals, habilitation therapy staff, medical/nursing staff, and behavioral staff (if appropriate). Examples of where individual PNMPs were not developed with input from the PST included: ▪ Individual #413's PSP, dated 9/11/09, stated: "continue PNMP and current assistive equipment issued by physical and occupational therapy." The PSP signature sheet did not document the attendance of an OT, PT, and SLP to discuss the rationale for the PNMP strategies, and ensure the integration of these strategies across multiple disciplines. ▪ Individual #355's PSP, dated 9/17/10, did not discuss his PNMP, revised 9/17/10. There was no signature sheet attached to the PSP. ▪ Individual #422's PSP, dated 8/21/09, signature sheet listed team members that had a relationship to the individual, but the OT, PT, and SLP were not included. There were no signatures by any PST member. <u>PNMPs are reviewed annually at the PSP meeting, and updated as needed.</u>	

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		In zero of 21 records reviewed (0%), PNMPs were reviewed annually at the PSP meeting, and updated as needed. As discussed above, there was no evidence that the PNMPs were actually reviewed at the PSP meetings, particularly for those individuals for whom habilitation therapies staff were not present to meaningfully review the PNMPs. Without such review, they were not adequately integrated across disciplines, and recommendations from other assessments and/or team members were not incorporated into the plans. <u>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.</u> In zero of 4 records reviewed (Individual #39, Individual #199, Individual #452, and Individual #176), were PNMPs reviewed and updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results. For example: ▪ On 9/16/10, the PNMT assessed Individual #39, but the PNMT had not revised her PNMP, dated 6/4/10. ▪ Individual #199 was hospitalized multiple times for pneumonia, on 1/2, 2/17, 3/26, and 4/30/10. His PNMP was not revised to include the PNMP components and to minimize his risk for aspiration pneumonia. ▪ Individual #452 was hospitalized for pneumonia on 6/11/10, and admitted to the Infirmary multiple times for pneumonia. Her PNMP was not revised to include the PNMP components as defined in the SA and HCG to minimize her risk for aspiration pneumonia.	
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.	<u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> Thirty individual observations were completed of staff's implementation of dining plans and/or PNMPs. Overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or mealtime plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, risks due to falls, etc. The following provides additional details regarding the observations: ▪ In four of 12 observations (33%), staff were following mealtime plans. ▪ In zero of 16 observations (0%), staff were following wheelchair positioning instructions. ▪ In zero of four observations (0%), staff were following alternate positioning instructions. ▪ In zero of five observations (0%), nursing staff were following the PNMP to include diet texture/fluid consistency, positioning instructions, and use of appropriate adaptive equipment for medication administration.	Noncompliance

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		Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: ▪ Individual #453's dining plan, dated 3/5/10, instructions stated "collar for meals and position wheelchair to the side of the table, she should not face the table because of seizures." Individual #453 was not wearing her collar during dinner, and her wheelchair was not positioned to the side of the table. ▪ Multiple individuals were not in optimal alignment and support in their seating systems. ▪ Individual #356's dining plan, dated 5/7/10, instructions stated: "Remind him to hold his head up." Staff did not cue him to hold his head up during the meal. ▪ Individual #319's dining plan, dated 7/22/10, list of assistive dining equipment included the use of a non-skid mat, which was not available for him during the evening meal. His plate and bowls moved constantly as he was trying to scoop food. ▪ Individual #2 was seated by himself at a table. His dining plan precaution stated: "monitor bite size and eating pace." Staff did not approach him during the meal to slow his pace and/or provide assistance with his utensils. ▪ Individual #147's dining plan position stated: "encourage upright position." Individual #147 was poorly positioned in her seating system, and staff did not reposition her before and/or during the meal. ▪ Individual #113 was observed in the Infirmary, and he was poorly positioned in his bed. He was on his left side and curled in a fetal position. The focus of his PNMP stated: "reduce the risk of respiratory complications from reflux with positioning and equipment." His poor bed positioning placed him at risk, which was of particular concern given that he was in the Infirmary due to an illness. ▪ Individual #398 was observed in the Infirmary in his seating system. He was poorly positioned in his seating system with one-to-one staff. He was not repositioned by staff during the observation. ▪ Individual #182 was poorly positioned in his seating system. ▪ Individual #448 was presented with her medication while she was in her seating system. She was poorly positioned. The nurse did not have Individual #448's PNMP to refer to during the administration of her medication. The nurse did not present her medication with a good grip youth spoon as prescribed on her dining plan. ▪ Individual #50 received her medication through her tube in bed. Her dining plan stated: "[Individual #50] DOES NOT eat in bed due to respiratory problems." The nurse did not refer to her PNMP. ▪ Individual #72 was poorly positioned on her back in bed. She did not have pillows under her knees or her arms as prescribed in her PNMP. ▪ Individual #251 was observed in her residence during a meal. There was no dining plan in the area, and she was poorly positioned. She coughed and cleared	

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		her throat throughout the meal. Her BMI was 16.84, which placed her in the underweight category. She was in need of an updated mealtime and nutrition assessment to review the efficacy of the current mealtime seclusion strategy, because she continued to remain underweight, which placed her at risk nutritionally and medically. The implementation of competency-based individual-specific PNMP training for all staff in the Infirmary and Cardinal should be a priority. During multiple observations by the Monitoring Team, staff were not following individuals' PNMPs, which placed individuals at risk of harm. Positioning protocols for all alternate positioning, when individuals are in seating systems, during mealtime or when individuals receive eternal nutrition, as well as during tooth brushing, medication administration, bathing/showering, and personal care, should be reviewed with all staff, including nursing staff. PNMPs should be integrated into Nursing Care Plans to minimize identified risk factors for individuals. The consistent implementation of PNMPs is important to ensure the health and safety of these individual at highest risk. The Habilitation Therapies Department had developed a document entitled Criteria for Determining Level of Need When Dining, dated 9/3/10. This was a matrix for determining the level of staff assistance needed during mealtimes. It included the following categories: ▪ **Fed:** Individual is assisted to eat meal/snack by staff. ▪ **Assistance:** Staff must be sitting at table with specific individual. Individual assists self, but requires full-time physical assistance to scoop, manage bite size, reduce risk of overfilling mouth, pace eating/drinking rate, manage liquids, give lemon ice and/or sips of liquid throughout meal, be repositioned, prevent taking food from others, etc. ▪ **Intermittent assistance:** Staff must be sitting at table, but may assist one to two individuals. Individual is able to eat by self, but requires intermittent verbal or physical assistance to obtain food, manage bite size, reduce risk of overfilling mouth, pace eating/drinking rate, prevent taking food from others, gather food on plate, take lemon ice before meal, take sips of liquid and/or lemon ice throughout meal, scoop, reposition, etc. ▪ **Monitored:** Staff must be at table and may be able to monitor two or more individuals on a case-by-case basis. Individual assists self, but requires verbal prompt as needed to limit bite size, encourage sips of liquid, gather food, use equipment appropriately, etc. ▪ **Independent:** Individual is able to set up meal, open cartons, assist self entirely with or without assistive equipment. Using this matrix, the Habilitation Therapies Department assigned individuals to the	

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		level of assistance they required during mealtimes. This information was used to determine the appropriate staffing ratios for mealtimes. Based on interview, this analysis had been presented to Facility Administration for their review. The Habilitation Therapies Department was to be commended for completing this analysis designed to assist Facility Administration in developing and implementing strategies to provide appropriate staffing ratios to support mealtime safety. A document entitled Completed PNMP Coordinator Training Schedule, undated, documented the following training: ▪ Wheelchair Positioning Training, on May 5th; ▪ Simply Thick Competency, on May 6th; ▪ Lift/Transfer Training, on May 7th; ▪ Sign Language, on May 18th, 20th, and 25th; ▪ Kitchen Training, on May 21st; ▪ Lift/Transfer Training, on May 23rd; ▪ Developmental Disabilities, on May 25th; ▪ Therapeutic Handling, Positioning and Work Order Procedures, on June 2nd; ▪ Optimal Eating Skills Part I, on June 4th; ▪ Optimal Eating Skills Part II, on June 6th; ▪ Optimal Eating Skills Part III, on June 7th; ▪ Compression Hosiery, on June 16th; ▪ Unified Records, on July 7th; ▪ Pre-thickened Liquids, on August 2nd; ▪ In-services, on August 24th; ▪ Bed Positioning, on September 8th; ▪ Family Style Training, on September 10th; ▪ Anti-Reflux, Updated Meal/Snack Monitoring Forms and Updated Speech and Hearing Monitoring Forms, on September 15th; and ▪ Newer Updated Meal/Snack Monitoring Form, on September 22nd. PNMP Coordinators were responsible for demonstrating the following job competencies: ▪ Demonstrate competency in Dining Room Observation and reporting problems to responsible department; ▪ Demonstrate ability to read Diet Cards; ▪ Demonstrate understanding of Dining Plan Precautions; ▪ Demonstrate ability to carry out Dining Plan Instructions; ▪ Demonstrate understanding of Diet Textures and use of Thicken Up and lemon ice; ▪ Demonstrate competency in mixing Simply Thick; ▪ Recognize and describe purpose of Dining Equipment; ▪ Demonstrate ability to relate instructions on PNMP to focus statements;	

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		▪ Describe purpose of assistive equipment; ▪ Demonstrate competency in PNMP Observations and reporting problems to HT; ▪ Demonstrate competency in Positioning: o In Bed (use of bolsters, pillows etc., as applicable); o GERD (reflux) precautions; o Aspiration precautions; o Pressure relief: • Describe cause of pressure wounds; and • Describe pressure relieving devices and techniques (i.e., cushions, mattresses, position changes, etc.); and o Wheelchair positioning (importance of hip placement, leg alignment in seat, trunk positioning, headrest and seatbelt); ▪ Demonstrate Competency in Equipment Application: o Applying splints; o Palm Protectors; o Orthotics/splints; and o Hosiery; ▪ Demonstrate competency in lifting, transferring, and repositioning; ▪ Demonstrate ability to monitor and use ARJO equipment, bath benches, wheelchairs, walkers. Determine the need for equipment repair as well as request needed repairs in a timely fashion; ▪ Optimal Eating Skills; ▪ Developmental Disabilities; ▪ Therapeutic Handling and Positioning; and ▪ Bed Positioning. Thirteen PNMP Coordinator Competency Check-Off forms were submitted for review. The PNMP Coordinator (PC) Job Performance Competencies form documented the task, date completed, and staff initials of competency-tester. There was a legend at the bottom of the form for competency determination for each task. One of the following was to be circled for "T" (tested), "V" (verbal), and "P" (performed) although the column on the form had "D" for demonstrated not "P" for performance. The appropriate therapists and therapy assistants should complete a critical review of how competency was determined. There were competencies tested, that did not require a demonstration/performance to validate a PC's competency. For example, the competency indicator "Demonstrate ability to carry out Dining Plan instructions" was "tested." The PC did not have to demonstrate their ability to implement individual-specific dining instructions. Knowledge of positioning was "tested," and not demonstrated. PCs should be required to demonstrate, through a skills-based performance check-off, their ability to implement required job competencies. Therapists	

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		and therapy assistants should continue coaching and mentoring PCs to validate their ongoing competence in completing their job duties. The Monitoring Team's observation of a PNMP Coordinator in a dining area did not indicate that the PNMP Coordinator was competent to provide coaching, mentoring, and monitoring to the staff during mealtimes. Specifically, during the observation, the PNMP Coordinator did not intervene to correct position and alignment, or model for staff the correct techniques when dining instructions were not being followed.	
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.	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> Review of the Facility's training curricula revealed that it did not include adequate PNM training in the following areas: ▪ Generic and individual-specific mealtime risk triggers that alert staff to problems, and what staff were to do if these triggers were observed; ▪ Safe presentation techniques for food and fluid; ▪ Presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, and medication administration; and ▪ Techniques to promote independence and skill acquisition during mealtimes. The document entitled Orientation and Pre-Service Training Schedule 1st New Employee Orientation Sessions, revised 6/2010, included the following sessions related to physical and nutritional supports: Dietitian/Food Textures (one hour duration), Therapeutic Handling and Positioning (three hour duration), PNMP Practicum (four hour duration), Deaf Awareness (45 minute duration), Communicating with People Who Live Here (one hour and 30 minutes duration), Sign Language (one hour and 45 minutes duration). The total time included in NEO for staff to receive foundational training in physical and nutritional supports was 12 hours. There were no learning objectives and competencies provided for the training in physical and nutritional supports that was designed to provide foundational knowledge and skills related to competent implementation of the PNMP. <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> A written test with 22 questions called Test Your Knowledge: PNMPs, was administered to new employees. There was a Skills Check Off for Body Mechanics and Therapeutic Handling and Positioning. There was no skill performance check-off for mealtime foundational skills. Based on a review of 21 individual records, in one (Individual #426) of 21 records (5%), there was confirmation of staff completion of a competency performance check-off for	Noncompliance

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		communication. There were no staff competency performance check-offs for individual PNMPs and/or dining plans. <u>All foundational trainings are updated annually</u>. Based on a review of the monthly Facility Competency Training and Development Calendar, a Lifting/Transfer refresher class was provided on a monthly basis. Forms were submitted for staff completion of an assessment checklist for a standard/pivot transfer, two-person manual lift, and mechanical lift. There were no Facility staff training reports submitted to document the percentage of Facility staff with responsibilities for the provision of direct supports who had completed competency-based training (written test and performance check-offs) in foundational physical and nutritional management. <u>Staff are provided person-specific training on the PNMP by the appropriately trained personnel.</u> Based on a review of staff PNMP training records, competency-based individual-specific training was not provided by appropriately trained personnel. This was illustrated as follows: ▪ In zero of 19 records reviewed (0%), PNMP Coordinators had been provided instruction by licensed therapists and/or assistants. ▪ In zero of 19 records reviewed (0%), licensed therapists, assistants and/or PNMP Coordinators had trained supervisors and/or other designated staff who would be responsible for implementation of PNMPs. ▪ In zero of 19 records reviewed (0%), licensed therapists, assistants, PNMP coordinators, and/or competency-trained designated supervisors/home managers, etc. had provided instruction to direct support professionals. <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> In zero of 21 staff training records reviewed (0%), staff who had successfully completed competency-based training provided assistance to individuals determined to be at an increased level of risk. For example: ▪ Individual #426 was assessed by the PNMT on 8/5/10. Documentation for competency-based staff training for his speech generating device was submitted, but no other competency-based staff training documentation was submitted related to the PNMT Evaluation recommendations. <u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u>	

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		Based on a review of staff training in 21 individual records, zero out of 21 (0%) showed that staff were re-trained when changes occurred on the PNMP.	
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 policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> <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> Based on review of the Facility's policy, AUSSLC did not have an adequate policy defining the monitoring system for PNMPs and meal observations. A policy should be developed to ensure that a system is in place to monitor staff implementation of PNMPs, including mealtime plans. At a minimum, such a policy should include: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; ▪ Identification of monitors and their roles and responsibilities; ▪ Formal schedule for residences to be monitored on a quarterly basis, with an identified staff schedule; ▪ A revalidation of monitors on an annual basis by therapists and/or assistants; and ▪ Results of monitoring activities in which deficiencies noted are formally shared for appropriate follow-up by the relevant supervisor. As stated in the baseline report, the Physical and Nutritional Management Policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, identification and definition of specific monitoring indicators for PNMPs, identified compliance levels expected, and/or the process to be followed if PNMPs were not being implemented as written. There were no revisions to this policy, nor did the Facility's POI address changes to monitoring. The Facility presented the following tools to be used to monitor implementation of PNM procedures and plans: ▪ The Habilitation Therapies Meal Observation and Training Roster, undated, which monitored the following areas of concern: o Positioning (head position, position in wheelchair, position at table, and enteral eating position); o Texture: • Food (puree, ground and chopped); • Liquid (tomato juice, nectar and pudding consistency); • Equipment (eating-in use, seating/dining, clean); • Dining Plans (out and in use, instructions followed, lemon ice served, liquids served with meal, correct texture, seconds	Noncompliance

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		offered); • Instructions posted (texture, thick-it and lemon ice); • Reported to nursing (excessive coughing, vomiting); and • Supervisory staff present. ▪ The Mealtime/Snack Observation Form monitored the following indicators: o **Dining room** (tables, chairs and floor clean; dining cards clean and on table; individuals set/assisted to set the table, meal served on-time; individuals begin eating 15 minutes after plate is served); o **Meal Service** (staff following dining card instructions; portions sizes and texture correct per diet card; liquid consistency correct; assistive equipment present and in use; seconds offered as appropriate; drink options offered; lemon ice served per mealtime/snack plans; liquids encourage throughout meal/snack; condiments offered; supplements served per individual's plan; refusal to eat and was an alternative offered; refusal to eat and number of times encouraged to try; dependently fed at a pace to prevent choking; risk factors observed such as coughing, choking, and vomiting; report risk factors as they occur to nurse; and snacks served match list for each on snack bag); o **Active Treatment** (individuals washed/sanitized their hands prior to seating; staff washed hands prior to service; wash hands in between assisting individuals; independence promoted; and after mealtime/snack hygiene carried out); o **Staff Performance** (supervisory staff present during mealtime/snack; staff redirected maladaptive behavior(s); staff able to state why assistive equipment is needed; staff able to state rationale for positioning instructions; staff explained need for texture modification, if applicable; staff able to explain why supplement is needed, if applicable; staff promoting a social atmosphere during meal; and staff able to identify training objective, if applicable); and o **Monitor Task** (share feedback with staff). The bottom of the form stated: "Please write a brief explanation for all questions answered 'NO' on the back of this form. Additionally, note any concerns and/or commendable actions. If issues are identified, provide staff with training, write a brief description on the back of this form regarding what training was provided and have the staff sign. **N/A**=should be noted if item does not apply." The Monitoring Team requested PNMP and mealtime monitoring conducted over the past two weeks, prior to the on-site review for all residences. Seven different monitoring forms were submitted, including:	

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- Mealtime Snack Observation Checklist, undated;
- Mealtime Snack Observation Form, undated;
- PNMP Monitoring Form - Bathing, undated;
- Lifting-Transfer Monitoring Form, undated;
- Habilitation Therapies PNMP Observation and Training Roster, undated;
- Speech Hearing Equipment Observation, undated; and
- Individual/Shared Communication Equipment Monitoring, undated.

PNMP Coordinators completed these monitoring forms. The following chart represents the number of monitoring(s) completed for each identified form per individual residences.

Residence	Mealtime/ Snack Observation Checklist	Mealtime/ Snack Observation Form	PMNP Monitoring - Bathing	Lifting/ Transfer Monitoring Form	PNMP Observation and Training	Speech Hearing Equipment Observation	Communication Equipment Monitoring
501	4	6	0	0	0	0	0
727C	0	1	2	3	7	0	0
727I	0	15	0	0	1	0	0
729	2	18	0	2	2	1	0
730	5	8	0	0	0	0	0
732D	0	15	3	1	0	1	0
732E	0	18	6	4	13	2	0
732M	0	14	9	10	11	2	0
772B	0	14	0	0	1	1	0
779F	1	36	1	1	0	0	0
779R	0	18	1	1	0	0	0
781	0	15	0	0	0	0	0
782	1	11	0	0	0	0	0
783	0	7	0	0	4	0	1
784	1	23	1	0	3	0	1
785	0	14	0	1	5	0	1
786	0	3	0	0	0	0	0
787	0	4	0	0	0	0	0
788	0	10	0	0	0	0	1
789	0	4	0	0	0	0	0
791	1	0	0	0	0	0	0
792	3	0	0	0	0	0	0

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793	1	24	0	0	1	0	0
794	2	1	0	0	0	0	0
795	3	16	0	0	1	0	0
796	0	7	1	0	2	0	0
797	0	17	0	0	2	2	0

A review of these multiple monitoring forms identified the following concerns:

- There were no procedures to define the frequency and schedule of monitoring, as documented by the randomness of the monitoring completed from residence to residence.
- There were no procedures to determine the frequency of monitoring for those individuals at highest risk.
- There were no instructions and/or definitions provided for the indicators on the seven monitoring forms.
- There were no policies/procedures to define the thresholds for staff re-training.
- There were no procedures to define the competency-based training for monitors, and the subsequent validation process to achieve accurate scoring and achieve inter-rater reliability.
- An analysis of these monitoring tools had not been completed to identify ongoing areas of concern in residences, and the development of corrective strategies to ameliorate individual-specific and/or systemic areas of deficiency with specific indicators.
- There were no procedures to report identified deficiencies to a supervisor for appropriate follow-up.
- These monitoring forms had not been integrated into the Facility's Quality Assurance and/or Risk Management systems.
- Cardinal and the Infirmary, residences for individuals with complex health and physical/nutritional support needs, received minimal monitoring.
- Monitors were not following the directions for the Mealtime/Snack Observation form that required an explanation for any item that was marked "no."
- The Mealtime/Snack Observation Form did not have a specific indicator for mealtime position and alignment. As stated above with regard to Section O.4 of the SA, during the Monitoring Team's observations, many individuals were not positioned before and/or during the meal.

A review of completed monitoring forms documented staff non-compliance without resolution. The following provides some examples:

- Staff were not following hand washing procedures;
- Staff were not following dining plan instructions;
- Meals were not served on time;

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		▪ Supervisory staff were not present during the meal; ▪ Individuals were not helping to set the table before meals to support independence; ▪ Staff were not following the positioning schedule; ▪ Staff were not positioning individuals correctly in alternate positions per their PNMPs; ▪ Staff were not offering second servings of food; ▪ Individuals were waiting a long time to eat; ▪ Staff were not checking to ensure individuals received correct diet texture and fluid consistency; and ▪ Staff were not able to explain why assistive equipment was used. Habilitation Therapies staff were completing monitoring, but it did not appear that this was resulting in improved outcomes for the individuals AUSSLC served. Non-compliance findings with monitoring indicators within residences were not being analyzed, summarized, and/or addressed. No monitoring summation reports were submitted. Compliance with PNMPs and dining plans should be the joint responsibility of Habilitation Therapies and all staff responsible for the provision of supports to individuals, including but not limited to residential staff, day program and vocational staff, nurses, the Dental Department, etc. Facility Administration, in collaboration with Habilitation Therapies staff, and Quality Assurance staff should analyze monitoring results and implement strategies to support staff compliance with individuals' PNMPs. This includes ensuring that when individual issues are identified, supervisory staff follow-up to address the immediate issues, but also should involve developing solutions to any systemic issues identified. <u>All members of the PNM team conduct monitoring.</u> Based on review of 21 individuals' records, the PNM Team completed the following: ▪ In zero of 21 records reviewed (0%), PNM Team members completed individual-specific monitoring. ▪ In zero of 21 records reviewed (0%), monitoring was conducted on a frequent basis for those individuals at highest risk, to ensure comprehensive assessment summary strategies were implemented. ▪ In zero of 21 records reviewed (0%), deficiencies noted during monitoring were corrected within an appropriate period of time. ▪ In zero of 21 records reviewed (0%), issues noted during monitoring were followed by the PNM team, and remained open until all issues had been resolved and appropriate trainings conducted. ▪ In zero of 21 records reviewed (0%), results of monitoring activities in which deficiencies were noted were formally shared for appropriate follow-up by the relevant supervisor.	

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		Examples of an individual where the PNM Team did not complete adequate monitoring included: ▪ PNMT members did not complete monitoring to ensure recommendations and measurable outcomes were being implemented in a timely manner for Individual #426, Individual #39, and/or Individual #182. <u>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.</u> A review of Facility reports, including those from Quality Assurance, did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM Team for analysis leading to the identification of potential issues, and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of, and/or frequency of, certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria should be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual-specific and systemic levels. This information should be integrated into the Facility's Quality Assurance, Incident Management and Risk Management systems. In addition, PNMT members should be actively involved in internal mortality reviews as a learning process, as well as a mechanism for improving supports to individuals with the most complex health, physical, and nutritional support needs. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> According to the document entitled AUSSLC Deaths Since 1/1/10, dated 9/9/10, seven individuals died within the time period from January to August 2010. Five of these individuals' deaths were attributed to acute respiratory failure, chronic respiratory failure, pneumonia, and aspiration pneumonia, which indicated these individuals had physical and nutritional support needs. Three of the individuals who died were selected for review (Individual #44, Individual #27, and Individual #136). The Nutritional Management Team and Health Status Team had reviewed these three individuals multiple times prior to their deaths, but as stated in the baseline report, the NMT reviews consisted of a chart review leading to recommendations that did not support an aggressive approach to minimize identified health risk indicators such as aspiration pneumonia. The PNMT did not provide an intensive, interdisciplinary, problem-solving approach for these individuals, resulting in a timely and proactive comprehensive assessment, including the development of outcomes for which strategies would be implemented. The following examples illustrated that immediate intervention was not provided even	

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		when an individual was determined to be at risk of harm: ▪ Individual #136's cause of death was documented as pneumonia. The NMT Report indicated that the NMT reviewed Individual #136 on 11/19/08 and 4/20/09. Individual #136 would have benefited from the expertise of a PNM Team to provide an intensive, interdisciplinary problem-solving approach. The team should have initiated a comprehensive assessment leading to the development of strategies to minimize her significant health risks, as evidenced by the Active Problem List in her PSP, dated 7/23/09, and NMT Individual Report(s), which identified spastic quadriparesis secondary to hypoxic encephalopathy, seizure disorder, hypothyroidism, gastroesophageal reflux, osteoporosis, enterally nourished, overweight, skin breakdown, constipation, dehydration, history of choking, dysphagia, respiratory distress, and chronic lung disease with poor management of her secretions. ▪ Individual 44's causes of death were documented as aspiration pneumonia, dysphagia unspecified, and severe mental retardation. The NMT completed 11 reviews from 7/18/07 to 12/22/08. The following problems were identified: H pylori, anemia, aspiration, gastrostomy tube, fundoplication, Barrett's Stricture and esophageal cancer. Individual #44 would have benefited from the expertise of a PNMT to provide an intensive, interdisciplinary problem-solving approach. This team should have initiated a comprehensive assessment leading to the development of strategies to minimize his significant health risks. ▪ Individual #27's causes of death were acute respiratory failure, aspiration pneumonia, and severe kyphoscoliosis. The NMT reviewed her nine times from 5/23/07 to 11/19/08, and documented the following problems: gastrostomy and jejunostomy tube(s), reflux, respiratory issues, and aspiration. Individual #27 would have benefited from the expertise of a PNMT to provide an intensive, interdisciplinary problem-solving approach. This team should have initiated a comprehensive assessment leading to the development of strategies to minimize her significant health risks. Furthermore, an extensive, critical review of events leading up these individual deaths would be an important learning strategy to identify future individual-specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs, most importantly, for individuals at the highest health risk levels. It would be important for a member(s) of the PNMT to be involved in such a review process.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop	<u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.</u> Based on the review of 21 individual records (Individual #39, Individual #182, Individual #426, Individual #452, Individual #327, Individual #74, Individual #54, Individual #372,	Noncompliance

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	and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	Individual #159, Individual #355, Individual #413, Individual #422, Individual #50, Individual #435, Individual #344, Individual #199, Individual #403, Individual #251, Individual #416, Individual #42, and Individual #331), for none of these individuals (0%), did the PNM Team complete a comprehensive assessment leading to the development of strategies. As a result, the PNMT did not document progress of individual strategies on a monthly basis to ensure their efficacy. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> Based on the review of 21 individual records, in none (0%) did the PNMT document the progress of individuals to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators. In none of the 21 records reviewed (0%), was it documented that if PNMPs were found through this monitoring not to be effective, that the PNMPs were updated.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.</u> Based on the review of nine individual records (Individual #50, Individual #456, Individual #107, Individual #34, Individual #310, Individual #189, Individual #286, Individual #121, and Individual #22) who were enterally nourished and/or received supplemental tube feedings, none (0%) of these individuals had received an annual assessment that addressed the medical necessity of the tube and potential pathways to PO (by mouth) status. Examples of individuals who received enteral nutrition and did not receive an annual assessment included: • Individual #107's OT/PT Update, dated 3/26/10, stated: "[Individual #107] has been reviewed numerous times in NMT for choking, stricture, full tube feedings, and aspiration. He received a G-tube in 2002 due to meal refusals and losing weight. Numerous attempts to return to oral feeding were made unsuccessfully." His PSP, dated 5/18/10, stated: "[Individual #107] should have his nutritional needs met with a feeding gastrostomy. He should undergo gastrostomy care." There was no evidence of an annual assessment to address the medical necessity of the tube. • Individual #50's PSP, dated 11/3/09, stated: "[Individual #50] has been reviewed extensively by the NMT for pneumonia and dysphagia. [Individual #50] receives all her nutrition via G-tube and has conservative anti-reflux measures in place." There was no evidence of an annual assessment to address the medical necessity of the tube. • Individual #22's PSP, dated 2/10/10, stated: "[Individual #22] was hospitalized	Noncompliance

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		1/12/10 for unresponsiveness, aspiration pneumonia, and dilantin toxicity. During hospitalization, a gastrostomy tube was inserted." There was no evidence of an annual assessment to address the medical necessity of the tube. • Individual #189 did not have a PSP. There was no evidence of an annual assessment to address the medical necessity of the tube. • Individual #34's OT/PT Update, dated 9/24/10, stated: "[Individual #34] has had no NMT activity in several years. He has had several videoesophagrams with no aspiration during any of these. Reflux occurred in a video in 1994. He takes anti-reflux medication and has conservative anti-reflux measures in place. The tube was placed as an alternative method of eating because of aspiration during a period of hospitalizations and due to weight loss. [Individual #34] resumed eating although he continues to have the G-tube which is used only for medications." There was no evidence of an annual assessment to address the medical necessity of the tube. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.</u> Based on a review of an identified sample of nine individual records, individuals were provided with a PNMP that included: ▪ In nine of nine records reviewed (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In nine of nine records reviewed (100%), transfer instructions were included. ▪ In zero of 9 records reviewed (0%), strategies for medication administration were included. ▪ In zero of 9 records reviewed (0%), strategies for oral hygiene were included. ▪ In nine of nine records reviewed (100%), individual adaptive equipment was included. ▪ In nine of nine records reviewed (100%), bathing/showering positioning and instructions were included. ▪ In nine of nine records reviewed (100%), personal care instructions were included. ▪ In nine of nine records reviewed (100%), communication strategies were included. <u>The need for continued enteral nutrition is integrated into the PSP.</u> Based on a review of eight individuals' PSPs who received enteral nutrition, none (0%) of the individuals' PSPs documented the rationale for the continued need for enteral nutrition. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD,</u>	

#	Provision	Assessment of Status	Compliance
		SLP or OT). Facility policies for Physical Nutritional Management, implemented 1/31/10, and Nutritional Management Team, implemented 1/31/10, did not clearly define the frequency and depth of evaluations required for an individual receiving enteral nutrition. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. A review of one individual's record (Individual #22) who recently received a gastrostomy feeding tube showed the individual received the following: ▪ In zero of one record reviewed, the individual was referred to the PNM Team for review and the development of a comprehensive assessment/summary. ▪ In zero of one record reviewed, the individual received interventions to promote continued oral intake. ▪ In zero of one record reviewed, monitoring was completed by the PNM Team to support the efficacy of the interventions. More specifically: ▪ Individual #22's OT/PT Update, dated 1/27/10, stated: "[Individual #22] has a history of aspiration since it was identified on video in 12/99. NMT has reviewed his case many times. He was hospitalized in 11/09 with aspiration pneumonia. He returned home, but was readmitted with respiratory distress in 1/10. At that time, his sister, who had declined placement of a G-tube as an alternate method of nutrition agreed to the G-tube." The PNMT did not complete a comprehensive assessment to develop strategies to promote continued oral intake prior to the placement of a feeding tube.	

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

1. A nurse should be identified to be a dedicated core member of the PNMT.
2. Ongoing opportunities should be provided for continuing education for all PNMT members, not just therapists, to support their responsibilities in working with individuals with complex physical and nutritional support needs.
3. In order for a dedicated PNM team to carry out the full responsibilities of a properly functioning team, there will be a substantial increase in the caseloads of the remaining therapists and dietitians. The Facility should complete an analysis to determine the number of therapy and dietitian positions necessary to support these professionals being active members of individuals' PSTs.
4. Individuals identified with complex physical and nutritional support needs should have a timely, proactive comprehensive assessment completed; development and implementation of identified strategies to meet measurable functional outcomes, including an appropriate PNMP; a schedule for regular review, ongoing documentation, monitoring and analysis to determine the efficacy of the supports provided; and modifications to strategies/plans, as necessary.
5. Criteria should be defined for referral of individuals to the PNMT. Individuals at highest risk should be prioritized to receive a PNMT comprehensive assessment. Upon completion of the comprehensive assessment, the PNMT should develop and implement intervention plans,

conduct individual-specific monitoring, develop and implement documentation guidelines/requirements, and complete a review and analysis of data collected, to determine the efficacy of supports provided at both the individual-specific and systemic level(s).

6. Because the PNMT should be working with individuals with the most complex health, physical, and nutritional needs, the PNMT should avoid including elongated timeframes for the completion of recommendations. There should be a sense of urgency to complete all recommendations, leading the individual to improved health and wellness.
7. The PNMT should utilize existing data regarding Infirmary admissions and hospitalizations to conduct an analysis and begin the process of initially identifying individuals who are in need of physical and nutritional supports.
8. In addition, the Facility's Incident Management and/or Investigation departments should conduct such an analysis to determine if there are systemic issues or causal factors that require resolution. The PNMT should play an integral role in this process. The PNMT should be responsible for determining not only the efficacy of the individual-specific outcomes for those individuals at highest risk and with the most complex health, physical, and nutritional needs, but also should be responsible for providing an analysis on a systemic level, and developing and monitoring thresholds/triggers for integration into the Facility Risk Management and Quality Assurance Systems.
9. The implementation of competency-based individual-specific PNMP training for all staff in the Infirmary and Cardinal should be a priority. Positioning protocols for all alternate positioning, when individuals are in seating systems, during mealtime or when individuals receive eternal nutrition, as well as during tooth brushing, medication administration, bathing/showering, and personal care, should be reviewed with all staff, including nursing staff.
10. PNMPs should incorporate strategies for medication administration and/or oral care for those individuals identified at risk. In addition, these PNMP strategies need to be integrated within an individual's Nursing Care Plan.
11. The PNMT should establish thresholds to trigger further evaluation based on degree of, and/or frequency of, certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria should be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided, at both the individual-specific and systemic level. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems.
12. The content for new employee orientation, in the area of physical and nutritional supports, should be reviewed to reassess the time allotment, as well as course content, to ensure staff receive the foundational knowledge and skills to implement physical and nutritional support plans safely.
13. Staff performance check-offs, used to determine competence, should include demonstration of proper position and alignment of individuals in wheelchairs, as well as in alternate positions and mobility systems; safe body mechanics; mechanical lift and two-person transfer; position and alignment at mealtimes; identification of food textures and fluid consistency; and safe presentation techniques for food and fluid.
14. Staff should be required to successfully complete a skill performance check-off to document staff competency with learning objectives. Job descriptions as well as the performance evaluations for direct support professionals should incorporate these training requirements.
15. Facility Administration, in collaboration with Habilitation Therapies staff and Quality Assurance staff, should analyze monitoring results and implement strategies to support staff compliance with individuals' PNMPs. This includes, ensuring that when individual issues are identified, supervisory staff follow-up to address the immediate issues, but also should involve developing solutions to any systemic issues identified.
16. The Facility's therapy staff should conduct frequent on-site audits to validate PNMP Coordinators are competent, and to provide coaching/ mentoring.
17. The monitoring policy for mealtime and PNMP monitoring should describe a monitoring system that includes criteria for, and identification of, who will complete the monitoring, competency-based training for monitors, descriptions of each indicator with monitoring strategy, definition of staff retraining thresholds, a validation/inter-rater reliability process, 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 Assurance systems. Such policies should define "regular" monitoring as required by the Settlement Agreement. In addition, policies for monitoring staff's implementation of PNMPs should be reviewed and revised, and Facility procedures should be developed, to ensure adequate monitoring as required by the SA and HCG.

18. PNMT members should be actively involved in internal mortality reviews as a learning process as well as an opportunity for improving supports to individuals with the most complex health, physical and nutritional support needs.
19. Procedures should be developed and implemented to ensure individuals at risk of receiving enteral nutrition are referred to the PNMT for completion of a comprehensive assessment.
20. Comprehensive evaluations should be conducted for 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. This will require assessment/evaluation by a number of team members, and review by the entire PST.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section P; o The following documents: Occupational Therapy and Physical Therapy Assessments, OT/PT/SLP consultations for the last year, OT/PT Treatment Plans, OT/PT Skill Acquisition Programs, PSP and PSP Addendums for the last year, Physical and Nutritional Management Plan with pictures, PNMP person-specific monitoring, PNMP Clinic Notes, Competency-based training for staff, Wheelchair assessment, OT/PT PSP monthly progress note and dining plan for the following individuals: Individual #231, Individual #81, Individual #235, Individual #28, Individual #3, Individual #291, Individual #198, Individual #327, Individual #262, Individual #437, Individual #368, Individual #54, Individual #417, Individual #381, Individual #401, Individual #170, and Individual #233; o Community Living Discharge Plan for Individual #233; o Community Living Discharge Plan for Individual #170; o List of Individuals who use Wheelchair as Primary Mobility, dated 9/13/10; o List of Individuals who use Wheelchair as Transport Mobility, dated 9/13/10; o List of Individuals who use Ambulation Assistive Devices, dated 9/10/10; o List of Individuals with Orthotics and/or Braces, dated 9/13/10; o Decubitus List, from 10/09 through 8/10; o PNM Maintenance Log for Wheelchairs, from 7/10 through 9/10; o OT/PT Assessments/Evaluations (template), not dated; o OT/PT Assessments/Evaluations and PSPs for Multiple Individuals, from 6/10 through 9/10; o Mat Assessments for Seating and Positioning (blank), undated; o Wheelchair/Mobility/Assistive Equipment Work Orders for Multiple Individuals, from 7/09 through 8/10; o PSP List for OT/PT/Speech, from 1/10 through 10/10; o Level of Assistance for Dining, dated 2010; o Meal and PNMP Monitoring Forms, dated 9/10; o OT/PT Documentation and Monitoring Results, from 12/09 through 10/10; and o OT/PT Consult Log, from 1/10 through 5/10. ▪ **Interviews with**: o Sarah Reves, AUSSLC Lead Occupational Therapist and Back-up to Department Head, PNMT Core Member; o Mace Welch, AUSSLC Interim Department Head, PNMT Core Member; o Christina Gernale, Certified Occupational Therapy Assistant (COTA); and o PNMP Coordinators. ▪ **Observations of**: o Residences 732-D, 732-E, 732-M, 779-R, 779-F, 779-H, Infirmary, 727-C, 795, 794, 793,

	792, 791, 501, 796, and 797; o PNMP Coordinator Meeting; and o Community Living Discharge Plan meeting for Individual #170.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps it took to assess compliance. Although the POI reviewed for AUSSLC did not include this component, the POI for Section P identified compliance with some indicators. However, based on the Monitoring Team's review, the Facility was not in compliance with some of these components of the SA. Examples of indicators that were rated in compliance, but non-compliance was found by the Monitoring Team included: ▪ The POI for Section P.1.3-12 documented compliance. The Monitoring Team did not concur with this designation of compliance because OT/PT Evaluation and/or Updates did not consistently follow the established outline format, and individuals were not assessed when they experienced a change in status. ▪ The POI for Section P.2.8 documented compliance. The Monitoring Team did not concur with the assignment of compliance, because individuals within the sample the Monitoring Team reviewed were not reviewed in the PNMP Clinic. During the entrance conference, the AUSSLC Habilitation Therapies Interim Director indicated that the Habilitation Therapies Department had implemented the following activities related to Section P after the initial baseline review: ▪ Habilitation Therapies staff had developed a process for on-the-job training for new employees. At the time of the review, the training was being revised. ▪ Habilitation Therapies staff developed a training program for bed positioning, and had finished training nurses and staff at the residence with individuals at highest risk.
	Summary of Monitor's Assessment: The current caseloads for occupational and physical therapists did not enable the therapists to be active members of the individuals' PSTs, and this will present significant challenges in meeting the standards set forth in Section P of the SA. According to the Staff Vacancy Report, the AUSSLC staff-to-individual ratio for OTs was 1:75, and for PTs, the ratio was 1:80. Whereas, for example, the Psychology staff-to-individual ratio was 1:25, with similar duties regarding assessment, planning, monitoring, and provision of direct supports and/or oversight. As a result, therapists were not active members of the PSTs, as evidenced by their lack of participation in annual PSP meetings. They had insufficient time to integrate therapy goals/objectives into formal skill acquisition programs, and to develop informal strategies to reinforce learned skills. The Facility, in collaboration with the Interim Habilitation Therapy Director/staff, should revisit the therapy and dietitian staff-to-individual ratio to enable these professionals to function as active members of the PST for individuals on their caseloads. Although individuals had OT/PT Evaluation Updates, updates had not been completed when there was a change in status, such as a diagnosis of aspiration pneumonia, diet downgrade, BMI in the super obesity range, unplanned weight loss, skin breakdown, and/or community transition. In addition, assessments did not lead to the development of direct or indirect treatment plans for individuals with identified needs.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>P1</td><td>By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.</td><td>In this section of the report, each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings.

<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u> According to the current census provided to the Monitoring Team, there were 376 individuals living at AUSSLC. The following chart represented the caseloads, at the time of the review, of the Occupational Therapists and Physical Therapists, which indicated there were 376 individuals living at AUSSLC:

<table>
<tr><th>Occupational Therapist(s)</th><th>Current Caseloads and Responsibility</th></tr>
<tr><td>OT #1</td><td>PNMT core member and Lead for PNMT; Lead OT and Supervisor of OTs, five PNMP Coordinators, and Wheelchair Shop; Lead OT for wheelchair fabrication; Lead for GI (gastrointestinal) Clinic, performs all videoesophagrams and supporting 20 individuals</td></tr>
<tr><td>OT #2</td><td>Backup OT for PNMT, Backup OT for videoesophagrams, OT for residences with most PNM needs, and supporting 107 individuals</td></tr>
<tr><td>OT #3</td><td>Responsible for supporting 148 individuals</td></tr>
<tr><td>OT #4</td><td>Responsible for supporting 96 individuals</td></tr>
<tr><th>Physical Therapist(s)</th><th>Current Caseload</th></tr>
<tr><td>PT #1</td><td>Interim Habilitation Therapy Director, Supervisor of PTs and three PNMP Coordinators, 2nd Level supervisor of other Department members</td></tr>
<tr><td>PT #2</td><td>Lead for Orthotics Clinic, PT for residence with most PNM needs, and supporting 83 individuals</td></tr>
<tr><td>PT #3</td><td>Lead for Pedorthotic Clinic, Lead PT for wheelchair fabrication, and supporting 97 individuals</td></tr>
<tr><td>PT #4</td><td>Responsible for supporting 106 individuals</td></tr>
<tr><td>PT #5</td><td>Responsible for supporting 89 individuals</td></tr>
</table>

There were five budgeted positions for Occupational Therapy, but the current OT caseloads reflected four OT positions. There were five Physical Therapy budgeted positions with no vacant positions. Thirteen PNMP Coordinator positions were approved and there were no vacant positions.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The current caseloads for occupational and physical therapists did not enable the therapists to be active members of the individuals' PSTs, and this will present significant challenges in meeting the standards set forth in Section P of the SA. According to the Staff Vacancy Report, the AUSSLC staff-to-individual ratio for OTs was 1:75, and for PTs, the ratio was 1:80. Whereas, for example, the Psychology staff-to-individual ratio was 1:25, with similar duties regarding assessment, planning, monitoring, and provision of direct supports and/or oversight. As a result, therapists were not active members of the PSTs, as evidenced by their lack of participation in annual PSP meetings. They had insufficient time to integrate therapy goals/objectives into formal skill acquisition programs, and to develop informal strategies to reinforce learned skills. The Facility, in collaboration with the Interim Habilitation Therapy Director/staff, should revisit the therapy and dietitian staff-to-individual ratio to enable these professionals to function as active members of the PST for individuals on their caseloads. Based on a review of CVs for each therapy clinician, the appropriate qualifications were found for the Interim Habilitation Therapy Director, four OTs, and five PTs. All OT and PT licenses were current. Continuing education documentation for the OTs and PTs showed attendance at only two continuing education courses within the past 12 months: ▪ NMT/PNMP/Equipment Webinar; and ▪ Seating and Positioning for dysphagia. The Facility should continue to support therapists' attendance at a variety of annual continuing education courses, to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at AUSSLC. The OT/PT Consultation Log was submitted with a listing of individuals receiving direct OT and/or PT services and a description of the focus of intervention. There were no individuals currently receiving direct OT and/or PT services per the OT/PT Consultation Log. According to a Consultation Report, Individual #54 was receiving direct PT services, but no formal PT Treatment Plan was submitted. Seventeen records were reviewed, including those for: Individual #231, Individual #81, Individual #235, Individual #28, Individual #3, Individual #291, Individual #198, Individual #327, Individual #262, Individual #437, Individual #368, Individual #54, Individual #417, Individual #381, Individual #401, Individual #170, and Individual #233. These 17 individuals had identified needs related, but not limited to, movement, mobility, range of motion, independence, regression of functional skills, a change in status, and/or community transition.	

#	Provision	Assessment of Status	Compliance
		<u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u> There had only been one individual admitted to the Facility since the previous review. This individual was no longer living at the Facility. This indicator will be reviewed during the Monitoring Team's next review. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> The OT/PT Evaluation Update template was as follows: ▪ General Information: o Active Problems; o Communication; and o Behavioral Considerations; ▪ Physical/Nutritional Management Plan (PNMP): o Focus; and o Review; ▪ Assistive Equipment; ▪ Assessments: o OT/PT Consults; o Foot Assessment; o Transfers; o Gait Assessment; o Fall Review; o Wounds; o Wheelchair; o Upper Extremities; o Oral motor/dining; and o Self care; ▪ Nutritional Management Team: o Review; and ▪ Recommendations. There were no guiding questions and/or prompts within each of the OT/PT evaluation domains to support a comprehensive assessment. Even though individuals had received an OT/PT Evaluation and/or OT/PT Evaluation Update, none of the 17 individual records reviewed (0%) had an OT/PT Evaluation and/or Update that incorporated the components identified in the OT/PT Evaluation and/or OT/PT Evaluation Update template. None of the 17 OT/PT assessments (0%) identified the need for OT and/or PT supports/services.	

#	Provision	Assessment of Status	Compliance
		The following individual received direct PT, but it was not recommended in the OT/PT Evaluation Update: • According to the OT/PT Consultation Log, Individual #54 received an "evaluation ambulation, walk with gait belt and 2 staff on 3/23/10". Her OT/PT Evaluation Update, dated 8/17/10, did not recommend direct PT services, but a Consultation Report, dated 9/2/10, documented that since 8/6/10, Individual #54 had received direct PT services for gait and transfer training. The consultation report indicated the PT would continue direct PT services for gait and transfer training daily (Monday through Friday), for four weeks. The PT documented that Individual #54 had met a goal of performing transfers with minimal assistance, with one person holding her gait belt and right hand. Three additional goals were identified. There was no OT/PT Treatment plan submitted, and/or documentation reporting on the progress and/or lack of progress with the identified therapy goals. Although individuals had an OT/PT Evaluation Update, there had not been updates when there was a change in status, such as a diagnosis of aspiration pneumonia, diet downgrade, BMI in the super obesity range, unplanned weight loss, skin breakdown, and/or community transition. The following individual concerns were identified: ▪ Individual #291's BMI was 50.5. A BMI score over 50 placed him in the "super obesity" category, and placed him at extremely high health risk. His OT/PT Evaluation, undated, recommended: "Give [Individual #291] the opportunity for physical exercise, including use of the stationary bicycle at his residence, exercise equipment and swimming (pending pool evaluation) to support his stated wish for weight loss." No direct OT and/or PT services were recommended to address his high risk status due to weight. ▪ Individual #73 was observed during a meal and coughed multiple times. The PNMP Coordinator in the dining room stated he had been referred to OT for a meal consultation. The most current OT consultation was 2/8/10 for "client is spitting out food while eating. Please evaluate." He had not been reassessed for mealtime concerns. ▪ On 3/4/10, Individual #28's diet texture was downgraded from finely chopped to ground, and on 3/12/10, downgraded again from ground to pureed. His most current OT/PT evaluation was 11/17/09. On 3/1/10, there was a consultation, but no mealtime assessment completed to address his change in status as reflected by two diet texture downgrades. ▪ Individual #235's diet texture was pureed, until on 2/1/10, he received a gastrostomy tube. There was no evidence of a comprehensive mealtime assessment to address strategies prior to the placement of his gastrostomy tube.	

#	Provision	Assessment of Status	Compliance
		▪ On 3/25/10 and 6/25/10, Individual #81 was diagnosed with aspiration pneumonia. His most current OT/PT assessment was dated 2/25/10. He had not received an updated assessment to address his change in health status. ▪ On 1/10/10, Individual #231 was diagnosed with aspiration pneumonia. His most recent OT/PT assessment was dated 7/1/09. There was not an updated assessment and/or OT/PT assessment to address his health status change. ▪ Individual #233's Community Living Discharge Plan (CLDP) identified her date of transition as 9/17/10. Her OT/PT Evaluation Update (OT, dated 5/6/10, and PT, dated 3/24/10) did not address community transition. ▪ Individual #170 had a CLDP in preparation for community transition to occur (tentatively) on October 21, 2010. Her most current OT/PT assessment was 1/14/10, which did not discuss community placement. ▪ According to the OT/PT Consult Log, on 4/28/10, Individual #417 was "evaluated for increase in coughing on pureed and nectar thick liquid." The most current OT Evaluation Update was dated 12/15/09. He did not receive an updated comprehensive mealtime evaluation. ▪ The Wound List documented three occurrences of skin breakdown for Individual #262, on 9/25/09, 11/6/09, and 5/5/10. There were no OT/PT assessment updates/consultations to address her recurrent skin breakdown. ▪ Individual #198 experienced an unplanned weight loss, of 15.1% of his overall body weight, in six months, and he was placed in the high-risk category for weight. His OT/PT Update, dated 4/16 and 5/18/10, did not address his significant weight loss, and did not include a comprehensive mealtime assessment. The large caseloads of OTs and PTs, with responsibilities including, but not limited to completing evaluations, developing and revising PNMPs, and participating in PNMP clinics, did not leave adequate time to provide direct therapy. This was evidenced by the absence of formal OT/PT treatment plans found in the individual records of 17 individuals. The OT/PT annual evaluation recommendations were generic in nature, and did not provide functional recommendations to the PST for consideration. <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> Based on individual record reviews, zero of the 17 individuals (0%) reviewed had received a comprehensive OT/PT assessment within the last three years. In addition, assessments were not updated when there were changes in status. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic</u>	

#	Provision	Assessment of Status	Compliance
		interventions. None of the 17 (0%) assessments reviewed addressed medical issues and health risk indicators, or utilized such information to establish a rationale for the recommendations/therapeutic interventions. Evidence of communication and or collaboration is present in the OT/PT assessments. Based on record review, zero of the 17 OT/PT Evaluation and/or Updates (0%) included the OT and PT signatures with dates.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP. Based on review of comprehensive OT/PT assessments and/or updates, for zero of 17 individuals (0%) had a plan been developed within 30 days of the date of the assessment/update. Within 30 days of development of the plan, it is implemented. As stated above, there were no plans developed and/or 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. None of the 17 individuals (0%) had direct or indirect OT and/or PT services integrated into their PSPs. 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. As noted above, none of the individuals reviewed had plans developed, and/or included in their PSPs. 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 person's status, transition (change in setting), or as dictated by monitoring results. Based on review of OT/PT documentation the one individual in the sample being provided direct treatment (Individual #54), for zero of one individual (0%), there was evidence that the individual was reviewed at least monthly for OT/PT Status.	Noncompliance
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	Staff implements recommendations identified by OT/PT. Examples are provided above, with regard to Section O.5 of the SA, of staff not following PNMPs developed by OTs and PTs. Based on observations of OT/PT interventions, all PNMPs and/or other intervention	Noncompliance

#	Provision	Assessment of Status	Compliance
	the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	plans were not implemented. In addition, during a lunch observation, a PNMP Coordinator did not intervene to coach staff to correct poor alignment and support, and to ensure staff followed dining plan presentation techniques. Observations by the Monitoring Team did not support that PNMP Coordinator(s) had achieved competency in the provision of foundational physical and nutritional support service delivery. PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training, with specific learning objectives and identified competencies. Such training should include foundational knowledge and skills related to the appropriate implementation of physical assistance supports including, but not limited to, risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming, and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include written tests and skills-based performance check-offs. Therapists need to conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required. It is essential that PNMP Coordinators are competent in the performance of their duties, because these staff are responsible for service delivery, as well as monitoring of direct support professionals. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.</u> Based on review of individual records, direct support professionals were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for zero of 17 individuals reviewed (0%) in the sample.	
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	<u>System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.</u> The Checklist for Internal Compliance Review of Critical Process Indicators Related to Physical/Nutritional Management of Consumers Requiring Such Services (Habilitation Therapies Handbook Physical and Nutritional Management, Section V. PNMP Clinic) stated: ▪ "Assistive equipment should be appropriate for the prescribed use, effective, well-fitting, well-maintained, clean and attractive. Assistive equipment should be monitored daily by Direct Contact staff for correct use and repair. Assistive equipment should be assessed for continued need and appropriateness by	Noncompliance

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	and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	professional staff at least annually and as otherwise indicated. ▪ PNMPs should be monitored by professional staff as scheduled/needed for proper application of equipment and techniques, to ensure effectiveness, and to correct problems at least annually and as other wise indicated." Based on the 17 individual records reviewed (Individual #231, Individual #81, Individual #235, Individual #28, Individual #3, Individual #291, Individual #198, Individual #327, Individual #262, Individual #437, Individual #368, Individual #54, Individual #417, Individual #381, Individual #401, Individual #170, and Individual #233), none of the individuals (0%) were assessed in the PNMP Clinic. The following concerns were noted: ▪ Individual #81's OT/PT Evaluation Update, dated 2/25/10, indicated he "moved from 732 Eagle to 779 Falcon due to decrease in mobility and functional skills. He received a gastrostomy tube with fundoplication in 12/2009 after meal refusals, weight loss, decrease in swallowing function, and significant reflux (identified on video 7/2009). He had numerous revisions to his PNMP to change his equipment, mobility, transfers, level of assistance required in self-care activities, diet texture, liquid consistency and positioning." No PNMP Clinic documentation was submitted to show that professional staff had monitored the assistive equipment to ensure its appropriateness and effectiveness, and to correct any problems identified. ▪ Individual #417's OT Evaluation Update, dated 12/15/09, stated: "His PNMP was adjusted thirteen times this past year due to [Individual #417's] overall changes and decline." No PNMP Clinic documentation was submitted to show that professional staff had monitored the assistive equipment to ensure its appropriateness and effectiveness, and to correct any problems identified. ▪ Individual #262's OT/PT Evaluation Update, dated 4/30 and 5/17/10, documented Individual #262's "PNMP has been revised to change instructions in her skin care program, add equipment to promote skin integrity, change positioning times, change dining equipment, and reflect current practice of wording. Her PNMP was altered to reflect her functional status change after her amputation. She has special equipment and instructions for her transfers." No PNMP Clinic documentation was submitted to show that professional staff had monitored the assistive equipment to ensure its appropriateness and effectiveness, and to correct any problems identified. ▪ Individual #327's OT/PT Evaluation Update, dated 9/14 and 9/30/10, stated that Individual #237's "PNMP had the following changes in the past year, on 7/19/10 a precaution was added for risk of choking and his diet texture was downgraded to chopped and in 8/10 instructions and equipment were added to reduce the risk of respiratory problems and reflux." No PNMP Clinic documentation was submitted to show that professional staff had monitored	

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		the assistive equipment to ensure its appropriateness and effectiveness, and to correct any problems identified. ▪ Individual #198's OT/PT Evaluation Update, dated 4/16 and 5/18/10, stated: "due to falls and balance issues, his PNMP has been revised over the past year to instruct staff to use a home transport wheelchair during fire drills and when he's sedated; and for staff to hold his gait belt and his hand when he's walking outside, when he's getting on/off the van, and for transfers during fire drills or if he's been sedated. He also showers with staff assistance." No PNMP Clinic documentation was submitted to show that professional staff had monitored the assistive equipment to ensure its appropriateness and effectiveness, and to correct any problems identified. <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> Based on review of the State and Facility's policies, a defined monitoring system was not in place to monitor staff implementation of PNMPs, and other OT/PT interventions. Such a policy should have included: ▪ Definition of monitoring process; ▪ Identification of monitors (licensed professional for OT/PT intervention plans), and their roles and responsibilities; ▪ Formal schedule for monitoring to occur; ▪ A revalidation of monitors on an annual basis by therapists and/or assistants; and ▪ A process for the results of monitoring activities in which deficiencies are shared formally with the relevant supervisor for appropriate follow-up. Additional information is provided above with regard to Section O.6 of the SA, and identifies in more detail individual-specific and systemic issues related to monitoring. <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> A policy did not exist that clearly defined the details of the monitoring system, including frequency and implementation requirements. Such a system should require that the program author review intervention plans monthly, including observation of staff's implementation of the plans. <u>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 (as discussed further with regard to Section O.5 of the SA)</u>. As noted above, issues were identified related to the competencies of the PNMP	

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		Coordinators who had responsibility for working with the individuals with the most complex needs, and the task of monitoring other staff's competence. It is essential that these staff consistently demonstrate competence in these areas. Staff competency-based training documentation was not submitted for staff providing supports to individuals at increased risk. Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (as discussed further with regard to Section O.4 of the SA). As noted above, a system for monitoring had not been developed and memorialized in policy. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. As stated above, individuals were not reviewed in PNMP Clinic to determine if the adaptive and/or assistive equipment was appropriate, and readily available to the individual. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs (as discussed further with regard to Section O.5 of the SA). As noted above, a system for monitoring had not been developed and memorialized in policy. Data collection method is validated by the program's author(s) . As noted above, a system for monitoring had not been developed and memorialized in policy.	

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

1. The Facility Administration, in collaboration with the Interim Habilitation Therapy Director/staff, should review the current therapy staffing to determine if there are sufficient staff (OTs, COTAs, PTs, and PTAs) to meet the requirements of the SA, provide appropriate supports to individuals with physical and nutritional support needs, as well as be active members of individuals' Personal Support Teams.
2. The Facility should continue to support therapists' attendance at a variety of annual continuing education courses, to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at AUSSLC.
3. The Habilitation Therapy Department should develop guiding questions and/or prompts, within each of the OT/PT evaluation domains, to support consistency between therapists, and ensure that comprehensive assessments are completed.
4. Current therapy services being provided to individuals should be integrated into PSP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally.
5. PNMP Coordinators should receive competency-based physical assistance and mealtime supports training, with specific learning objectives and

competencies identified. Such training should provide foundational knowledge and skills related to the appropriate implementation of physical assistance supports, including but not limited to, risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming, and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include written tests and skills-based performance check-offs.

6. Therapists should conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required.
7. Policies/procedures should be developed for the OT/PT monitoring system, with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of PNMPs and related equipment, and OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability, and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans, as well as activity plans. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Dental notes and Integrated Progress Notes for the following individuals: Individual #158, Individual #29, Individual #253, Individual #332, Individual #74, and Individual #350; o Dental Clinic - % Attendance, September 2009-September 2010; o Dental Clinic May, June, July [2010], type of appointment, and if refused/no show; o Refusals, Sept 2009 to 2010; o Dental Clinic – Prophylaxis Visits Sept 2009 to 2010; o Dental Clinic – Restorations, April 2010 – September 2010; o Dental Clinic – Treatment, April 2010-September2010; o Dental Clinic – Extractions, April 2010 – September 2010; o Dental Tracking Sheets from June-July 2010 (Daily Log); o Date of last annual dental exam/date of previous annual dental exam; o Austin State Supported Living Center Policy: Dental Services, undated; o Dental Clinic – % of Individuals using Mechanical Restraints, from 9/09 to 8/10; o Dental Clinic – Type of Restraint for last two years, Sept 2008 to Sept 2010; o Dental Clinic – % oral sedation, from January to July 2010; o Dental Clinic – % of Individuals requiring IV anesthesia; o Dental Clinic – New Admissions within the past six months; o Desensitization – 40 individuals, undated; o Staffing report, dated 4/29/10, for Individual #133; o Medical Record for the following individuals: Individual #339, and Individual #92; and o Since January 1, 2010, a list of all individuals admitted to the Facility's Infirmary and the length of stay. ▪ **Interviews with**: o Rhonda Stokley, DDS, Pharmacy Director; and o Dr. L Thompson, Dental Anesthesiologist. ▪ **Observations of**: o Individual #456; and o Dental Clinic.
	Facility Self-Assessment: According to the POI, the Facility's self-assessment indicated many areas of noncompliance, although there were areas that the Facility considered to be in compliance, or approaching compliance. For example, the use of IV sedation had allowed for successful treatment of many individuals. A system to track missed appointments was now in place, and the database was beginning to provide reliable and detailed information. Desensitization plans had been developed. However, the dentist had not had a collaborative role in developing or implementing these plans, and there was awareness of the need for improved communication with the Psychology Department in order to create a successful program.

	Summary of Monitor's Assessment: The Dental Department was generally meeting the routine, preventive, restorative, and urgent care needs of the individuals who resided at AUSSLC. However, there had been issues with the timeliness of annual dental assessments. The Dental Director was working to correct this. However, the high rate of restraint use, chemical and mechanical, was a challenge to the department. There was no oral health outreach program in the residences. Providing teaching and training, by a dental hygienist, in the residences would begin to prevent the need for dental procedures requiring chemical and mechanical restraints. Additionally, there should be rigorous desensitization plans that are implemented and followed, and revised as needed until successful. The dentist was unlikely to be successful in reducing restraint use without desensitization being a routine part of many individual's dental care. This will require oversight by the Psychology Department, and coordination with the Dental Department. The Dental Department had made much progress in obtaining accurate data for missed appointments. Improved and frequent communication with the QMRPs and residence managers was needed for the Dental Department to be efficient and effective. Policy development, especially involving Total Intravenous Anesthesia (TIVA), was an area of need.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	The Dental Director was the only full-time dentist in the department. Over the past months, the large backlog in treatment delays had been reduced and eliminated under the guidance of the Dental Director. Only recently had individuals been able to be seen every six months, and the new goal was for cleanings to occur every three to four months. There was identical recording in the individuals' active records and the office records. Everything was recorded on carbon copies, and the original was sent to the active record. Correspondence regarding individuals was kept separately in the dental office. Tooth brushing with suctioning was not used at AUSSLC. Concerns were raised as to the appropriate staff for the task of tooth brushing with suctioning, whether nursing staff or direct support professionals would be appropriate. This issue was not resolved in the past and it is recommended that this be revisited. A sister Facility has been successful with implementation of tooth brushing with suction and might be able to provide guidance with this issue. Annual assessments were reviewed for timeliness. Two measurements of timeliness were calculated. Annual assessments were considered timely when they were completed within or prior to the anniversary month of the following year. The dates of the two most recent annual dental examinations were reviewed for 188 individuals living in 14	Noncompliance

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		residences. Those having completed annual dental examinations within or prior to the anniversary month totaled 120 individuals. This was a compliance rate of 64%. An alternate measurement of timeliness was completion of the annual dental examination within 365 days of the prior examination. Using this parameter, the compliance rate was 56%. For the dental appointments that were missed, the Dental Department was beginning to track the various reasons for missed appointments, such as refusals, furlough, illness, conflicting off-campus appointments, etc. The Dental Department had met with the Information Technology personnel, and members of the Dental Department had been taught how to enter data into the database, and how to use the database. The Dental Department was now beginning to collect details on these categories. Some of the difficulties with collecting accurate data for this database were recorded in the submitted document: Dental Clinic May, June, July. The following provides some of the reasons for missed appointments that were recorded: For July 2010, Individual #19 had a missed appointment. The reason recorded was "no show, no answer when called home for reason." Individual #160 missed an appointment in July 2010. The reason documented was "no show, multiple phone calls to home for reason – no answer." Individual #362 missed an appointment in July 2010. The reason documented was "no show, multiple phone calls to home for reason – no answer. Finally talked to DCS (direct care staff) - did not know why said someone would call back – never heard back." Individual #30 missed an appointment in July 2010. The reason documented was "no show, multiple phone calls to home for reason – no answer." Individual #369 missed an appointment in July 2010. The reason documented was "no show, multiple phone calls to home for reason – no answer. Finally talked to DCS – did not know why said someone would call back – never heard back." Individual #276 missed an appointment in July 2010. The reason documented was "no show, multiple phone calls to home for reason – no answer." Individual #83 missed an appointment in July 2010. The reason documented was "no show, multiple phone calls to home for reasons – no answer." These examples illustrated the challenges in obtaining accurate information for the database. This will require increased communication and cooperation between the Dental Department, the QMRPs, and home managers. It is recommended that for cases in which there is no information despite telephone contact, that a form letter be developed and sent to the QMRP, which would include a request for the reason for the missed appointment, as well as the date, and signature of the QMRP. This method would provide documentation of communication, as well as increase the importance of gathering accurate information by requiring a QMRP signature and date. Individuals refusing appointments varied from month to month. The accuracy of the information was potentially problematic, based on the above examples that occur in the	

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		system. However, as mentioned, the Dental Department was beginning to implement systems to improve accuracy and completeness of information. From a submitted document, Refusals Sept 2009-2010, there appeared to be overall improvement in reducing refusal rates from 2009 to 2010. In 2009, the recorded number of refusals for September was 14, October 2009 was seven, November 2009 was 13, and December 2009 was four. For the calendar year of 2010, the month with the highest number of refusals was January, in which eight refusals were recorded. However, as noted above, there were a number of missed appointments in which the information was not obtained, despite efforts on the part of the Dental Department. As a result, it could not be determined if these were refusals, or if there were other reasons for the missed appointments. Prophylactic visits, for the six months prior to the Monitoring Team's visit, totaled 333 visits to the Dental Clinic. In April 2010, there were 59 visits, in May 2010, there were 61 visits, in June 2010, there were 53 visits, in July 2010, there were 60 visits, in August 2010, there were 57 visits, and in September 2010, there were 43 visits. The total of 333 visits in six months, suggested most individuals were receiving a prophylactic visit every six months, based on some individuals being edentulous, and some individuals refusing treatment. However, the information was not detailed enough to define the number of individuals that completed a prophylactic visit per each interval of time (i.e., number of individuals with prophylactic visits every three months, every four months, etc.). Dental treatment included the full spectrum of dental care, including crowns, fillings, and denture adjustments. The following information was taken directly from a list submitted by the Dental Department, entitled "Dental Clinic - Treatment April 2010 – September 2010." Procedures included under "treatment" were not separately listed, but the list excluded extractions, because those individuals listed on a list of extractions were not included on the treatment list. There might have been other procedures not included under the term "treatment." Whatever the Dental Department's interpretation was for the term "treatment" was assumed to be included. In April 2010, there were nine Dental Clinic treatment visits. In May 2010, there were 16 dental clinic treatment visits. For June, this number was 17, and for July the number was 16. The Dental Director went on leave in August, and this might have been reflected in the reduced numbers of treatments in August (seven treatments) and in September 2010 (six treatments). Restorations were a significant part of treatment. For April 2010, four restorations were recorded. For May 2010, there were 10 restorations. In June 2010, there were 14 restorations. In July 2010, there were 10 restorations, and in August 2010 there were five restorations. There were a number of extractions also recorded (April 2010 – three extractions, May 2010 - two extractions, June 2010 - seven extractions, July 2010 - seven extractions, and August 2010 - six extractions.)	

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		Emergency treatment was reviewed in submitted cases. ▪ Individual #158 was seen on 7/14/09 as an emergency. The concern was called in that same morning, and he was seen at 1515 the same day for pain in his gums on the left side. A local abrasion was found on the edentulous ridge, and a history was obtained of eating chips. Care instructions were given to the individual, as well as advice on alternative foods to eat until the traumatized ridge heals. ▪ Individual #158 was seen on 7/19/10 for complaints of soreness in the lower right side of the mouth. Some local injury to the edentulous area was found, and the dentist determined that it was likely due to chewing a hamburger a couple of days prior. Explanation was given to the individual, and instructions were given. ▪ On 7/15/10 Individual #29 complained of mouth pain at 0625, and at 1150, the PCP gave a new order to have him seen by the dentist. An appointment was made for the following morning. On 7/16/10, an emergency dental visit was completed. An acute cheek bite with ulcer was found. The dentist determined this was possibly due to recent seizure activity. Instructions on treatment of ulcer and reassurance were provided. ▪ On 7/26/10, at 0830, Individual #253 was noted to clamp her mouth shut, and shook her head side to side, pushing staff away when eating and taking medication. At the request of the Infirmary, the dentist saw her due to possible "sores" in the mouth. At 0930 she was seen in the dental office. She did not want to open her mouth, and a mouth prop was used. An exam was then completed, with no findings to suggest reason for pain or discomfort. The plan was that the Infirmary was to notify the Dental Department if the condition persisted or worsened. The dentist then contacted the PCP and provided an update on the findings. ▪ On 7/13/10, Individual #332 underwent restorative dental treatment. He was ordered Ibuprofen 400 mg QID for discomfort while awake through 7/17/10. He then developed worsening behaviors and was seen 7/15/10, placed under IV Propofol for less than five minutes, and examined for any acute causes. The two fillings placed on 7/13/10 were still intact, and occlusion was considered good. No causes were found for the behaviors. Noted were some facial scratches to the area below the left earlobe, right cheek, below the chin, and a minor cheek bite on the right side of the mouth. ▪ Individual #74 was seen on 6/30/10 for her annual assessment. At that time, she was noted to have two areas of ulceration, at the tip of the tongue and slightly ventral to that area. She was prescribed medication and returned on 7/9/10. The tongue was more ulcerated, and the individual continued to have discomfort. She was seen one week later on 7/15/10. Lesions on the tongue had not changed. The direct support professionals had observed her chewing on	

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		her tongue. The dentist gave orders to prompt the individual to stop chewing the tongue whenever the behavior was noticed. The plan was to recheck in two weeks, photograph if a camera was available, and do biopsies. An entry on 10/7/10 documented the difficulty with obtaining consent from the guardian. Forms were sent twice and there was discussion with the guardian twice. The forms were sent the third time by certified mail. ▪ The Infirmary called the Dental Department on 7/20/10 concerning Individual #350 and SIB to her jaw. The Dental Department was informed that the residence would call on 7/21/10. When that did not occur, and the Dental Department called the residence, and was told that there were no complaints. The Dental Department recommended that she be seen anyway. On 7/22/10, the residence called and informed that staff would attempt to bring her to the Dental Department, but this did not occur. She was seen on 7/26/10 at 0815. The dentist examined her, and there were no findings. This was communicated to the nurse and the direct support professionals. ▪ Individual #350 was noted to be holding her chin while eating on 9/20/10. She was asked to come in while the dentist anesthesiology was there on 9/22/10. She did not show up, and the Dental Department spoke with the case manager and rescheduled her for 9/28/10 when the dentist anesthesiologist returned. No information was submitted for follow up. Due to the delays in annual assessments for many individuals, and the many missed and refused appointments that, at times, cause delays in treatment, the Facility remains out of compliance with this component of the SA.	
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	The dental manual consisted of one undated policy: Austin State Supported Living Center Policy: Dental Services. This served as a general guideline to dental care at the Facility, but was lacking in important details, such as the exact definition of timeliness of completion of annual assessments, as mentioned with regard to Section Q.1 of the SA. It is recommended that this policy be revised and updated to include important details, as well as provide consistency with the current SO policy and procedure manual for dental care. Additionally, there should be a number of policies and guidelines for such clinical areas as TIVA, TIVA post monitoring, oral sedation tracking, oral sedation pre, intra, and post monitoring, tracking of missed appointments, and process of determining which individuals should undergo TIVA, etc. For monitoring of post anesthesia care, the following records were reviewed: ▪ Individual #92 had IV anesthesia on 12/16/09, and a dental note was written in the IPN. She underwent cleaning, x-rays, and exam. She was placed post-anesthesia in the Infirmary for observation. Orders were written: "Infirmary for	Noncompliance

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	minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	2 hr observation following dental appt with IV anesthesia. Vitals q (every) 15 min first hour, q 30 minutes 2nd hr as pt will tolerate. If vital stabilizes may then return home. Tylenol 1000 mg po stat (one dose)." ▪ Individual # 92 also had IV anesthesia on 7/15/10. There was a dental note in the IPN. She was observed in the Infirmary, and then a nursing note at 1600 indicated monitoring. Vital signs were recorded, as well as oxygenation. There was no bleeding from the mouth noted, and she was described as not sedated, at which time she was discharged to her residence. A nursing note at 2345 indicated she was still being monitored in the residence. ▪ Individual #339 underwent IV anesthesia sedation on 8/3/10 for dental work. She then went to the Infirmary for monitoring. The nurses continued monitoring according to the protocol, and continued review each shift for three days from 8/4/10. The nurses had a good understanding of the monitoring post IV anesthesia protocol. There were a number of overnight admissions to the Infirmary for observation of post-anesthesia dental treatment (according to a listing of reasons for Infirmary admissions). These included the following individuals: Individual #190 from 8/17 to 8/18/10; Individual #165 from 8/10 to 8/11/10; Individual #290 from 8/10 to 8/11/10; Individual #325 from 7/8 to 7/9/10; Individual #128 from 7/7 to 7/8/10; Individual #267 from 7/7 to 7/8/10; Individual #206 from 6/24 to 6/26/10; Individual #80 from 6/24 to 6/25/10; Individual #32 from 6/22 to 6/23/10; Individual #274 from 6/9 to 6/10/10; Individual #433 from 6/7 to 6/8/10; Individual #229 from 6/3 to 6/4/10; Individual #191 from 5/25 to 5/28/10 (three day stay); Individual #238 from 5/19 to 5/21/10 (two day stay); Individual #390 from 5/19 to 5/20/10; Individual #204 from 4/28 to 4/29/10; Individual #148 from 4/22 to 4/23/10; Individual #273 from 4/14 to 4/16/10 (two day stay); and Individual #423 from 3/24 to 3/25/10. These admissions suggested a prolonged recovery from the anesthesia, or post-dental procedure concerns or complications, such as swelling or bleeding. Review of additional information indicated the majority of these prolonged admissions were for post extraction monitoring. However, the dental policy did not reflect this as part of the routine procedure of the department. There should be a policy or section of a policy concerning post treatment care, outlining the reasons and length of time for Infirmary care. This should be monitored for quality improvement purposes to ensure it is being followed (i.e., individuals who have had extractions are not returning to the residence immediately if the policy states otherwise). If there are prolonged stays in the Infirmary, these should likewise be tracked. In the above list, there were two two-day stays and one three-day stay. There should be a tracking mechanism in the Dental Department to determine whether these were expected stays or represented unforeseen circumstances or complications. The goal would be to reduce any complication rate over time.	

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		Dental Clinic information was submitted for May, June, and July of 2010. For May 2010, there were 105 dental clinic visits scheduled. Eight visits or 8% were missed appointments. The show rate was 92%. For the 97 individuals that actually attended clinic visits, the oral sedation rate was 26%. Seven percent required IV sedation and 15% required restraints. In June 2010, there were 116 Dental Clinic visits scheduled. There were 20 missed appointments, which represented 17% of the total number of appointments. This gave a show rate of 83%. For the 96 individuals that actually attended the Dental Clinic, the oral sedation rate was 21%. The IV sedation rate was 15%. The restraint rate was 14%. For July 2010, there were 114 appointments scheduled. Of these, 18% were missed appointments and 82% were kept. The oral sedation rate for all appointments kept was 19%. The IV sedation rate for all appointments kept was 23%. The restraint rate for all appointments kept was 8%. The rates of attendance at the Dental Clinic were similar to those calculated by the Dental Department: May 2010 was 92%, June 2010 was 83%, and July 2010 was 81%. The rate of oral sedation use was similar to the rate calculated by the Dental Department: May 2010 was 26%, June 2010 was 21%, and July 2010 was 19%. The Dental Department estimated that 29% of the individuals, who currently resided at AUSSLC, routinely required IV anesthesia. The department also noted that approximately 15% of the remainder required IV anesthesia for certain situations (fillings, extractions, root canals, etc.) The Dental Department provided information concerning mechanical restraint use. The Human Rights Department counted 177 mechanical restraints in Rights Assessments from 9/09 to 8/10. Based on a census of 376, it was estimated that 47% of the population residing at AUSSLC used mechanical restraints for dental procedures. This does not represent an unduplicated count. In 2009, three types of mechanical restraints were documented, wristlets, seatbelts, and papoose restraints. August 2009 was the last month in which papoose restraint use was recorded. Wristlets and seatbelt remained as the documented types of restraints. For the last year, restraint use was documented as the following: ▪ September 2009 - 21 visits requiring restraints; ▪ October 2009 - 14 visits requiring restraints; ▪ November 2009 - 13 visits requiring restraints; ▪ December 2009 - 19 visits requiring restraints; ▪ January 2010 - 13 visits requiring restraints;	

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		▪ February 2010 - 23 visits requiring restraints; ▪ March 2010 - 31 visits requiring restraints; ▪ April 2010 - 20 visits requiring restraints; ▪ May 2010 - 15 visits requiring restraints; ▪ June 2010 - 14 visits requiring restraints; ▪ July 2010 - seven visits requiring restraints; and ▪ August 2010 - four visits requiring restraints. There was a range of restraint use from four to 31 per month. Some individuals required more than one type of restraint. The lower number of restraints used in August might, in part, be due to the Dental Director going on leave, and there being fewer dental appointments as a result. In order to reduce the use of both mechanical and chemical restraints, including IV sedation, desensitization plans had been created. Although teams had met to discuss desensitization for those who receive pretreatment sedation or restraints, there had often been no formal plan of implementation. According to the Dental Director, there has been no success to date. Some of the desensitization plans focused on tooth brushing. This is perhaps the first step in an eventual successful dental visit. Many of these desensitization plans occurred in the residential setting. Additionally, there had been activity, at the dental office, involving desensitization. Some of the individuals arrived for a visit, and some sat in a chair. At times, the direct support professionals accompanying the individual were asked to explain the desensitization plan or current step, but the direct support professionals responded with "I don't know." There was a log kept of anyone who completed a visit to the Dental Department as part of a desensitization plan, but no one had asked to review the log. This indicated that there was no follow-up to determine if the desensitization plan was progressing, or would need further review by the team. Reportedly, desensitization also became more chaotic when an entire group arrived, by transport, for a desensitization visit. This may not be the most efficient use of Dental Clinic staff time, the individual's time, nor direct support professionals' time. There seemed to be little information concerning whether these group arrivals for desensitization were at all helpful in accomplishing the desensitization goals. Desensitization plans were reviewed for the following individuals: Individual #316 (training objective completion date 7/8/11), Individual #263 (training objective completion date 2/24/11), Individual #99 (training objective completion date 5/25/11),	

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		Individual #374 (training objective completion date 6/9/11), Individual #306 (service objective completion date 4/1/11), Individual #161 (service objective completion date 1/29/11), Individual #135 (service objective completion date 5/14/11), Individual #208 (training objective completion date 7/21/11), Individual #140 (service objective completion date 4/8/11), Individual #42 (training objective completion date 5/26/11), Individual #173 (service objective completion date 4/15/11), Individual #230 (training objective completion date 9/15/11), Individual #253 (training objective completion date not identified), Individual #287 (training objective completion date 5/21/11), Individual #96 (service objective completion date 8/12/11), Individual #370 (service objective completion date 8/3/11), Individual #379 (service objective completion date 4/14/11), Individual #346 (service objective completion date 1/27/11), Individual #277 (service objective completion date 2/17/11), Individual #32 (service objective completion date 2/25/11), Individual #409 (service objective completion date 3/3/11), Individual #397 training objective completion date 1/29/11), Individual #93 (training objective completion date 1/10/11), Individual #381 (training objective completion date 12/4/10), Individual #288 (service objective completion date 6/1/11), Individual #182 (service objective completion date 5/4/11), Individual #421 (training objective completion date 5/26/10 – no further training objective or completion date provided after this date), Individual #364 (training objective completion date 2/9/11), Individual #86 (service objective completion date 4/9/11), Individual #308 (service objective completion date 3/18/11), Individual #201 (training objective completion date 1/12/11), Individual #379 (service objective completion date 4/14/11), Individual #425 (training objective completion date 3/16/11), Individual #100 (training objective completion date 2/17/11), Individual #278 (training objective completion date 5/13/11), Individual #416 (training objective completion date 1/9/11), Individual #185 (training objective completion date 11/27/10), Individual #44 (training objective completion date 8/5/10 – no further training objective or date of completion submitted), Individual #34 (training objective completion date 9/22/11), and Individual #195 (training objective completion date 3/23/11). The desensitization plans were brief. Each appeared to respond to the unique challenges and needs of the individuals, some requiring focus on tactile defensiveness with oral care, to routine and periodic visits to the dental office. There were no quarterly monitoring data or progress reports attached to these plans to verify if any had been implemented, or monitored, and whether or not the team received information concerning any progress toward accomplishing these goals and objectives. During the next visit, the Facility will be requested to submit monitoring information based on these service and training objectives, as well as analysis of information after date of completion, with information concerning further team meetings regarding the next step(s).	

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		However, given that no QMRP or other team member had reviewed the dental log for visits, suggested there had been little tracking of success of implementation for those plans in which a dental visit was part of the desensitization. Further, there had been no successful desensitization plan focusing on dental care for any individual as of the Monitoring Team visit, according to the Dental Director. If follow-up monitoring indicated there had been little progress with desensitization and improved ability to cooperate with dental care, then it is recommended that the Facility obtain consultation with a psychologist or other professional who can assist AUSSLC with creating an efficient and effective program of desensitization for those individuals needing dental care. At the time of the review, there appeared to be little interaction between the Dental and Psychology Departments An additional way to reduce the use of mechanical and chemical restraints would be an aggressive plan for improved oral hygiene, measured by an improved oral hygiene index. If there was improved hygiene, there might be a reduced need for restorative care, extractions, and chemical and mechanical sedation. The Dental Department would benefit from adding a dental hygienist position, with concentration of time in the residences, teaching individuals appropriate tooth brushing techniques, as well as mentoring the direct support professionals who assist the individuals in oral hygiene. Additionally, an additional dental assistant is needed to assist in physical positioning and direction during the dental exam and treatment process. The addition of these two positions would allow the department to meet the needs of the population. For those individuals refusing dental care, the PST is responsible for creating and implementing a plan to reduce the refusal rate. One example was submitted of this process. Individual #133 had a history of missing several dental appointments. The team met on 4/29/10, and developed an interdisciplinary team recommendation to assist in resolution of this problem. The Dental Director indicated such team meetings and recommendations were sometimes helpful in reducing refusal rates for some individuals, but they might not be effective for other individuals. In the example provided, there was no data collection since the completion date of 4/29/10 to provide proof of implementation or monitoring to evaluate degree of success. It is recommended that this be done, and that data be collected to determine progress and positive impact.	

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

1. For cases in which an individual misses an appointment, and there is no information despite telephone contact, a form letter should be developed and sent to the QMRP, including a request for the reason for the missed appointment, as well as the date and signature of the QMRP completing the form.

2. The Dental Director should seek guidance from an SSLC that has been successful in implementing a program of tooth brushing with suction, because this would benefit many individuals at AUSSLC, and assist in protecting individuals from harm related to issues such as aspiration.
3. The Dental Director should update and formalize any existing dental policies and procedures. These should include tracking of missed appointments, criteria for oral sedation administration, oral sedation tracking, monitoring of oral sedation prior to the visit, post procedure monitoring, etc. In addition, there should be policies and procedures covering all aspects of TIVA administration (criteria for selection, monitoring before, during, and after procedure, names of medications prescribed, etc.).
4. The Dental Director should review the post procedure course of individuals that required an overnight or longer stay in the Infirmary to determine the reason for the prolonged recovery, document the reason in the record for future reference, and highlight any additional risk to future IV, or oral sedation, or dental procedures to minimize potential future complications.
5. A challenge to the Dental Department is to reduce the rate of IV sedation over time. A plan should be created to accomplish this (i.e., reducing the current 29% estimated rate by 20% in 5 years, etc.) with steps and processes to actively pursue this goal.
6. Similarly, the Dental Department should develop a plan to reduce the use of mechanical restraints from the estimated current 47% of individuals (not controlled for potential duplication).
7. The Dental Director should meet with the Psychology Department to review the current desensitization plans and implementation process, as well as other strategies to reduce the need for restraint. The experience that the Dental Director has with the current plans should be shared.
8. For plans that have been implemented by PSTs for individuals that refuse dental visits, there should be implementation and tracking of implementation, with data collection that is shared with the team, and results in revisions, as necessary, until the visit is successful.

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

1. The Dental Department should promote an oral hygiene program in the residences. This will require a full-time dental hygienist whose main focus is teaching and training oral hygiene in the residences. Additionally, an additional position of a dental assistant is needed to provide support in examination and treatment of these individuals.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section R; o The following documents were requested: SLP Assessment, SLP Progress notes, SLP communication program, communication device instructions, PSP and PSP Addendums, Behavior Support Plan, SLP consultations for the last year, SLP documentation for the last year, and communication dictionary for the following individuals: Individual #426, Individual #393, Individual #350, Individual #374, Individual #332, Individual #108, Individual #228, Individual #448, Individual #161, Individual #284, and Individual #355; o List of Communication Dictionaries, undated; o Alternative and Augmentative Communication (AAC) Equipment List, dated 9/13/10; o Speech-Language Evaluation (blank), undated; o AAC and SLP Assessments and corresponding PSPs for Multiple Individuals, from 12/09 through 8/10; o Speech and Hearing Equipment Observation (blank), undated; o Speech and Hearing Equipment Observation by Home, dated 9/10; o Communication Dictionaries for Multiple Individuals, from 8/07 through 7/10; o Communication Assessment Master Plan-Habilitation Therapies, revised 9/16/10; and o List of Individuals receiving Direct Speech Services and Focus of Intervention, dated 9/16/10. ▪ **Interviews with**: o Kim Milstead Ingram, MEd, CCC-SLP, Lead SLP; o Caryl Price, MA, CCC-SLP; o Prachi Tare, MS, CCC-SLP; and o Mari Lee Chartier, MA, CCC-A. ▪ **Observations of**: o Residences 732-D, 732-E, 732-M, 779-R, 779-F, 779-H, Infirmary, 727-C, 795, 794, 793, 792, 791, 501, 796, and 797.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps it took to assess compliance. Although the POI reviewed for AUSSLC did not include this component, the POI for Section R identified compliance with some indicators. However, based on the Monitoring Team's review, the Facility was not in compliance with some of these components of the SA. Examples of indicators that the Facility rated as being in compliance, but non-compliance was found by the Monitoring Team included: ▪ The POI for Section R.2.3 indicated that the Facility was in compliance with the following indicator: "100% of records show that all people identified with communication needs receive a comprehensive assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities and development of new skills." The comments section stated: "comprehensive assessments occur per the master plan based on a priority rating.

	When needs are identified, they are addressed." The Monitoring Team did not agree with this finding of compliance. For example, individuals with identified needs, within the sample of records reviewed, had not received a SLP assessment in over 10 years. ▪ The POI for Section R.2.3 indicated that the Facility was in compliance with the following indicator: "100% of records reviewed show that the SSLC will use a system-approved evaluation tool to identify individuals for communication needs." The Monitoring Team reviewed SLP evaluations that did not follow the SLP Evaluation format in the Habilitation Therapies Handbook, revised 2009. ▪ The POI for Section R.3.7 documented compliance with the following indicator: "100% of records reviewed and observations and interviews completed show that AAC devices are meaningful to the individual." The Monitoring Team did not concur with the finding of compliance as individuals' AAC devices were not integrated into PSPs, and SLPs were not active participants in the PST. ▪ The POI for Section R.3.12 indicated that the Facility was in compliance with the following indicator: "100% of records reviewed show that devices and their use are monitored regularly to insure implementation." There were no formal policies to define the monitoring process. During the entrance conference, the AUSSLC Habilitation Therapies Interim Director indicated that the Habilitation Therapies Department had implemented the following activities, related to Section R of the SA, following the initial baseline review: ▪ Basic sign language classes had been offered to staff since June 8th. The class format was currently being reviewed to improve functional outcomes, and was anticipated to restart on October 15th. ▪ Three videophones for people who were deaf/hearing impaired had been installed on campus, and were working. They were located at the Speech and Hearing Augmentative Communication Lab, and in Residences 501 and 772B. ▪ The Facility had begun to hire staff fluent in American Sign Language (ASL). A Home Supervisor, who was certified as a level one interpreter, was working in the residence of one individual who was deaf (772), and was making a significant difference in the life of the person who lived there. ▪ A total of 788 staff received sign language refresher training (based on signs taught in new employee orientation), and Speech and Hearing staff offered social skills training on a quarterly basis.
	Summary of Monitor's Assessment: Even though two additional SLPs had been hired, the caseloads for speech language pathologists remained inadequate to allow therapists to be active members of individuals' Personal Support Teams, and provide adequate functional communication supports to the individuals. The ratio of SLP staff to individuals will continue to provide significant challenges in meeting the requirements of Section R of the SA. While Speech Language Pathologists were completing evaluations, some of which identified the need for augmentative/alternative communication devices, there were not sufficient resources to provide direct and/or indirect speech therapy supports for individuals with an identified need. Only two of 376 individuals (less than 1%) living at AUSSLC were receiving direct speech services. To the credit of the SLPs, there were multiple individuals with communication devices on campus (low tech and high tech), as well as

	many generic devices, but there was not a current framework within the PSP process to integrate these devices into formal, teachable moments, such as integration into skills acquisition programs. In other words, there were not adequate processes, formats, and/or training of staff in place to support therapists and teams working together to integrate the use of individuals' AAC devices into their daily lives through the development and implementation of meaningful, functional, measurable objectives. The SLP Department had begun to develop customized instructions for individuals with AAC devices. The instructions were placed within the PNMP section of the Individual Notebook. A smaller version was placed with and/or on each device. The SLP and Psychology Department had agreed upon a process and procedures for SLPs and psychology staff to work together to integrate strategies to address individuals' communication needs with their behavioral needs. This had begun to happen for a few individuals. Since the baseline review, three videophones were in place. The videophones were located in the Augmentative Communication Lab, and Residences 772 and 501, where the individuals who used them lived. Classes in American Sign Language had been offered since May 4, 2010. At the time of the on-site review, the classes had been recently suspended, to restructure the classes with the goals of improving staff attendance and outcomes. The new curriculum was anticipated to include competency-based testing. In addition, the Facility had been making an effort to hire staff with fluency in American Sign Language. This had had a positive impact for one individual, but issues remained with having an adequate number of fluent staff to ensure that all individuals on campus who used sign language as their primary mode of communication had staff available on a regular basis who could communicate with them. The Facility must continue to seek solutions to provide an environment that enables individuals who are deaf, and/or use sign language as their primary mode of communication, to communicate with staff, peers, and the community.

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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	In this section of the report, each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The Facility provides an adequate number of speech language pathologists or other professionals [i.e., Assistive Technology (AT) specialists] with specialized training or experience. Training should include augmentative and assistive communication. There were five budgeted positions for SLPs. Two SLPs were recently hired and the SLP Department was staffed with five SLPs. The following chart represented the current caseloads of the SLPs:	Noncompliance

#	Provision	Assessment of Status	Compliance
	communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.		

SLPs	Current Caseloads
SLP #1	Dedicated PNMT Core Member, and supporting two individuals
SLP #2	Behavior Committee, Responsible for residences 501, 779F, 787, 785, 792, 794, 730, and 795, supporting 92 individuals
SLP #3	Responsible for residences 732M, 782, 796, 781, 788, 779R, and 729, supporting 88 individuals
SLP #4	Responsible for residences 783, 784, 786, 772, 727C, 732D, and 732M, supporting 93 individuals
SLP #5	732E, 779H, 797, 789, 791, 793, and 795, supporting 102 individuals

As of January 1, 2011, all SLP responsibilities were anticipated to include attending the Behavior Support Committee. The two newly hired SLPs were in training, but would assume responsibilities for their caseloads in October and November 2010, respectively. The two senior SLPs would be assisting the new SLPs with their caseloads until they were able to assume full responsibility. Even though two additional SLPs had been hired, the caseloads for speech language pathologists would not allow therapists to be active members of individuals' Personal Support Teams, and provide adequate functional communication supports to the individuals and their teams. This will provide significant challenges in meeting the requirements of Section R of the SA.

Four of the SLPs were licensed to practice in the state of Texas. One of the SLP's licenses had not been renewed in a timely manner. However, based on interview, the license remained "current" within the grace period.

Clinical instruction completed by the Facility's five SLPs for the past 12 months showed attendance at statewide conferences, and courses in the area of physical and nutritional management and assistive technology.

Communicative Aiders and Speech Generated Devices (SGDs) (simple and complex) are provided to individuals based on need and not staff availability. All individuals in need of AAC services, receive AAC services. SLPs actively participate in all facets of care in which communication is relevant.
Two of the 12 records reviewed (17%) indicated individuals with identified language difficulties were receiving active speech treatment and/or participating in a speech program. The individual records reviewed were: Individual #426, Individual #393,

#	Provision	Assessment of Status	Compliance
		Individual #350, Individual #374, Individual #238, Individual #332, Individual #108, Individual #228, Individual #448, Individual #161, Individual #284, and Individual #355. It should be noted that two of 376 individuals (Individual #426 and Individual #393) (less than 1%) living at AUSSLC were receiving direct speech services. These two individuals were included in the record review. The following describes the direct speech services they were receiving: ▪ A SLP had developed instructions for Individual #426's speech generating device. His PNMP, revised 9/30/10, incorporated his communication strategies. There was a PSP Addendum, dated 9/29/10, for the purpose of adding Individual #426's SGD to his PSP. However, his SGD had not been integrated into skill acquisition programs and/or informal activities to ensure Individual #426 had the multiple opportunities to regularly use his SGD device so that it became his "voice" throughout the 24-hour day. Competency-based training, documenting the use of the SGD, was present for multiple PNMP Coordinators. ▪ Individual #393's device had not been released so that he could use it at the residence and in his day program. At the time of the review, the SLP continued to see him two times per week to teach him to navigate and utilize his Dynavox, a speech generating device. A Communication Service Log documented the arrival of his Dynavox on 7/22/09. Individual #393 began his Dynavox training on 3/23/10. He had participated in 42 training sessions between 3/23/10 and 9/2/10. The SLP recommendations, included in his PSP, dated 8/16/10 were: o Continue to have access to his picture communication book to facilitate his ability to express his wants and needs. He actively uses his book on a daily basis and staff should help Individual #393 keep his book clean. o Continue to receive training in the use of his Dynavox V Max speech generating device for functional communication. o Dynavox V Max should be mounted on his walker and released to him only after he has clear understanding of how to use the device appropriately. No formal therapy program with functional outcomes was present to identify the criteria for a delivery date of the AAC device to the individual for use in his residence and day program. No PST members signed the PST Signature Sheet to identify the team member composition of the PST. Examples of individuals with identified speech or language difficulties not receiving direct SLP services included the following: ▪ Individual #355's PNMP, revised 9/17/10, listed his assistive equipment as a picture communication book and picture schedule. His PSP, dated 9/17/10, did not document the participation of a SLP, nor were these devices integrated into his PSP training and/or service objectives.	

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		▪ Individual #284's Speech Language (SL) Evaluation, dated 12/11/09, documented the use of a "portable picture communication schedule, which she should continue to use everyday according to the instructions provided in her PNMP and posted on or near the equipment itself." A SL Evaluation Update, dated 5/19/10, recommended the continued use of her portable picture schedule. The SLP did not recommend speech therapy services as Individual #284's "needs can be best addressed in the context of daily living activities." Her PSP, dated 5/26/10, did not integrate the use of her picture schedule into training and/or service objectives. ▪ Individual #161's Speech Language Evaluation Update Equipment Review, dated 1/7/10, documented the use of two communication boards, one for use in his residence and the other for use in the Senior Activity Center. The evaluation reported little progress in communicating choices by pointing to pictures on his picture communication board in either environment. The SLP recommended a Picture Exchange Communication System (PECS) to communicate choices and needs in different environments. His PSP, dated 1/29/10, did not integrate the use of his PECS in skill acquisition programs. There was no documentation that the SLP attended his annual PSP. ▪ Individual #228's Speech Language Evaluation Update Equipment Review, dated 4/8/10, documented the continued use of her communication book, picture board, and use of speech generating device with vibrating option on pictures, so that she could be aware when auditory messages were being delivered. Her PSP, dated 4/12/10, did not integrate the use of her communication devices into her action plan objectives, nor was a SLP in attendance at the annual PSP. ▪ Individual #332 was identified on the list of individuals who engaged in the "Top 10 Peer Aggression." His most current SLP Evaluation was dated 10/10/95. He had not been reassessed in close to 15 years. The evaluation stated he "needs to use signs, gestures or pictures to communicate effectively with others." His PSP, dated 8/20/10, under Speech/Language, dated 8/29/09, indicated "speech language therapy is not indicated as [Individual #332's] needs can be best addressed in the context of daily living activities." There was no signature sheet to document the participation of PST members during the annual PSP. He did not have a Behavior Support Plan. His Personal Support Program, dated 9/5/08, documented his aggression as "hitting, kicking, scratching, biting, and/or pushing others. Included attempts such as physically moving toward someone in an attempt to do harm." Individual #332 needed SLP services to provide an effective, non-aggressive option to communicate. ▪ Individual #238's Staffing Report, dated 3/25/10, indicated that Individual #238 "aggressed towards a house mate and two staff members while being transported on the van back to his residence." His most recent SL evaluation, dated 10/2/00, was 10 years old. His PSP, dated 3/24/10, did not discuss his	

#	Provision	Assessment of Status	Compliance
		current communication status, nor did a SLP attend the meeting. Individual #238 needed an effective way to communicate with his peers and staff. ▪ Individual #374's Speech Language Evaluation documented her communication equipment as a wallet-sized picture communication book and two picture schedules. The SL Evaluation recommended: o "SL therapy is not indicated as [Individual #374's] needs can best be addressed in the context of daily living activities. o Continued use of the communication equipment is recommended following the guidelines noted in the PNMP." Her PSP, dated 6/15/10, did not integrate her communication devices into training objectives. Individual #374's PST needed the expertise of a SLP to actively participate in all facets of care in which communication was relevant. ▪ Individual #350 was observed in her residence during breakfast. Staff and Individual #350 were not able to effectively communicate with each other. Her SL Evaluation stated: "[Individual #350] is an 18 year old woman who has a profound hearing loss and communicates with sign language augmented by pointing to picture symbols, gestures and some written words or short phrases." SL therapy was not recommended, and SL "should be reassessed if there is a significant change in communication skills or upon IDT recommendations." Individual #350's PST needed the expertise of a SLP to actively participate in all facets of care in which communication was relevant. ▪ Individual #448 was observed receiving her medication in her residence. Direct staff, nursing staff, and Individual #448 did not have an effective means to communicate with each other. Her most recent SL Evaluation was over 10 years old. Individual #448's PST needed the expertise of a SLP to actively participate in all facets of care in which communication was relevant.	
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 in need of AAC services are identified as being in need of AAC services.</u> As is discussed above with regard to Section R.1, two of the 12 records reviewed (17%) indicated individuals identified with severe expressive/receptive language had AAC services investigated, assessed, and had been identified as being in need of AAC services. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> There was only one individual who had been admitted since the last review, and he had since left the Facility. This individual's record was not reviewed. The Facility's Speech-Language Evaluation format was being revised to include more specific information under the AAC assessment heading. It also was being reformatted and more accurate instructions were being developed. The proposed SL Evaluation format was:	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Reason for Referral; ▪ Significant Information; ▪ Reports from Significant Others; ▪ Observations; ▪ Findings; ▪ Receptive/Expressive Language; ▪ Augmentative Communication; ▪ Articulation; ▪ Voice and Fluency; ▪ Oral Mechanism; ▪ Hearing and Vision; ▪ Clinical Impressions; and ▪ Recommendations: o Communication Equipment; o Language/Modality Preference; and o Communication/Active Treatment Instructions. Twelve individuals' records were reviewed (Individual #210, Individual #54, Individual #53, Individual #49, Individual #98, Individual #264, Individual #26, Individual #66, Individual #312, Individual #62, Individual #176, and Individual #196). In zero of the 12 records reviewed (0%), the Speech Language Evaluation followed the Speech-Language Evaluation as presented in the Habilitation Therapies Handbook Physical and Nutritional Management, revised 2009. <u>If receiving services, direct or indirect, the individual is provided a comprehensive speech-language assessment at a frequency that ensures relevance and appropriateness of goals.</u> In zero of the 12 records reviewed (0%), goals and objectives were determined to be functional and meaningful as evidenced by the demonstration of progress and or improvement. <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> In zero of 12 records reviewed (0%), individuals had goals/objectives/outcomes written by the SLP, and followed on a monthly basis if service was direct, and quarterly if indirect. Examples are provided above, with regard to Section R.1 of the SA, of individuals diagnosed with severe language difficulties where AAC was assessed or investigated, but SLP supports were not recommended. As noted in that section, goals and objectives were not developed to integrate AAC devices across all natural environments for the	

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		individual. These examples illustrate the impact of not having an adequate number of speech language pathologists to address the functional communication needs of the individuals residing at AUSSLC. While Speech Language Pathologists were completing evaluations, some of which identified the need for augmentative/alternative communication devices, there were not sufficient resources to provide direct and/or indirect speech therapy supports for individuals with an identified need. To the credit of the SLPs, there were multiple individuals with communication devices on campus (low tech and high tech), as well as many generic devices, but there was not a current framework within the PSP process to integrate these devices into formal, teachable moments, such as integration into skills acquisition programs. In other words, there were not adequate processes, formats, and/or training of staff in place to support therapists and teams working together to integrate the use of individuals' AAC devices into their daily lives through the development and implementation of meaningful, functional, measurable objectives. The goal for an individual with an augmentative/ alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to use the device in a variety of natural environments. Without this, the Facility will not meet the intent of the SA for a communication device to be an integral part of how an individual communicates on a daily basis. The use of AAC devices can modify classroom, residence, work and social environments for individuals with intellectual disabilities through increasing participation, making choices, and enhancing communication skills. Most importantly, when an individual has learned how to use an AAC device to communicate successfully, the perceptions and stereotypes of familiar and/or unfamiliar communication partners change from not believing the individual would be able to communicate, to exploring multiple strategies to communicate with an individual. <u>For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC services. Note: this may be included in the PBSP.</u> The Communication Services policy, dated 10/7/09, Section II.D on Assessment stated: "Assessments will consider the behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions." The policy did not provide additional information beyond this statement. A review of individuals' evaluation updates and/or screenings did not support that SLPs were collaborating with psychology staff to assess and explore functional communication strategies for individuals who had challenging behaviors. Procedures needed to be developed to define the SLPs' role in working with individuals	

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		with challenging behaviors, including collaboration with the individuals' psychologists and PSTs. None of the nine records of individuals with BSPs reviewed (Individual #448, Individual #350, Individual #374, Individual #238, Individual # 332, Individual #228, Individual #161, Individual #108, and Individual #284) (0%) documented collaboration with the psychologist and SLP in the development of the Behavior Support Plans. The SL Department had developed the following procedures, with suggested changes for collaboration between the Psychology and Speech Departments, for the development of communication dictionaries: ▪ Initial Communication Dictionary (CD) would be initiated and created by the SLP; ▪ When new CDs were created by the SLP, the SLP and the Psychologist for the individual would collaborate to integrate appropriate behavioral support techniques in the third column of the CD. ▪ When the Psychologist began to create a Positive Behavior Support Plan, the Psychologist would initiate contact with the SLP to collaborate regarding any needed revisions to the existing CD. ▪ Completion and/or annual review of the CD would be completed by a collaborative effort between the SLP and Psychologist. ▪ The finalized CD would be approved by both the Psychologist and SLP via email for evidence of collaboration. ▪ This approval would be distributed to the Chief Psychologist and Lead SLP for submission to the SA Presentation (evidence) Notebooks (Section K and R). ▪ The finalized CD would be placed in the PNMP section of the book for reference. Per documentation submitted, the AUSSLC Lead SLP and Chief Psychologist approved these procedures. Individual CD's were submitted documenting the implementation of these procedures for Individual #154, Individual #355, Individual #423, and Individual #327. Certificate of Attendance documented the Lead SLP and two SLPs attended 21 hours of the Introductory Workshop entitled "Teaching Verbal Behavior to Children with Autism and Related Disabilities". <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> A policy did not exist that outlined the assessment schedule and staff responsibilities. The Communication Services policy, dated 10/7/09, Section II on Assessments stated: "comprehensive communication assessment will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need."	

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		As stated in the baseline report, AUSSLC had developed criteria for priority assignment used to schedule augmentative communication assessments: ▪ Priority 1 - individuals with a Behavior Support Plan and/or autism who do not speak; ▪ Priority 2 - individuals with a Behavior Support Plan and/or autism who speak; ▪ Priority 3 - individuals without a Behavior Support Plan and/or autism who do not speak; and ▪ Priority 4 - individuals without a Behavior Support Plan and/or autism who speak. Per report, significant progress had not been made in the implementation of augmentative communication assessments according to the assigned individual priority criteria.	
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 services are clearly integrated into the PSP.</u> None of the 12 records reviewed (Individual #426, Individual #393, Individual #350, Individual #374, Individual #238, Individual #332, Individual #108, Individual #228, Individual #448, Individual #161, Individual #284, and Individual #355) (0%) had a clear rationale and description of communication interventions integrated into the PSP. Specific examples are provided above, with regard to Section R.1 of the SA, of individuals for whom communication strategies were listed in PSP, but these strategies were not integrated into action plans and/or skill acquisition programs. As stated above, for an individual to succeed in learning how to communicate effectively with an AAC device, there must be multiple learning opportunities, formal and informal, across all environments (residence, work, leisure, and community inclusion opportunities). <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> None of the 12 records reviewed (0%), in which communication interventions were referenced in the assessment section of the PSP, had evidence of integration throughout the PSP of the individual's methods for functional communication, as well as strategies for use by staff. Such programs generally were just listed or referenced, but not integrated into other programs, such as the individual's BSP, day program, skills training in the residence, leisure activity programs, work environments, and informal activities within their daily schedule.	Noncompliance

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		AAC devices are portable and functional in a variety of settings. None of the PNMPs with an AAC component and/or AAC device instructions reviewed (0%) reinforced the use of AAC devices that were portable and functional in a variety of settings (i.e., mealtime, work, leisure, residence, and community outings). AAC devices are individualized and meaningful to the individual. One (Individual #426) of the two records reviewed for individuals receiving direct speech services (50%) clearly indicated how the direct speech language services would be individualized, and encourage the use of speech generating devices beyond the direct speech services sessions. However, for the second individual (Individual #393) receiving direct speech services, there were no formal communication programs developed with individualized strategies for use by staff to reinforce what was being learned in direct speech therapy. The absence of formal integration of the AAC communication device in their daily schedules did not support the AAC devices being functional and meaningful to the individual. Individuals were not provided with multiple opportunities to practice the use of their AAC device. The SLP Department had worked to develop customized instructions for individuals with AAC devices. The instructions were placed within the PNMP section of the Individual Notebook. A smaller version was placed with and/or on each device. Individuals with mid and/or high tech devices were the first priority group. The SLPs were working to add instructions for individuals with low tech devices. In addition, PNMPs were being updated to reflect all communication equipment. The future plan was to include all communication strategies as part of the PNMP section of the Individual Notebook. Three videophones were in place. The Monitoring Team observed Individual #210 at his residence (772) attempting to use his videophone, but he was not able to connect to the internet. Individual #210 reported that he talked approximately weekly with family using the device. Two additional videophones were located in the Augmentative Communication Lab, and at 501 Forest Circle for use by Individual #350. Classes in American Sign Language had been offered since May 4, 2010. In 9/10, classes were suspended to restructure with the goal of improving staff attendance and outcomes. It was anticipated that an updated four-hour course would be offered, starting October 15, 2010, each Friday morning, from 8 a.m. until 12 p.m., and afternoon, from 1:30 p.m. to 5:30 p.m. It was anticipated that the revised curriculum would include competency-based testing using a checklist of identified competencies. The Facility should be commended for providing these classes, but this alone will not solve the problem that individuals living at AUSSLC were not able to communicate adequately with	

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		staff, their peers, and members of the community. Since the baseline review, efforts were being made to hire staff who were fluent in sign language. A positive addition was that a Home Supervisor, who was a Level 1 Interpreter, was hired for Residence 772 Main Street. The Monitoring Team observed the Home Supervisor and Individual #210 effectively communicating. This was exceptionally good news for Individual #210, but Individual #350 continued to live in a residence where staff were not able to communicate with her effectively, nor she communicate with them. The Facility should continue to seek solutions to provide an environment that enables individuals who are deaf to communicate effectively with staff, peers, and members of the community. <u>Staff are trained in the use of the AAC services and devices.</u> Based on a review of 12 individuals' records (Individual #426, Individual #393, Individual #350, Individual #374, Individual #238, Individual #332, Individual #108, Individual #228, Individual #448, Individual #161, Individual #284, and Individual #355), one of the 12 (8%) included competency-based staff training documentation. In-service Due Data forms were submitted with staff names and signatures, but these forms did not consistently document competency-based performance check-off for staff. These forms indicated that staff verbalized and/or demonstrated the skill, or there would be no indication that staff had verbalized and/or demonstrated the skill. Staff must be able to demonstrate their competency in understanding and operating an AAC system (low tech and high tech), as well as understand how to engage/prompt an individual with the AAC device in multiple environments. Competency-based assessment should require staff to demonstrate both of these sets of skills. Moreover, there were no formal communication programs (for staff to reinforce what was being learned in direct SLP therapy sessions) documented in the 12 records reviewed, even though two of these individuals were receiving speech therapy services. <u>Communication strategies/devices are implemented and used.</u> Observation of Individual #426 was not possible during the on-site review because he was hospitalized. Individual #426 was one of the only two individuals who were being provided direct speech therapy services to improve his skills in using his SGD. The other individual, who was provided direct therapy, was only using his SGD with the SLP. Examples of individuals where staff did not implement a communication program as written included: ▪ Individual #53's Dynavox was not easily accessible to her, and was not turned on when the Monitoring Team conducted an observation. A staff person turned on the Dynavox, but the volume was so low it could not be heard over the shredder. Individual #53's device was not functional and meaningful to her in the work setting.	

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		▪ Individual #98 did not have his communication book on his person during the Monitoring Team's observation. ▪ Individual #264's system was broken. ▪ Individual #26's communication book was not with him. Staff showed the communication book to the Monitoring Team, but it was not readily accessible for use by Individual #26. ▪ Individual #176's communication device could not be located by staff. ▪ Individual #62 communication device was not plugged in, and he was not accessing the device. <u>General AAC devices are available in common areas.</u> Observations in 15 residences (732-D, 732-E, 732-M, 779-R, 779-F, 779-H, 727-C, 795, 794, 793, 792, 791, 501, 796, and 797) confirmed that general AAC devices were present in common areas. One observation in these residences (7%) demonstrated that staff encouraged individuals to utilize common area AAC devices. Individual #374, in Residence 796, was using her picture schedule with staff.	
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.	<u>Monitoring system is in place that: tracks the presence of the AAC device; working condition of the AAC device; the implementation of the device; and effectiveness of the device.</u> There was no policy developed for communication devices and the use of functional communication. Based on interview, the development of this policy will require collaboration between disciplines. The following practices were planned for development and implementation: ▪ PCs were asked to monitor/model at least weekly at each residence/workshop and turn in a monitoring form. The monitoring tool served as a guideline for staff retraining and understanding of systems at each residence for each individual. ▪ SLPs had completed validity checks of the monitors via the monitoring process in the past, however, there was inconsistency due to staff shortages. ▪ One trial of inter-rater reliability was performed by each of two SLPs with a PC in August. Inter-rater reliability checks were to be implemented with the newly revised monitoring tool. ▪ The SLP Department was currently developing lists of training competencies specific to individuals' communication equipment. ▪ The SLP Department was adding communication strategies to the PNMP. The Individual/Shared Communication Equipment Monitoring tool had been revised and	Noncompliance

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		instructions were developed for each performance indicator defined. The tool was being used by SLPs and PCs only. The PCs were introduced to the revised tool on 9/29/10. A Speech and Hearing Equipment Observation form also was submitted but it was not clear if this form would continue to be used and/or eliminated. There were no instructions provided for this form. Six of 12 individual records reviewed (50%) (Individual #161, Individual #284, Individual #228, Individual #374, Individual #350, and Individual #355) documented monitoring in some of the following aspects of AAC device utilization: ▪ In two of 12 reports reviewed (17%), the presence of the AAC device was documented; ▪ In zero of 12 reports reviewed (0%), the working condition of the AAC device was addressed; ▪ In two of 12 reports reviewed (17%), the implementation of the device was addressed; and ▪ In zero of 12 reports reviewed (0%), the effectiveness of the device was documented. Multiple individuals were reviewed on a form and it was difficult to discern the monitoring status for each individual. However, some examples of staff non-compliance with AAC devices included: ▪ Individual #355's Speech and Hearing Equipment Observation forms documented staff were not following communication plans and equipment was not available. ▪ Individual #350's Speech and Hearing Equipment Observation forms documented communication plans were not followed. ▪ Individual #374's Speech and Hearing Equipment Observation forms documented staff not prompting her to use her picture schedule. <u>Monitoring covers the use of the AAC devices during all aspects of the person's daily life in and out of the residence.</u> The Individual/Shared Communication Equipment Monitoring form documented the location of where the monitoring occurred. Based on staff report, plans were for PCs to monitor at least weekly in the individual's residence/workshop, but this had not been formalized into policy. <u>Validation checks are built into the monitoring process and conducted by the plan's author.</u> As noted above, the current monitoring had not been developed and memorialized in	

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		policy, and, therefore, it was not clear that this validation process was in place.	

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

1. The SLP Department should complete an analysis of the duties required of an SLP to be an active, participating member of an individual's PSP, including but not limited to attending annual, quarterly and addendum PST meetings; development and implementation of SLP programs for direct and/or indirect services; competency-based training; monitoring; etc. This analysis should identify the number of SLP positions needed to achieve compliance with Section R of the SA.
2. Individuals' communication devices and strategies should be consistently integrated into their PSPs through skill acquisition programs, as well as their BSPs to ensure the AAC devices are meaningful to individuals and that they have a voice in multiple environments.
3. Speech and language department staff should continue working with psychology staff to ensure that functional communication skill strengthening and training is included in Behavior Support Plans, as appropriate.
4. All individuals who do not have effective means of communication should be assessed, and, as appropriate, 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.
5. The AUSSLC Management Team, in collaboration with the Speech Pathology Department, should develop and implement a plan to support the implementation of generic and individual-specific communication systems across a 24-hour day. The Facility should continue the implementation of the pilot communication project in the residence for individuals with a primary diagnosis of autism, which is focused on the development and implementation of functional communication systems across all environments. This should promote interdisciplinary planning, development, and implementation of an environment that supports and encourages functional communication throughout the 24-hour day.
6. The Facility must continue to seek solutions to provide an environment that enables individuals who are deaf and/or use sign language as their primary mode of communication, to be able to communicate adequately with staff, peers, and members of the community.
7. Appropriate methods to test staff competency with regard to the use of AAC devices, as well as to engage the individuals in their use, should be developed and implemented.
8. Policies/procedures should be developed for the communication monitoring system, with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of the functional communication programs and equipment; staff utilization of generic AAC devices; fit, function, availability, and use of AAC devices; and staff competency with regard to functional communication devices and programs. There should be established thresholds for staff retraining; identification, training, and validation processes for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

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 Section S Presentation Book, including: Section S Plan of Improvement, dated 5/17/10; Section S Supplemental Plan of Improvement, dated 7/2/10; Section S Corrective Action Plan; Retirement Program Assessment, revised 7/14/10; Retirement Program Assessment for Individual #384 and Individual #416; Pre-Treatment Sedation/Desensitization Meeting Minutes, dated 7/1/10, and 8/23/10; Supported Employment Pursuit Plan, dated 9/10; Community Outings Calendars, dated 4/10 through 9/10; Men's Daily Hygiene and Appearance Checklist, dated 9/27/10; Women's Daily Hygiene and Appearance Checklist, dated 9/27/10; Active Treatment, Dignity and Respect, and Group Management Observation, revised 8/9/10; Completed Observation Forms, dated 9/8/10 through 10/1/10; Active Treatment Committee (ATC) and Board Certified Behavior Analyst (BCBA) Meeting Minutes, dated 9/3/10; Psychology and Vocational Trainers Meeting Minutes, dated 10/1/10; Learning to Teach, dated 7/10; and Sample Data Sheets; o Personal Support Plan Process Policy #004, dated 7/30/10; o Personal Support Plans (developed under new policy/process) for the following individuals: Individual #355, Individual #432, Individual #445, and Individual #291; o Personal Support Plans for the following individuals: Individual #251, Individual #183, Individual #369, Individual #228, Individual #428, Individual #49, Individual #319, Individual #82, Individual #289, Individual #283, Individual #267, Individual #395, Individual #410, Individual #139, and Individual #280; o Positive Assessment of Living Skills (PALS): Individual #355, Individual #333, Individual #53, Individual #146, Individual #34, Individual #293, Individual #238, Individual #5, Individual #291, Individual #239, Individual #26, and Individual #63; o Personal Focus Worksheet for Individual #26; o Inventory for Client and Agency Planning (ICAP) for Individual #26; o Comprehensive Assessment Program Planning System Summary/Work Routines for the following individuals: Individual #6, Individual #333, Individual #32, Individual #152, Individual #163, Individual #3, Individual #325, Individual #180, Individual #224, Individual #192, Individual #421, Individual #247, Individual #241, Individual #99, Individual #346, Individual #223, Individual #26, Individual #410, Individual #189, and Individual #139; o Training Objective Data Sheets for the following individuals: Individual #53, Individual #406, Individual #428, Individual #84, Individual #49, Individual #319, Individual #277, Individual #276, Individual #448, Individual #238, Individual #326, Individual #16, Individual #395, Individual #77, Individual #80, Individual #291, Individual #167, Individual #26, Individual #202, Individual #74, Individual #442, Individual #410, Individual #139, and Individual #280;

	○ Description of On- and Off-Campus Work Programs/Sites; ○ Description of On-Campus Day Programs; ○ Summary of Outings by Residence; ○ List of Individuals Attending Each Day Program; ○ List of Individuals Employed; and ○ Supporting Visions: Personal Support Planning - presentation and participant workbook, dated 7/10. ▪ **Interviews with**: ○ Tom Cochran, Coordinator of QMRP Services, and Sarah Knowles, Director of Active Treatment, on 10/4/10; and ○ Sarah Knowles, Director of Active Treatment, on 10/6/10. ▪ **Observations of**: ○ Residence 501, Residence 727, Residence 729, Residence 730, Residence 732, Residence 772, Residence 779, Residence 781, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; ○ Infirmary; ○ Workshop 503, Workshop 510, Workshop 527, Workshop 532, Workshop 544, Workshop 732, and Workshop 775; ○ Life Skills Center 512; ○ Personal Support Planning Meeting for Individual #26, on 10/7/10; and ○ Human Rights Committee Meeting, on 10/7/10.
	Facility Self-Assessment: The Facility's POI indicated that it was not in compliance with any areas addressed in Section S of the Settlement Agreement. However, the POI identified a number of actions that the Facility had taken to improve its development and implementation of habilitation, training, education, and skill acquisition programs. It was apparent, from the introductory meeting held with staff from the Facility that changes had occurred since the baseline visit. The Facility Director reported that there were no vacancies in direct support professional positions, one residence had been closed and individuals moved to other residences on campus, and admission to AUSSLC had been temporarily closed to allow staffing to be stabilized and other actions to be taken to improve services. During tours of the Facility, direct support professionals reported that "mandatory holdover" was very rare and that staffing conditions had greatly improved. The Facility is commended for its efforts in this area. According to the POI and the initial presentation, the Facility staff identified a number of areas in which they believed improvements had been made. For example, it was reported that the Director of Active Treatment, QMRP Coordinator, and their staff had taken steps to improve the habilitation services provided to the individuals residing at AUSSLC. Initial training in a new Personal Support Planning process had begun and plans were underway to transfer the writing of training objectives to the QMRP staff. Additional

	materials had been purchased to help with this process. The Director of Active Treatment had begun working collaboratively with the Director of Behavioral Services and the psychology staff to expand staff training in the area of teaching individuals with developmental disabilities. The Director of Active Treatment only recently had assumed responsibility for vocational services. She reported that she was interested in improving the assessment(s) used to determine individuals' interests and skills, while also expanding the types of work available to individuals, both on- and off-campus. Lastly, she had introduced a tool to monitor and help improve the individuals' personal hygiene and appearance, and was beginning to collect measures of active engagement throughout the day.
	Summary of Monitor's Assessment: While many of the changes presented in the POI were positive and held promise of continued improvement in the future, there remained a need to address the activities available to individuals throughout the day. Observations revealed a continued absence of interesting and age-appropriate materials designed to meet the needs and preferences of the individuals served at the AUSSLC. When tasks/activities were presented, they were often nonfunctional, repetitive, and involved materials that were worn or damaged. Comprehensive assessment of an individual's preferences, strengths, and needs continued to be an area that required improvement. Only through assessment can individuals' PSTs identify skill deficits that will lead to the development of a comprehensive plan of habilitation. Training objectives remained compromised. Improved descriptions of skills to be learned, enhanced scheduling for training of these skills, and clearer instructions to staff in implementing teaching programs, were all areas in need of improvement.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	A review was conducted of the revised Personal Support Plan Process Policy #004, dated 7/30/10. The policy, as written, provided many appropriate and commendable standards, including, but not limited to: a) the use of assessment to determine an individual's current level of need; b) the opportunity for individuals to live, work, and recreate in integrated settings; c) competency-based staff training; d) skill acquisition training in all environments; e) clearly written behavioral objectives for all skill acquisition programs; and f) training objectives that address a range of areas, including personal hygiene, social skills, communication, domestic activities, leisure skills, community skills, and employment. Further, on page 14, the policy noted: "If training objectives are not able to be conducted in a community setting, justification must be documented." Lastly, the policy indicated that members of the Personal Support Team would review all assessments in preparation for the annual meeting. The Monitoring Team requested copies of all Personal Support Plans that had been developed since this new format/process had been implemented. The Facility identified and provided copies of four plans, for Individual #355, Individual #432, Individual #445,	Noncompliance

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		and Individual #291. Each of these plans was reviewed to determine adherence to the revised policy. ▪ Individual #355: This plan was developed on 9/17/10. The individual's preferences and interests were listed, and a description of living options was provided. Necessary supports and services were reviewed, followed by a section outlining needs and obstacles not formally addressed in the plan. Although the document provided a good amount of important information about the individual, there was no clear review of the results of any formal assessment that had been completed to identify the individual's needs. Further, the 17 training objectives identified in the plan addressed only four areas of skill need. Four objectives addressed the individual's learning to save part of his paycheck, four objectives addressed work behavior (i.e., time spent working and units of work completed), three addressed street crossing behavior, three addressed the individual's ability to identify his multivitamin, and four addressed reduction of problem behavior. Although the policy indicated that a variety of skill areas would be addressed, this individual's plan did not include objectives designed to enhance his skills in the areas of personal hygiene, social, communication, domestic, or leisure activities. Although a service objective indicated that the individual would participate in an off-campus activity four times each month, there was no clear training objective designed to enhance his skills in the community, nor was there a justification for this omission. The objectives as written did not meet all requirements for behavioral objectives. ▪ Individual #432: The plan developed on 9/10/10 for this individual followed a similar format. Here too, there was no review of a formal assessment with the corresponding needs identified. A total of 16 training objectives were identified: two objectives each addressed learning to place clothes in a hamper, accepting a receipt after making a purchase, washing her hands before meals, indicating her need to use the bathroom, and swallowing her medication. Four other objectives addressed work behavior, and one addressed brushing her teeth. The last two of the 16 objectives were related to the individual's maintaining good health, as evidenced by her remaining free from seizure-related injuries and muscle pain. It was unclear how these were training objectives. Although there were objectives addressing many skill areas (e.g., personal hygiene, domestic, communication, and work), missing still were objectives that clearly identified leisure skill development or community involvement. Criterion for mastery was not always evident. ▪ Individual #445: This plan was developed on 9/8/10, and followed the same format. As noted regarding the previous plans, there was no review of the information gained from a formal assessment with regard to skill needs. There were a total of 18 objectives. Two objectives each addressed learning to retrieve a purchase, learning to place laundry in the washing machine, and learning to	

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		make a snack (a skill the individual had expressed an interest in learning). One objective addressed each of the following: learning to brush her teeth, learning to identify medication, and learning to identify the benefits of medication. Four objectives addressed work behavior, and five objectives addressed improvement in general behavior. While there were many functional skills identified for this individual to learn, missing was an objective designed to help this person learn necessary skills in the community. No justification for this lack of community-based training was provided. ▪ Individual #291: This plan was developed on 9/2/10 and provided a wealth of information about the individual. A number of areas of need were identified in this information, however, no formal assessment was reviewed. A total of 14 training objectives were identified. Two objectives each addressed cleaning his work area, obtaining additional work materials, and continuing to work. These areas, and work refusal were identified as areas of need. Regrettably, there were no additional training objectives designed to expand this individual's work activities or work locations. Other objectives included, identifying medication and its side effects (four in total), and improved patterns of behavior (four in total). Although there were three service objectives related to community activities or the potential for community employment, there were no objectives that addressed specific training in the community. The Monitoring Team was provided a copy of the documents (i.e., outline and participant workbook) used to train staff on the new PSP process. While the training clearly and appropriately indicated that assessments should not be read at the PSP meeting, it remains important that a review of the assessment outcomes be conducted. Without considering the information gleaned from a careful assessment of individual need, one cannot design a program to promote growth and independence. An additional 15 Personal Support Plans were reviewed. ▪ For 12 of 15 of these plans (80%) current assessments were identified. The Inventory for Client and Agency Planning was outdated for Individual #289, but the Positive Assessment of Living Skills and a vocational assessment were current. ▪ Training objectives were included in 11 of these 15 plans (73%). ▪ Of these 11 plans, only one (9%) included an objective that specified training in the community (Individual #82). ▪ Although personal hygiene and work related behavior were addressed in the majority of the plans, (73%), objectives to develop enhanced leisure and domestic skills were not as common. ▪ For most training objectives, the schedule for training was daily or multiple times weekly. In other cases, however, the schedule was much too lean.	

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		Examples included: Individual #183 was scheduled to learn to put coins in a vending machine, and retrieve the item purchased four times each month. Individual #280 was to learn to tolerate sitting in a dentist chair with one visit per month. Limited opportunities to learn these skills will compromise the individual's acquisition of the skill. ▪ For others, the schedule for training was not identified for every objective. Examples included: Individual #428, Individual #289, Individual #395, and Individual #410. In the case of Individual #139, the schedule for objectives under Action Plans #3, #4, and #5 was listed as "When Training Occurs." A total of 111 Training Objectives and corresponding Data Sheets, representing 23 individuals, were reviewed. Each was analyzed with regard to specific information/requirements as outlined in the Settlement Agreement monitoring tool. Findings are summarized below. ▪ A task analysis was present in only 21% of the objectives. In one case, the task analysis that was provided was not related to the identified skill. Individual #406 was to learn to clean his personal living space, but the task analysis consisted of three steps related to bathing (i.e., wash upper body, wash lower body, rinse off soap). Individual #395 was to learn to state the value of coins, but the steps of the program indicated that staff would point to a specific coin and state its value. It was unclear what behavior the individual was supposed to exhibit. Without a clear outline of the steps involved in a task, it is difficult for staff to know what behavior the individual is learning, or to assess the individual's competence or lack thereof in performing the skill. ▪ Training objectives should also include an operational definition that clearly describes, in measurable terms, the behavior the individual is expected to demonstrate. Only one of the training objectives provided this information. Examples of where this information is absent included: Individual #74 was learning to "tidy" her room, but it was unclear what behavior constituted "tidying." Individual #77 was to "thoroughly wash her body," but there was no definition of this behavior. Individual #410 was to learn to work "calmly," but this behavior was not defined. Individual #139 was learning to "…identify a quarter or exchange tokens for an item," but no definition was provided and it was unclear how these two behaviors comprised one objective. A similar problem was identified when reviewing objectives for Individual #202. He was learning to "… hand money to a cashier… or go to the soda machine." Again, the behavior was not defined and these two activities involved very different skills. Without a clear description of the expected behavior, it is difficult to teach a skill or determine one's proficiency. ▪ In order to ensure sufficient trials for learning occur, objectives should include a schedule of implementation. While some objectives indicated the number of	

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		times per month that an objective was addressed, the number of trials to be conducted was missing. Also missing from every objective was a clear description of a schedule for implementation. While the day/time to collect data was often included, it remained unclear how many opportunities for learning were to take place. Some objectives indicated that teaching would occur a limited number of times each month. Individual #448 and Individual #280 were going to learn to tolerate dental exams/work by having the opportunity to lay in the dentist chair or sit in the dentist office, respectively, once monthly. While the staff were commended for their efforts to desensitize individuals to regularly scheduled medical or health care procedures, enhanced tolerance for dental work is unlikely with such limited exposure to the pertinent environment. ▪ Only four of the 111 objectives (4%) identified the relevant, discriminative stimulus. In the four objectives for Individual #84, the stimulus was presented as a question that would be asked of the individual. At times, objectives included discriminative stimuli that were not natural. For example, an objective for Individual #53 indicated that he would inform the staff of the item he planned to purchase before going shopping. Exposure to available items is a more natural discriminative stimulus for determining one's purchase. ▪ Additional concerns were raised regarding the limited focus on developing independent skills. For example, Individual #139 was going to learn to wipe herself after toileting, upon staff request. This is a natural part of this self-care routine that the individual should learn to complete independently. ▪ The actual teaching strategies that staff were to employ to help the individual acquire a skill were identified in only six of the 111 objectives (5%). Without an explanation of the manner in which the skill should be taught, there is a risk of inconsistent and/or poor teaching. This can significantly compromise learning. ▪ Sixteen of the 111 objectives (14%) identified the reinforcer to be provided contingent upon correct responding. In 75% of these objectives, the reinforcer was added to the data sheets in September of this year. In every case, the reinforcer was identified as verbal or social praise. Four of the 16 objectives included tangible reinforcers as well, such as music (Individual #276) or low calorie snacks (Individual #84). In order to motivate people to learn, it is essential that improved responding results in access to some clearly identified reinforcer. While it is highly recommended that social praise be paired with any contrived reinforcer, it is essential that preference assessments be completed in order to ensure that the consequence for correct responding is something that will increase the future likelihood of correct responding. Social praise from a range of staff, particularly if there is not an established positive relationship with a particular staff member, is not likely to function as an effective reinforcer. ▪ None of the objectives included a description of the consequence for incorrect responding.	

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		▪ Maintenance and generalization of the skill was not addressed in any of the training objectives. ▪ While a method of data collection was identified, in many cases, the data recorded did not match the instructions. In 25 objectives, the instructions indicated that the level of assistance was to be documented using a code provided. However, staff simply noted whether the individual had performed the skill (Y) or not (N). Other problems were noted for Individual #16, where the coding system did not match the objective, and for Individual #139, where the recorded data did not match any of the coding options. ▪ Additional concerns included: Individual #84 had an objective to learn to put lotion on her body, but the teaching description was the same as choosing clothing, and data had been collected for five months. This same individual had an objective to grasp and play an instrument, but the teaching description included information about making a purchase. Again, data had been collected for several months. Individual #395 was learning to state the value of coins with physical prompts from staff. It was unclear how a staff member could physically prompt a verbal response. Individual #139 had an objective to learn to hand money to a cashier. However, the related goal was to improve her daily hygiene and personal management skills. Lastly, Individual #280 was identified as someone who was both blind and deaf, yet her objectives included verbal instructions from staff, and one indicated she make a choice after looking at a selection of musical instruments. As was noted in the baseline report, Planned Activity Checks (PLACHECKS), a measure of engagement, were completed during four days of the on-site review of the Facility. PLACHECKS (Doke & Risley, 1972) involve a momentary time sample in which engagement is recorded. The observer scans the environment, noting whether each individual is engaged or not engaged at the moment of observation. A percentage of engagement is then calculated. PLACHECKS were conducted in every residence, in every workshop area, and in the Life Skills Center. The data is summarized below. ▪ A total of 36 PLACHECKS were collected in the workshop areas. Engagement ranged between 0% and 100%, with a mean of 30.5%. ▪ Two PLACHECKS were collected in the Life Skills Center. Engagement ranged between 43% and 100%, with a mean of 71.5%. ▪ A total of 56 PLACHECKS were collected in the residential environments. Engagement ranged between 0% and 100%, with a mean of 33.6%. Many of the concerns raised in the baseline report remained in evidence. For example: ▪ In workshop 503, an individual was observed putting elastics on a bundle of material, only to then remove the elastics. This pattern was repeated over and over.	

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		▪ In workshop 544, an individual was observed moving notebook binders from one location to another. Once he had moved all the binders, he un-did his work by placing the binders back in the original container. This same pattern of behavior was observed in workshops 532, 775, and 779. ▪ Other individuals were observed placing pamphlets or letters in a bin after receiving the item from a staff member. Still other individuals were learning to place letters/cards in envelopes. ▪ During one visit to workshop 775, an individual had completed the task of stuffing envelopes, only to have the staff member seated opposite him take it apart to re-present the same material. ▪ Much of the materials used were worn and in poor condition. These tasks were non-functional, with no clear beginning or endpoint. Even if these activities were considered opportunities for training, the training provided was inadequate and misguided. Activities provided in the residences were not improved either. On multiple occasions, individuals were observed sitting with no materials to keep them engaged. For example: ▪ Repeated visits to one residence found Individual #428 lying on the floor of the living room with his hands in his mouth. ▪ Individual #202 had moved to a new residence when 772 was closed. His response to the move was noted to be quite positive, with greater involvement in activities. While he was observed in the midst of his housemates, he was not engaged during the Monitoring Team's visits. A review of his attendance records at workshop also suggested that his participation in activities outside of his residence remained poor (0% attendance over 11 days). ▪ In the Castner residence, a group of individuals were observed in a darkened area of the building, as a movie played on the television. What was unusual was that simultaneously, strobe lights were in motion in the same area. ▪ Other individuals were observed sitting in their rooms or in other isolated areas. Individual #15 was doubled over in her wheelchair as she engaged in repetitive vocalizations. A staff member approached to ask, "What's going on baby?" ▪ Individual #143 was seated alone in a separate section of the residence. A staff member suggested that visitors should be "wary" of this person. ▪ Individual #280 was in a bedroom, seated at a table, with her feet up on the chair, and one arm inside her shirt. She was repeatedly moving beads back and forth on what appeared to be a child's toy. ▪ Individual #137 was sitting idly in the living room of her residence. She hit herself three times and screamed repeatedly. A staff member approached, and stated her name several times as she stroked her hair. Although this individual did not have a Positive Behavior Support Plan, caution is advised with regard to	

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		providing attention following an unwanted behavior, because there is a risk that such attention might reinforce the behavior. This is particularly true in an environment in which individual attention is not provided frequently, and there are limited materials/activities to keep individuals actively engaged. ▪ In three residences (772, 792, and 797), individuals were encouraged to serve themselves or otherwise participate in activities related to mealtime. These residences were the exception, however, as observation in the majority of the residences reflected no effort to expand the individuals' skills or involvement in this activity. The Director of Active Treatment is commended for her initial effort to introduce a monitoring tool that will allow staff to observe and measure engagement levels. The Monitoring Team recommended that she develop a definition of engagement so that there is a consistent criterion used during observations. Staff using this tool are encouraged to provide feedback to staff regarding positive observations, and also to offer suggestions for improvement. At the time of the visit, data collected on skill acquisition were not presented in graphic format. Without a clear understanding of the success or failure of a teaching program, corresponding changes to these programs likely are not made in a timely manner. This results in the individual remaining in a situation where progress and skill development is impeded and/or compromised. Data collected on all skill acquisition programs should be presented graphically, and reviewed at a minimum of once quarterly. This will allow for ongoing monitoring, with program revisions completed in a timely manner. If training is not accomplished due to individual refusal to participate, psychology staff should be involved to help design programs to improve participation, be it through change in presentation, choice in activity, or something similar. Data also should be collected to evaluate the success or failure of maintenance and generalization of newly acquired skills. Steps have been taken to enhance the training provided to staff in teaching individuals with developmental disabilities. It is recommended that further revisions to the training program be considered after review of Cooper, Heron, and Heward (2007) and Snell and Brown (2011). The changes to training related to the material presented in new employee orientation. While such didactic training is necessary to develop a base of understanding, staff training should be a blend of didactic and on-the-job, competency-based training.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of	The Monitoring Team requested copies of the 10 most recently completed assessments of adaptive behavior using the Positive Assessment of Living Skills. Provided were assessments for Individual #355, Individual #333, Individual #53, Individual #146,	Noncompliance

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	individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Individual #34, Individual #293, Individual #238, Individual #5, Individual #239, and Individual #63. Of these 10, only two (Individual #34 and Individual #63) appeared to be complete. All others included only portions of the assessment. Examples include: ▪ Individual #53 had been assessed in only three areas: dining room skills, leisure skills, and campus travel and orientation; ▪ Individual #146 had been assessed in only four areas: social skills, laundry/clothing care, food storage and preparation, and money management and shopping; ▪ Individual #238 had been assessed in only five areas: bathing, social skills, dining room skills, leisure preferences, and money management and shopping; and, ▪ Individual #5 had been assessed in only three areas: dental hygiene, sensory characteristics, and money management and shopping. As mentioned in the baseline report, comprehensive assessment of an individual's needs requires an examination of capabilities in all areas of daily living. When assessment is limited to pre-determined areas, the individual's plan might also be limited in its inclusion of appropriate training objectives. The Positive Assessment of Living Skills assessments were reviewed for two additional individuals, Individual #291 and Individual #26. In both cases, the assessment was incomplete. For Individual #26, there were some inconsistencies between the assessment and the summary provided on the Personal Focus Worksheet (not dated). The assessment indicated the individual selected his own clothing, but the worksheet information indicated that staff chose his clothes. The assessment indicated he was completely independent with toileting needs, but the information included on the worksheet suggested he required assistance with cleaning after toileting. Care should be taken to ensure that information transferred from one document to another is consistent. The Inventory for Client and Agency Planning also was reviewed for Individual #26. Sections A through E only were completed on this assessment. The Monitoring Team attended the Personal Support Plan meeting for Individual #26. The individual was present, along with staff from a range of disciplines. There was an in-depth discussion regarding his preferences and needs. Towards the end of the meeting, one participant noted that, "… as a Team, we need to come up with objectives." Staff then began to suggest different activities that could become part of the individual's plan. There was no reference to an assessment that identified the individual's strengths or skill deficits. Suggestions for training objectives were presented randomly, without clear recognition of the individual's learning needs. When it was time for a review of the individual's rights, there were no materials employed to help the individual understand the subject matter.	

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		A total of 20 vocational assessments were reviewed. For each of these, a portion of the Comprehensive Assessment Program Planning System, consisting of a review of the individual's current skills in 25 to 28 areas related to work routines, was completed. In some assessments, more person-specific information was included under "Notes," and in all of the assessments, there was an indication regarding "Prognosis for More Independence" and "Suggested Method." The prognosis was indicated as poor (-), questionable (?), or good (+). There was no legend to explain the coding used in the "Suggested Method" section. The current vocational assessment did not create a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history, or interest inventory. Several of the assessments included training objectives for consideration by the individual's interdisciplinary team. Examples of objectives include: ▪ Learning not to reposition work materials (Individual #6 and Individual #421); ▪ Learning to accept criticism or instruction (Individual #6, Individual #192, and Individual #421); ▪ Learning to work for a period of time (Individual #6, Individual #32, Individual #152, Individual #180, Individual #224, Individual #247, Individual #241, Individual #346, Individual #189, and Individual #139); ▪ Learning to stay in one's assigned seat, respect another's space (Individual #152, Individual #421, and Individual #139); ▪ Learning to clean one's work area (Individual #32, Individual #163, and Individual #346); ▪ Learning to set up one's work material (Individual #163 and Individual #346); ▪ Learning to fill a counting jig (Individual #32, Individual #163, Individual #247, and Individual #189); ▪ Learning to sustain work before asking for a break (Individual #325 and Individual #139); and ▪ Learning to work without displaying identified problem behaviors (Individual #421, Individual #247, and Individual #223). While some of these objectives might be appropriate, the assessment did not indicate a determination of the individual's work preference. Further, during the monitoring visit, many of the workshop areas revealed repetitive activities, involving worn materials, with little demonstration of effective strategies to motivate the individuals to sustain work behavior. Until these areas are addressed, objectives such as those listed will be difficult to achieve. An additional concern was raised when reviewing the assessment document with regard to prognosis for improvement. Of 15 assessments, only nine (60%) suggested that the	

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		likelihood for improvement of the individual's skills was positive in 50% or more of the measures where prognosis was noted. For the remaining six individuals, a poor prognosis was identified in 39% (Individual #99), 19% (Individual #32), 13% (Individual #346), 8% (Individual #163), or 0% (Individual #247and Individual #189) of the skills noted. In some cases, this included a prognosis that the individual could not learn to participate in choosing a job, obtaining work materials, positioning work materials, or in putting away work materials. Assessments should identify ways in which one's skills can be improved, even if it is simply in the degree to which an individual participates in the assigned task or activity. As noted above, assessment of individuals' needs continued to be incomplete. Staff were using a variety of tools to determine an individual's strengths and skill deficits, but in most cases, only portions of the assessment was completed. The Director of Active Treatment indicated that she was exploring alternatives to the vocational assessment used at AUSSLC. She is commended for this effort. A comprehensive assessment of adaptive behavior also is critical to developing programs that will meet the needs of the individual in all areas of daily living, including, but not limited to, communication, socialization, self-care, domestic, leisure, vocational, and community skills.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As noted above with regard to Section S.1 of the SA, reviews of individuals' PSPs showed that adequate assessments had not been completed, and that it was unclear how assessment information had been used to develop meaningful goals and objectives. This component of the SA requires that assessment information be used to develop interventions, strategies, and supports that "effectively address the individual's needs for services and supports." These deficiencies will need to be corrected to comply with the SA. In addition, during the on-site review, it was again apparent that many individuals spend much of their time unengaged, or without access to interesting and meaningful activity (refer to the PLACHECK data reported with regard to Section S.1 of the SA). Further, when activities were provided, they were often nonfunctional, or not appropriate for the individual's age. Consideration must be given to the individual's preferences and the	Noncompliance

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		expansion of service delivery beyond what has typically been provided. Caution is also advised when making assumptions about an individual's interest based upon his/her disability. The proposal for the "Autism Home" included a list of needs based upon generalizations regarding necessary supports and interests of individuals diagnosed with an Autism Spectrum Disorder (ASD). Individuals with ASD meet specific criteria as outlined by the American Psychiatric Association. These criteria identify impairments in social and communication skills, as well as restricted patterns of behavior and interests (APA, 2000). Absent from these criteria are behavior problems or sensory issues, yet both of these areas were noted as a need in the proposal. Staff should consider the unique needs of each individual. Generic programming should not be provided based upon a diagnostic category.	
	(b) Include to the degree practicable training opportunities in community settings.	Training opportunities in the community remained an infrequent occurrence. While Personal Support Plans included service objectives that indicated the individual would have an opportunity for community involvement, this was limited to once to four times each month. As is discussed in further detail above with regard to Section S.1 of the SA, of the plans reviewed, out of 11 plans reviewed, only one objective was identified that indicated actual learning in a community setting. Further concerns were raised during observations conducted the week of the monitoring team's visit to AUSSLC. During the Human Rights Committee meeting, discussion took place regarding Individual #167, who recently had moved to a different residence. This individual was experiencing difficulty adjusting to the change. One of the committee members suggested that the PST explore this individual's transfer to the state hospital, not for an evaluation, but rather as a permanent place to reside. The rationale given was that this individual had indicated a preference for the hospital. State hospitals should not be viewed as a potential residential site for an individual with developmental disabilities. A more appropriate response would have been to explore a variety of living options for this individual, including other residences on campus and community-based arrangements. When the discussion turned to Individual #156, a recommendation was made to pursue volunteer work at the local library. While this recommendation for a community-based activity was encouraging, a more appropriate pursuit would have been for paid employment in the community for this young man. Consideration needs to be given to expanding the opportunities available to the individuals residing at AUSSLC for community involvement. The Director of Active Treatment is commended for her efforts to keep staff informed of available activities each month in the Austin community, but staff are encouraged to look at the activities currently in place at the Facility, and consider ways that these could be expanded to the	Noncompliance

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		community. For example, the week of the monitoring visit, several individuals were participating in a choir festival in San Angelo, which was very positive. Another individual was observed singing along to the radio. Staff reported that this person knew every song, and clearly enjoyed engaging in this activity. Consideration should be given to exploring opportunities for individuals to participate in recreational choral groups in the Austin area. Similarly, it appeared that some of the individuals attending the Life Skills Center enjoyed the group sing along or the Bingo game. Consideration should be given to finding similar activities that take place in the Austin community that would be open for participation. Normalization principles always should be followed when individuals participate in activities in the community, including, for example, ensuring that small groups of individuals participate in activities to encourage integration with their non-disabled peers. Another consideration, related to the principle of normalization, was the need to continue to improve individuals' personal hygiene and physical appearance. Observations throughout the week of the visit revealed individuals with dirty and/or poorly styled hair, and worn, dirty, and/or poorly fitting clothing. This was a situation that had not improved since the baseline visit. The Director of Active Treatment had developed a monitoring tool for staff to use to assess this area of need. This data should be used to effect positive change for the individuals served.	

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

1. To promote adequate habilitation and skills training, individuals should have access to materials that are of interest to them, that are in good working order, and that support the development of functional skills.
2. Ongoing staff training and supervision will be necessary to ensure that staff are provided the support necessary to promote learning among the individuals served.
3. Comprehensive assessment of adaptive behavior should occur at a minimum of once each year. The Positive Assessment of Living Skills, or some similar tool, should be completed in full to ensure that all areas of need are addressed in the individual's Personal Support Plan. Skills identified should be functional, age-appropriate, and matched to the individual's preferences.
4. Once training objectives are identified, programs should be written to include the following information:
    a. A behavioral objective that includes, a description of the conditions under which the behavior is to occur, a description of the behavior in observable and measurable terms, and the criteria used to determine mastery;
    b. A schedule for training, including the number of trials to be provided (ensure that the schedule provides sufficient opportunities for learning to occur);
    c. The setting in which training will take place;
    d. Specific materials needed;
    e. Guidelines for teaching, including the discriminative stimulus, prompting strategies, fading of prompts, task analysis where appropriate, and the implementation of shaping and chaining strategies;
    f. Identification of reinforcers;

g. Schedules of reinforcement;
h. Error correction procedures;
i. Steps taken to ensure maintenance and generalization of newly acquired skills, including data collection; and
j. A clear description of data collection procedures.

5. The vocational assessment process should be revised to incorporate a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history, or interest inventory.
6. A plan should be developed to ensure inter-observer agreement measures are collected on skill acquisition programs.
7. Data collected on all skill acquisition programs should be presented graphically, and reviewed at a minimum of once quarterly. This will allow for ongoing monitoring, with program revisions completed in a timely manner. If training is not accomplished, due to individual refusal to participate, psychology staff should be involved to help design programs to improve participation, be it through change in presentation, choice in activity, or something similar. Data also should be collected to evaluate the success or failure of maintenance, and generalization of newly acquired skills.
8. Further revisions to the training program for staff on teaching individuals with developmental disabilities should be considered after review of Cooper, Heron, and Heward (2007) and Snell and Brown (2011). Staff training should be a blend of didactic and on-the-job, competency-based training.
9. Staff also should be provided training in incidental teaching strategies so that opportunities for instruction that arise throughout the day can be addressed. This includes, but is not limited to, the involvement of individuals in meals, in residence maintenance, etc.
10. Opportunities for learning, working, and recreating in the community should be greatly expanded. Individuals should not only have access to events and facilities in the Austin area, but they should have specific plans for developing skills in the community.
11. Preference assessments are recommended to ensure that potentially effective reinforcers are incorporated into all training objectives.
12. The empirical support should be reviewed for any therapies provided to individuals served by AUSSLC, including, for example, sensory activities. Each individual residing at AUSSLC presents with unique strengths, interests, and needs. Even for those individuals diagnosed with Autism, there is very little literature to support the beneficial effects of sensory integration (see National Autism Center, 2009; Schreibman, 2005). As materials are purchased and activities are developed to enhance the habilitation and training provided to the individuals residing at AUSSLC, the focus should remain on functional and age-appropriate skill development, that will allow for greater independence and an enhanced quality of life.

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

1. The Director of Active Treatment is encouraged to develop a definition of engagement that staff can use as a guide when completing PLACHECKS. It is suggested that the Director of Active Treatment review standards that were used by Dyer, Schwartz, and Luce (1984). Staff using this tool are encouraged to provide feedback to staff regarding positive observations, and also to offer suggestions for improvement.
2. As is noted above with regard to Section D of the SA, the Facility's efforts should continue to address the personal hygiene, grooming, and dress provided to individuals. It is suggested that the Director of Active Treatment refer to McClannahan, McGee, MacDuff, and Krantz (1990) for additional measures beyond the newly implemented monitoring tool.
3. As also is noted above with regard to Section D of the SA, the Facility's efforts should continue to enhance the overall quality of the environments in which the individuals live, work, and recreate.

References:

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McClannahan, L.E., McGee, G.G., MacDuff, G.S., & Krantz, P.J. (1990). Assessing and improving child care: A personal appearance index for children with autism. *Journal of Applied Behavior Analysis, 23*, 469-482.

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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 Individuals Assessed for Placement since 1/1/10, and resulting recommendations, undated; o List of individuals referred for placement since 1/1/10; o List of Individuals who Have Requested Community Placement but Have Not Been Referred, undated; o List of individuals with a Community Living Discharge Plan developed, since 1/1/10; o List of individuals who transitioned to a community setting since 1/1/10; o Community Placement Report, dated 9/13/10; o Community Placement Obstacles from 7/1/2009 to 9/13/2010; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o Living Options Discussion Record, dated 3/31/10; o AUSSLC Corrective Action Plan, Section T, Step B.14, undated; o Sign-in sheets and materials presented at meetings between the Admissions Placement Coordinator, Post-Move Monitor and discipline-specific groups; o PSPs and related assessments for the following individuals: Individual #285, Individual #177, Individual #280, Individual #72, Individual #354, Individual #208, Individual #144, Individual #18, and Individual #320; o Community Living Discharge Plans, PSPs, and related assessments for: Individual #259, Individual # 459, Individual #233, and Individual #441; o Post-Move Monitoring Checklists for: Individual #233, Individual #47, Individual #40, Individual #33, Individual #13, Individual #9, Individual #441, Individual #211, Individual #218, Individual #459, and Individual #259; o Self-Advocacy Committee Meeting minutes for 1/27/10, 2/24/10, 3/31/10, 4/28/10, 5/26/10, 6/4/10, 7/2/10, 7/29/10, 8/6/10 though 8/8/10, 8/17/10, and 8/25/10; and o Presentation Book for Section T. ▪ **Interviews with**: o Mary Birdsong, Admissions/Placement Coordinator; and o Holly Lindsey, Post-Move Monitor. ▪ **Observations of**: o PSP annual review meeting for Individual #68; o Post-Move Monitoring Visits for Individual #259, on 10/6/10; o Visits to various residences and day programs on campus; and o CLDP meetings for Individual #170 and Individual #410.
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the

	steps the Facility took to assess compliance. Although the POI reviewed for AUSSLC did not include this component, the POI correctly identified that overall, AUSSLC was currently not in substantial compliance with the requirements of Section T of the SA. The POI indicated compliance with some indicators within this section. At times, the Monitoring Team agreed with this assessment, but at other times, the Monitoring Team did not. Specifically: ▪ The POI indicator that 100 percent of the individuals had been assessed for placement. However, as is discussed below, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. ▪ The Monitoring Team found the Facility in compliance with T.1.h. of the Settlement Agreement. This provision requires the Facility and/or State to provide the Monitor with a community placement report. The Facility also found itself in compliance with this requirement. ▪ Several of the indicators related to T.1.c, which related to the identification of the actions needed from Facility staff and others to ensure an appropriate and safe transition. The Monitoring Team found that many actions were missing and/or did not contain sufficient detail. ▪ The indicators that post-move monitoring had been completed. This was consistent with the Monitoring Team's findings. However, as is discussed below, concerns were noted with regard to the standards used in monitoring.
	Summary of Monitor's Assessment: Individuals' PSPs did not consistently identify all of the protections, services, and supports that needed 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. PSPs had begun to identify obstacles to individuals moving to the most integrated setting appropriate to meet their needs. However, the following issues were noted: 1) the obstacles often were listed as need areas for the individual, such as behavioral issues, medical concerns, etc., as opposed to identifying services or supports that either were unavailable or did not exist in the community; 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible, or timeframes for completion; and 3) the strategies often involved services to be provided to the individuals at the Facility, but did not include identifying support configurations in the community that would address individuals' needs. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be 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. Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, they all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. Some concerns were noted with regard to the standards being used to monitor essential and non-essential supports. This was exacerbated by the lack of definition in the Community Living Discharge Plans.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	On 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This policy was updated on 3/31/10, with minor revisions. This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual, to the most integrated setting, was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's 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 AUSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations. The professional teams supporting individuals at AUSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.	Noncompliance

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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 Monitoring Team's pre-visit document request, the Facility did not provide any Facility policies related to transition and discharge. In its POI, the Facility indicated that it was operating using the State policy, and was in the process of determining if changes needed to be made to address Facility-specific issues. If the Facility decides to adopt the State's policy in full, this should be indicated in its policy manual. If not, then a Facility policy should be developed/revised to address transition and discharge processes and practices.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	Since the baseline review, a new PSP process had been put in place. This is discussed in further detail with regard to Section F of the SA. However, this process was at the very initial stages of being implemented. Requirement T.1.b.a of the SA is dependent on individuals' plans being comprehensive and integrated, as well as obstacles to individuals' movement to the most integrated setting being defined clearly, and addressed adequately. At the time of this most recent review, little improvement was seen in either of these areas. 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 needed to ensure their 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 dental/medical, nursing and habilitation therapies, and medical and habilitation therapies); 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 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	Noncompliance

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		about what protections, supports, and services the individual needs to ensure that the 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>: Generally, in the PSPs reviewed, obstacles to an individual's movement to the most integrated setting appropriate to his/her needs and preferences, and/or strategies to overcome such barriers, were not clearly identified. For example: ▪ Individual #18's PSP, dated 11/10/09, alluded to obstacles, but did not specifically identify them. No plans to overcome obstacles were included. The same was true for Individual #72, who had her PSP developed on 9/8/10. ▪ Individual #144's PSP, dated 8/26/10, identified the only obstacle as the LAR's belief that AUSSLC was the best place for her to live. No details regarding the LAR's specific concerns, or preferences with regard to the services offered by AUSSLC, were articulated, and, therefore, no plans to address such concerns were identified. The same was true for Individual #354. ▪ Some specific barriers were identified for Individual #280. They were listed as: "[Individual #280] has medical issues that require 24 hour nursing. Specialized transportation – public transit is reluctant to serve people with mobility devices that have unusual configurations. Lack of extensive therapies, sensory program, etc. in a centralized location. Guardian's request – [Individual #280's] father… stated that he is very satisfied with the excellent [direct support professionals] in AuSSLC and this is [Individual #280's] home." However, no plans to overcome the barriers were identified.	
	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.	Consistent with the baseline review, AUSSLC, in conjunction with the Mental Retardation Authorities (MRAs), had engaged in a number of activities to provide education about community placements to individuals and their families or guardians, to enable them to make informed decisions. This had taken a number of forms, including: ▪ On November 6, 2009, a provider fair was held. This event was planned in conjunction with the MRAs with whom the Facility regularly works, as well as a number of providers. According to the Admissions/Placement Coordinator, the fair was well attended by individuals, staff, and families. An upcoming provider fair was in the planning stages at the time of the most recent-on-site review. ▪ Visits to community group homes and day programs were continuing to occur. Such visits offered individuals and Facility staff the opportunity to obtain first-hand knowledge of what community supports were available, to meet provider staff, and potentially other people with whom they could have the opportunity to	Noncompliance

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		live or work. The MRAs were responsible for working with community providers to offer these community exposure trips. AUSSLC Social Work staff were responsible for identifying individuals to participate in these trips. AUSSLC is encouraged to continue offering regular visits to community homes and day programs. ▪ Individuals and their guardians also were provided information through the MRA Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process. ▪ In addition, another training session was being planned during which MRAs would meet with PST members to provide training on services and supports available in the community. ▪ At the monthly Self-Advocacy Meeting, individuals reportedly informally talked about community options. This was illustrated in the minutes from the meeting on 8/25/10, when one of the members shared with the group his recent experience with transition activities related to an upcoming move to a home in the community. In August 2010, members of the group also attended a three-day Texas Advocates Conference in Corpus Christi, Texas. It appeared that a number of topics discussed related to community living, including, for example, "Living by Your Own Choice," "Do You Want to Achieve Independence and Success," and "Self-Determination in Action." It is very positive that the Facility provides supports to facilitate individuals' participation in such activities. 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 would allow someone with first-hand knowledge about the process, including the challenges as well as the successes, to share information and provide support. The individualization of this process is key to ensuring that individuals and their guardians have been provided education that allows them to make an informed choice, as required by the SA.	
	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,	The SA anticipated that the Facility would require 18 months to complete this activity. However, to assess the Facility's progress, the Monitoring Team requested, as part of its document request, a list of individuals who had been assessed for placement since July 1, 2009, pursuant to the new or revised policies, procedures, and practices related to transition and discharge practices. The list provided appeared to be a list of all individuals who had had an annual PSP meeting since 1/1/10.	Noncompliance

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	and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	As is discussed above with regard to Section T.1.a of the SA, the individuals' PSPs that were reviewed did not document an independent assessment, by the professionals on the team, of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs. The Facility's POI documented that compliance had been attained with regard to the indicator that 100 percent of the individuals at AUSSLC had been assessed for placement. This was inconsistent with the Monitoring Team's findings.	
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:	As noted with regard to Section T.1.a of the SA, the DADS policy on most integrated setting practices was being revised. This included development of a new CLDP document format, and the process for managing the CLDP. Recent training had been conducted by the DADS central office continuity of care coordinator on the new CLDP. The monitoring team had the opportunity to review this new CLDP form. Many of the changes to the CLDP format were in response to discussions that Monitoring Team members had with Facility and State staff during on-site monitoring visits, as well as in response to findings noted in baseline monitoring reports. The Monitoring Team appreciates and acknowledges the Facility and State's responsiveness. At the time of the on-site monitoring visit, the Facility had begun to implement the new format, but was at the beginning stages of this process. Additional comments regarding the specific CLDPs reviewed are offered later in this section. The following comments are based upon a review of a blank template: ▪ Overall, the form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. ▪ The new process directed the PST to begin the CLDP process at the point of referral. This was an improvement from the previous process. This will provide an opportunity for PST members to be involved in all aspects of transition, including visiting potential community providers, ensuring that all relevant assessments are completed and reviewed, and following up after the individual has moved, by reviewing the results of each post-move monitoring visit. ▪ A list of standard items to be completed and in place prior to every individual's move now appeared on page 6 (e.g., 30-day supply of medications, signed physician orders, required adaptive equipment). In the previous format, these items filled (i.e., unnecessarily cluttered) the list of essential supports and, thereby, detracted from the PST's ability to focus on identifying those essential and nonessential supports that were truly based upon individual needs and preferences. ▪ The list of summaries and recommendations on page 9 was also an improvement. It was designed to help the PST remain focused on its primary	Noncompliance

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		task related to reviewing assessment, that is, ensuring that all recommendations are reviewed and, moreover, that recommendations are then included in the list of essential or nonessential supports. ▪ Psychiatry should be added to the list of summaries and assessments. ▪ The review of every action plan (i.e., training objective and service objective) was another good addition to the process. The final statement on page 12, however, indicated that the PST could only make recommendations about action plans. It is the opinion of the Monitoring Team that the PST can, and should, make certain action plans (training objectives and/or service objectives) essential or nonessential supports, if the PST believes that implementation of any of these plans is important. The CLDP is the PST's chance to specify the supports and services that the provider must agree to provide. PSTs should be assertive in this area and not squander this opportunity. DADS should remove the statement on page 12 because it appeared to be at odds with the State's desire for transition to grow out of the PSP process. ▪ It was also good to see that the CLDP required a description of the evidence to indicate whether or not an essential or nonessential support was in place. This was a new component to the CLDP. PSTs will need to be thoughtful and ensure that the requirements look for observable, objective evidence with specific criteria. ▪ The pre-move site review should also be sure to include the list of standard items on page 6. This could be added to the list on page 23. The Monitoring Team looks forward to reviewing the full implementation of these new procedures. Community Living Discharge Plans were reviewed for four individuals. This sample was drawn from the list of eight individuals who had transitioned to the community since the last review. As noted after the baseline review, at AUSSLC, the CLDPs contained a substantial amount of extremely valuable information regarding the individuals, and their needs for protections, supports, and services. However, the narrative information included in the plans was not consistently translated into measurable action steps, and/or essential supports and services. The process that was in place at AUSSLC should continue to be refined to ensure that individuals are provided the supports they need when they move to the community. This is discussed in further detail below with regard to Section T.1.e of the SA. With regard to timeliness of the Community Living Discharge Plans, it appeared that all four that were reviewed were developed only a few weeks prior to the individual's	

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		transition date, making adequate transition planning difficult. Particularly because the Facility was attempting to define essential and non-essential supports during the CLDP meeting, as opposed, for example, to identifying them for each individual as part of the annual PSP meeting, such a short window between the CLDP and transition date made it difficult to ensure that all essential supports were identified, and that provider and Facility responsibilities with regard to discharge were both identified and implemented. Based on review of the new CLDP template, it appeared that they would be developed sooner in the transition process. A positive practice was related to the Facility's efforts to involve more team members in the transition process. The Admissions Placement Coordinator and Post-Move Monitor had provided in-service training to a number of staff groups, including nursing, OT/PT, psychology, the QMRPs, and Active Treatment staff. Review of the meeting documentation showed that this training had been individualized to meet the needs of the various groups, and emphasized their roles in the transition planning and implementation process. Facility staff shared that this was beginning to result in some changes in the outcomes for meetings and the individuals. For example, a positive outcome had occurred for Individual #170. Habilitation Therapies staff had visited the home to which she was planning to move, and identified a number of items that needed to be modified and/or corrected. The community provider then addressed the outstanding issues. This was very positive, and provides an example of the types of supports and evaluations that it would be appropriate for teams to write into CLDPs as essential supports. The increased team involvement was evident at the two CLDP meetings that members of the Monitoring Team attended. At both of these meetings, numerous team members were present, and shared their expertise with the community provider, as well as in contributing to the development of the CLDP.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, the CLDPs did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and the steps that were identified 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. 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. None of four CLDPs (0%) adequately defined the Facility staff's role in assisting community provider staff to learn about these	Noncompliance

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		plans and their implementation. When such training was referenced, the CLDP did not define what the training would consist of, who was expected to complete the training, or what the expectations were with regard to the competency of the community provider staff in implementing the programs. Although based on interview, it appeared that AUSSLC staff were assisting in the transition by accompanying individuals to their new residences, and attending portions of pre-move visits, this was not formalized in the CLDPs reviewed. Sometimes this was mentioned in the narrative regarding activities that had occurred before the meeting. But again, because the CLDPs were being developed sometimes days before a transition, these activities were not defined as measurable action steps. As noted above with regard to Section T.1.c of the SA, many individuals would benefit from team members, particularly habilitation therapies staff or psychology, conducting an assessment of the environment, and making recommendations, as appropriate, prior to the time the individual transitions to a community home and/or day program/vocational site. Although this had occurred for at least one individual, it was not written into CLDPs as an essential support. 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 provides an example 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: ▪ Individual #233 had complex behavioral, psychiatric, medical, physical, and nutritional support needs. She transitioned to a foster care setting. Individual # 233's CLDP listed the names of staff responsible for in-service training. This did not provide sufficient information regarding the content of the training, who was expected to complete the training, and/or the measurable expectations with regard to the training (e.g., competency in implementing a plan or treatment).	
	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 identified target dates for the completion of actions steps included in CLDPs, as well as the person responsible by name in three out of four of the plans reviewed (75%). It appeared that this was a function of Individual #441's plan being developed earlier in the six-month period. Hopefully, with the implementation of the new CLDP format, this issue will be resolved.	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to	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. For four of the four plans reviewed (100%), sign-in sheets were provided that	Substantial Compliance

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	facilitate their decision-making regarding the supports and services to be provided at the new setting.	confirmed the presence of the individual and his/her guardian.	
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.	Based on the documented dates of assessments reviewed at the CLDP meetings, it appeared that assessments had been updated within 45 days. However, this was difficult to confirm. In response to a document request for the assessment used in the CLDP process, the Facility provided copies of the summary already included in the CLDP, not signed copies of the actual assessments or updates. In addition, in order for this item to be in substantial compliance, some sort of checklist or tracking tool should be used that lists all required and optional (i.e., as needed depending upon the individual) assessments, so that PSTs and community providers can be assured that no relevant assessments are missing.	Noncompliance
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 four CLDPs reviewed included essential and non-essential supports. However, as during the baseline review, it appeared that the Facility was still 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 made it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. In none of the four plans reviewed (0%) was a comprehensive set of essential and non-essential supports identified in measurable terms. The following provides only a few examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ Individual #9's Post Move Monitoring Checklists listed her essential supports. One of them, under the section on residential supports, read: "pica-safe environment." A similar non-essential support was identified under the vocational/day program section that read: "Evidence of ongoing monitoring for PICA risks (especially cigarette butts)." These were not measurable, and made monitoring difficult. This was evidenced by the Post-Move Monitor's comments. For example, with regard to the residential site on 7/1/10, the Post-Move Monitor noted: "Nobody there smokes and paper is kept away from [Individual #9]." It was not clear if paper and cigarette butts were the only requirements for a "pica-safe environment" or not. At the 90-day monitoring, the Post-Move Monitor found the residential program to be compliant with the pica requirement and stated: "While this is not done on a routine or scheduled manner, [Individual #9] is on a 1:1 almost the entire day and is watched closely." Although from the Monitoring Team's perspective this does appear to be	Noncompliance

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		adequate, it was clear that the Post-Move Monitor was having difficulty measuring the term "Pica-safe environment" without more written direction from the team that developed the CLDP. The team, for example, had not required written documentation of monitoring of the environment, nor had it defined what a "pica safe environment" for this individual was. Another example was a non-essential support that read: "Bowel movement monitored." The Post-Move Monitor scored this as a "Yes," with the comment "Not logged, although [provider staff] stated that she is going about 3 times per day." Technically, one could conclude that this was being monitored because staff were able to report on it. However, a more measurable requirement should have been included so that everyone understood clearly whether or not written documentation needed to be maintained, and if so, with what frequency. Likely such data would be completed on each shift. It also should have been identified who would monitor such data, and for what, and when reporting to nursing or medical staff was necessary. ▪ Individual #259's CLDP did not integrate the ground diet that the assessment section noted was necessary. He also had a hearing impairment, but the CLDP did not identify measurable steps that community provider staff needed to take to accommodate for this. Rather, the CLDP stated: "Interactions sensitive to hearing loss." His CLDP did not identify the level of staffing necessary, despite his history of elopement, aggressive behavior, and "inappropriate sexual behavior," which was not defined. ▪ Individual #233's CLDP indicated that she had a need for a "Behavior analyst/psychologist on staff or contract." No measurable criteria were defined with regard to what this person's roles or responsibilities would be with regard, for example, to review of the behavior support plan, and revision as appropriate; training of staff; monitoring of data on a regular basis, etc. Individual #233 had a lengthy list of adaptive equipment on page 3 of her CLDP. No mention was made in the essential or non-essential supports regarding the need to maintain and/or use such equipment, except for a cooling vest. Likewise, there was no requirement included that the provider would ensure access to therapists who would continue to monitor Individual #233's needs with regard to this equipment or its use. According to the information in the narrative of the CLDP, she was overweight, and had a chopped diet texture. It also appeared that a nutritionist followed these issues, but none of this was incorporated into the essential or non-essential supports. In addition, her physical and nutritional management needs, and medical complexities appeared to require nursing and clinical staff to conduct regular follow-up while she was at the Facility. This was not addressed in the essential or non-essential supports, or justified as not being needed in the narrative. It was clear that she required close supervision due to	

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		her inability to feel pain, and the high risk for her injuring herself. Her supervision level and/or how that would be accommodated in the new foster care setting were not addressed in the essential or non-essential supports. With regard to monitoring by the MRA or other means to ensure essential supports were in place prior to an individual's transition, as noted in the baseline review, the MRA was conducting a review. However, this was just a general safety review, and did not document whether or not essential supports had been confirmed. At the time of this on-site review, the MRAs continued to use the same form and process. Based on interview, the State and Facility recognized that these were not adequate assessments. In order to correct this deficiency, the Facility had begun using a form entitled "Pre-Move Site Visit," which was a part of the revised CLDP process. The Post-Move Monitor indicated that in conducting these visits, she invited the MRA staff to conduct joint reviews. This happened sometimes, but not always. In reviewing some of the most recent Pre-Move Site Visit forms, it appeared that appropriate steps had been taken to confirm that essential supports were in place. Specific evidence was listed to show that the Post-Move Monitor had verified essential supports were present. For example: ▪ On 9/17/10, Individual #233 transitioned to a foster care provider who was receiving supports through a provider agency. Prior to her transition, on 9/9/10, the Post-Move Monitor completed a visit to the foster care provider's home. Some of the essential supports Individual #233 required were a behavior analyst on staff or contract, which was confirmed through a copy of the contract; an arrangement for the individual to be seen by a PCP within 48 hours of her transition, for which an appointment had been scheduled; and a written safety plan addressing behavioral and medical emergencies posted in the home, which the Post-Move Monitor visually confirmed. As the new format required, the Post-Move Monitor also conducted a general review of the home environment, the activity schedule, transportation, and in-service training of staff. As appropriate, the Post-Move Monitor had attached documentation to the report. ▪ Likewise, the Pre-Move Site Visit form for Individual #40 showed that the Post-Move Monitor had confirmed the physical existence of items such as a fenced back yard, a safe smoking area, and locking mechanism for a drawer in which knives and other sharp objects were maintained. In addition, she had reviewed documentation to confirm that training identified as an essential support had been completed. It appeared that her review included both the home and day/vocational site. When issues were identified, such as lighter fluid not being locked, the Post-Move Monitor addressed this with the provider. This review was conducted two days before the individual moved, resulting in the essential supports being confirmed prior to his transition.	

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T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	As is discussed above with regard to Section E of the SA, the Facility had adopted the review tools that the Monitoring Teams developed. The Facility was in the beginning stages of implementing these. A Corrective Action Plan had been developed for Section T, and addressed the monitoring process itself. It specifically addressed the Monitoring Team's recommendation, from the baseline review, that a monitoring process be devised to address this component of the SA, and that expectations be set "with regard to the frequency of review, the sample size, the criteria used to determine acceptable levels of performance, and the follow-up activities that are expected to occur." The Monitoring Team recommended that once monitoring was conducted, that data be analyzed, and appropriate corrective action plans be developed and implemented. The Facility indicated that initial monitoring criteria had been developed, but "We are still in the beginning stages of monitoring and have not done data analysis or developed Corrective Action Plans."	Noncompliance
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	Based on a review of PSPs and interviews with staff, AUSSLC continued to be in the initial stages of identifying obstacles to placement on an individual basis. As a result, the Facility had not yet collected sufficient data for analysis and submission of a report to the State. The Monitoring Team looks forward to examining such reports as part of future reviews. The Facility had collected information about the barriers for a small group of individuals, including individuals who had requested community placement, but whose teams had not recommended transition to the community. The resulting report was entitled "Community Placement Obstacles from 7/1/2009 to 9/13/2010." The report listed 15 individuals, the obstacles to referral for community living, and a summary of this data. The reasons listed included "LAR Choice" for 66.7 percent of the individuals, "Behavior/Psychiatric" for 13.3 percent, "Citizenship/Funding Issues" for 6.7 percent, and "MAR Not Present" for 13.3 percent. No analysis of the information, or plans to address the issues identified, were included. As indicated in the baseline review, this report showed the beginning stages of identifying obstacles in an aggregate fashion. However, as this document illustrated, it would be more helpful if obstacles to placement were more specifically defined. The broad categories of "LAR Choice," and "Behavior/Psychiatric," for example, provided little information about what the obstacle or barrier was. In order for the State and the Facilities to adequately address barriers, they should be: 1) defined with sufficient detail to allow the State to identify and address issues related to the current community system; and 2) identify the protections, supports, and/or services that are currently lacking or not available to allow transition to the community.	Noncompliance

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	feasible, DADS will seek assistance from other agencies or the legislature.	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 or the timeliness with which services can be accessed in the community (e.g., certain types of medical services) might be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes. 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.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. The report listed individuals who had been referred by their teams for community placement between 7/1/09 and 2/28/10, including the individual's name, the date of referral, and, if applicable, the date the referral had been rescinded. The list included 12 names of individuals referred, none of whom had had their referrals rescinded. The second page of the document listed nine individuals who had been transitioned to the community during this time period.	Substantial Compliance

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	facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Timeliness of Checklists: Post-move monitoring documentation was reviewed for 11 individuals. Of the 27 required visits, 27 (100%) had been documented as having been completed on time. 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. Efforts clearly were being made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. This should be improved further when the new CLDP format is implemented, and teams are better defining the evidence expected to confirm the existence of an essential or non-essential support. The biggest difficulty the Monitoring Team noted was with regard to the standards used to monitor. In some cases, this related to the limited description teams had provided in the CLDPs. An example of this is given with regard to Section T.1.e related to Individual #9's post-move monitoring activities. As is discussed above, the monitoring efforts were stymied because the team had not adequately defined a "pica-safe environment." Questions also arose with regard to the stringency of monitoring standards in situations where community teams decided that protections, supports, and services that the Facility teams had identified as essential or non-essential supports did not need to be provided. In some instances, this appeared to be accepted, but without adequate justification. Examples of these concerns included: ▪ Individual #13's CLDP included an essential support for an "Alarm/posey alarm." The 45 to 90 day monitoring report indicated that the alarms were present, but not in use, and no BSP was in use. When asked, the provider produced a copy of the most recent individual plan in which the team had discontinued these protections and supports. Although individuals' needs might change, for such drastic changes, that have the potential to impact the safety of the individual and others, adequate justification should be provided in	Noncompliance

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		the monitoring report for not pursuing it further. No such justification was provided. This would be a good example of where the new requirements, for review by the PST of each monitoring report, will be beneficial. This will allow the Post-Move Monitor to access the opinions and expertise of the entire team. ▪ Individual #441's day program services repeatedly were identified in the narrative of the monitoring reports to be substandard. However, they were rated as a "Yes." This was not helped by the weak description of the supports to be provided: "Participation in a dayhab until vocational services are available." Likewise, this individual's leisure activities were described as riding around, but the Post-Move Monitor noted that: "he does not know Austin well and wants to see it." The individual might be accepting of inadequate supports, but the Facility should not. The primary reasons for conducting post-move monitoring are to identify whether or not all 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. This is commendable, and should continue. With regard to follow-up activities, the Facility was making efforts to provide hands-on assistance, in some cases, when community providers were not effective in addressing individuals' needs. For example: ▪ Individual #441's post-move monitoring follow-up visits showed steady decline in his appearance, as well as his willingness to participate in daily activities. He refused to participate in a day program. Facility staff made repeated attempts to work with the community provider to assist them in identifying an appropriate day program for Individual #441. The community provider staff failed to follow through on a number of occasions. This did not deter Facility staff. Members of Individual #441's Facility PST went to visit him, and decided that retraining of provider staff was necessary. It also was agreed that the community provider's BSP was inadequate, and that AUSSLC's plan would be implemented until the community provider developed a more comprehensive assessment and plan. Facility staff also made efforts to again set up a time to take Individual #441 to visit other day programs. These were commendable efforts on the part of Facility staff to ensure the success of the individual's transition to the community. It should be noted that Individual #441's CLDP was written several months ago, and included very limited descriptions of essential and non-essential supports. The Facility should conduct a critical	

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		analysis of the planning and transition processes for any individual whose placement is in jeopardy, to determine if any revisions should be made to existing procedures and/or practices. ▪ Individual #47's post-move monitoring reports showed consistent follow-up, even after the 90 days had elapsed. The Facility has made progress in this area since the baseline review, particularly with regard to documenting the methodologies used to monitor. The Facility is encouraged to continue to improve the standards used to monitor by both defining better the essential and non-essential supports, and consistently holding community providers accountable for the provision of these supports. When a community team makes the decision to revise the protections, supports, and services the Facility team had determined to be necessary, there should be a full review by the Facility PST, and justification if an element of the CLDP is modified. If there is not adequate justification, then the Facility should use its best efforts to ensure such supports are implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the on-site review, a member of the Monitoring Team accompanied the Post-Move Monitor on monitoring visits to Individual #259's day program and home. The Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. In addition, the Post-Move Monitor was very helpful in providing ideas to address issues raised. In the report, the Post-Move Monitor also thoroughly documented her findings and interactions with the individual and the community provider staff. Based on the reviews that were conducted for Individual #259 in comparison with his CLDP, it appeared that the Post-Move Monitor reviewed relevant documentation, and conducted appropriate observations and interviews. It should be noted, however, that the concerns identified above with regard to the continuing need for improvement in the depth and quality of CLDPs will affect the level of monitoring that will be required. As CLDPs are improved, and there are additional measurable services, supports, and protections included in the plans, the expectations for the Post-Move Monitor will increase. As is noted above, it is essential that modifications be made to the CLDPs to ensure they include comprehensive and measurable definitions of the protections, services, and supports provided. This will require the Post-Move Monitor to conduct many more observations of, for example, meal times, staff interactions with individuals, and/or the environment, and will require much more extensive review of data, such as behavioral data, data related to PNMPs, and interviews with direct support professionals to ensure their understanding of such supports, etc. Continuing findings of substantial compliance for this requirement of the SA will be dependent on post-move monitoring	Substantial Compliance

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		activities keeping pace with the evolution of the community living discharge planning process.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite	Since 7/1/09 and the time of the review, there had been no alternate discharges of individuals served by the Facility. As a result of no alternate discharges having occurred, this component of the SA was not rated.	Not Rated

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	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.		

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

1. The professional teams supporting individuals at AUSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.
2. If the Facility decides to adopt the State's policy on the Most Integrated Setting Practices in full, this should be indicated in the Facility's policy manual. If not, then a Facility policy should be developed/revised to address transition and discharge processes and practices.
3. 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. It is particularly important for individualized activities to be identified in individuals' PSPs, as appropriate, and implemented.
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 the revised Community Living Discharge Plan template and process:
    a. Psychiatry should be added to the list of summaries and assessments.
    b. The PST can, and should, make certain action plans (training objectives and/or service objectives) essential or nonessential supports if the PST believes that implementation of any of these plans is important. DADS should remove the statement on page 12 related to the

team only being able to recommend the implementation of action plans, because it appeared to be at odds with the State's desire for transition to grow out of the PSP process.

c. The pre-move site review should also be sure to include the list of standard items on page 6 (e.g., provision of 30-day supply of medication, current physician orders, etc.). This could be added to the list on page 23.

8. The State and Facility should conduct critical analyses of the transition planning and implementation processes for any individuals who return to the Facility, who require more restrictive levels of placement from their community setting (e.g., are transferred to a mental health hospital after transitioning to the community), or whose community transitions are in jeopardy.
9. The Facility should improve the standards used to monitor, by both defining better the essential and non-essential supports in the CLDPs, and consistently holding community providers accountable for the provision of these supports. When a community team makes the decision to revise the protections, supports, and services the Facility team had determined to be necessary, there should be full review by the Facility PST, and justification if an element of the CLDP is modified. If there is not adequate justification, then the Facility should use its best efforts to ensure such supports are implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.
10. Consideration should be given to identifying essential and non-essential supports as a standard part of developing annual PSPs. In addition to the resulting documents being helpful to direct support professionals and others at AUSSLC, it would begin this process much earlier for individuals who eventually transition to the community.
11. 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.
12. 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.
13. With regard to monitoring activities related to the Facility's performance with regard to this section of the SA, the Facility should:
    a. Continue to expand its monitoring activities in this area; and
    b. Analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC Guardianship Status list, undated; o AUSSLC WH Guardianship Status list, dated 8/30/10; o AUSSLC Guardianship Status list, dated 8/30/10; o AUSSLC TC Guardianship Status list, 8/30/10; o AUSSLC CE Guardianship Status list, 8/30/10; o List of individuals by residence with guardianship status, requested on site, undated; o List of Residents Obtaining Guardianship, undated; o List of Residents Referred for Guardianship; and o List of Residents Referred for Guardianship Since April. ▪ **Interviews with**: o Leslie Banks, Social Worker.
	Facility Self-Assessment: The Facility self-assessment showed that it continued to be in noncompliance with most of the requirements of Section U of the SA. This was consistent with the findings of the Monitoring Team. The only inconsistency was that the Facility found itself in compliance with the indicators related to the Facility maintaining a list of individuals who "lack both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision," and to update the list semi-annually. Although the Facility had a list, and continued to update it, the Facility's response to the document request for the baseline review, as well as the Monitoring Team's review of individuals' PSPs showed that no process was in place to determine an individual's "functional capacity to render a decision." The Facility also indicated it was waiting for State Office to provide guidance on the prioritization process. Until such processes are in place, it remains unclear whether or not the list is accurate. The Facility had begun to monitor its compliance with Section U of the SA. It was using a monitoring tool based on the Monitoring Teams' review protocol. One issue that needed to be resolved was whether the interview questions were going to be used, and if so, what sample would be drawn to complete the questionnaire. Evidently there was some confusion, and individuals who did not have guardians were being included in the sample for interview questions that the Monitoring Teams had designed to be used with individuals who already had guardians. This is an example of where the tools needed to have instructions developed, and potentially needed to be modified to meet the needs of the Facility.
	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. AUSSLC did not have a specific guardianship policy, but had some policies related to the informed consent decision-making process.

	The Social Work staff at AUSSLC had continued to review and assign priority ratings to individuals needing guardians, based on information obtained from individuals' teams. However, the assessment tools being used by the Facility were inadequate to assist teams in identifying an individual's specific capacities or incapacities for providing informed consent in various areas, and/or in identifying supports that could potentially increase an individual's decision-making capacity. AUSSLC continued to use its valuable resources to assist them in identifying guardians for individuals. Specifically: ▪ Since the baseline review, a total of eight individuals had obtained guardians. Four of these guardians were family members, and four were from Family Eldercare. ▪ AUSSLC continued to make referrals to a private, nonprofit guardianship agency called Family Eldercare. Unfortunately, the waiting list for this program was long. It was estimated to be approximately two years. Since the baseline review, an additional five individuals were referred, with a total of 25 individuals on the waiting list for a guardian with this agency. ▪ In addition, the local Travis County Probate Court operated a Guardianship Assistance Program. This program allowed family members, who wanted to petition the court for guardianship, to do so at no cost to the family member. Since the baseline review, an additional four individuals were referred to this program, with a total of 31 individuals in the referral process at the time of the review.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most	Similar to the baseline review, staff indicated that DADS Central Office was still in the process of developing a policy on guardianship and consent. This policy was expected to provide guidance to the Facilities with regard to the implementation of these SA requirements. AUSSLC did not have a specific guardianship policy, but had policies that referenced guardianship and/or consent, including: Refusal of Treatment by Individual or Parent/Guardian, dated July 2004; Individual/Legally Authorized Representative "Decision –Making" Authority for Treatment and Services, dated January 2008; Human Rights Committee, dated February 2004; and Appeal of Agency and Human Rights Committee Decisions, dated May 2000. None of these provided a description of the processes to be used for: 1) determining an individual's capacity to make informed decisions; or 2) identifying an individual's level of priority for pursuing guardianship. Based on staff interview and document review, each individual served by the Facility had been assigned a priority level for the need for guardianship. The following were the priority levels and their definitions: ▪ Priority 1 – Those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with	Noncompliance

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	restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	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; ▪ Priority 2 – Those who are able to express their wishes, have less restrictive programming, and may have a volunteer or advocate not affiliated with the SSLC who assists in advocating for them; and ▪ Priority 3 – Those who have a current Legally Authorized Representative (LAR)/Guardians. During the baseline review, it was reported that, on at least an annual basis, individuals' teams discussed the need for guardianship. According to documents provided, the assessments being used to assist teams in making these decisions included the Positive Assessment of Living Skills, and the Inventory for Client and Agency Planning. Neither of these assessment tools included an in-depth review of an individual's capacity to make decisions about various topics, for example, health care, programming, release of information, etc. Likewise, neither of these assessments was designed to identify supports that might assist an individual to make certain decisions. It was anticipated that the State Office policy would provide guidance with regard to these issues. Based on interview, it was estimated that teams had identified the need for guardianship for approximately 100 individuals. The Facility developed this list without the benefit of a State policy on this subject. As noted above, the Facility's process for determining the need for guardianship was not adequate, because it did not assess an individual's functional capacity to make decisions. Once the State policy is issued, the Facility may need to reconsider the prioritization of individuals on the list. The Facility should be commended, though, for the effort it undertook to identify individuals needing guardians, and attempting to prioritize the list.	
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	The Facility's status on this requirement generally remained as it had during the baseline review, except that some additional referrals for guardians had been made, and some individuals had obtained guardians. Since the baseline review, a total of eight individuals had obtained guardians. Four of these guardians were family members, and four were from Family Eldercare. As was reported during the baseline review, there were ongoing attempts to obtain guardians for individuals. For example, AUSSLC was fortunate to be able to make referrals to a private, nonprofit guardianship agency called Family Eldercare. The model used by Family Eldercare involved the use of a combination of staff and volunteers. A volunteer was frequently assigned to develop a relationship with the individual who was the subject of the guardianship, and to develop knowledge of the individual's preferences	Noncompliance

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	primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	and desires. Staff members from Family Eldercare were the care/case managers, and were responsible for the actual decision-making, with input from the volunteers. Criteria for acceptance by Family Eldercare included no family involvement, or family who had clearly stated that they had no interest in ever becoming the individual's guardian. The waiting list for services with this agency was fairly long. Staff estimated that the wait time was approximately two years. Since the baseline review, an additional five individuals were referred, with a total of 25 individuals on the waiting list for a guardian with this agency. In addition, the local Travis County Probate Court operated a Guardianship Assistance Program. This program allowed family members, who wanted to petition the court for guardianship, to do so at no cost to the family member. This resource appeared to be helpful in assisting Facility staff to identify guardians for people who needed them. The Facility appeared to be actively engaged in educating families about this program through team meetings, and Social Worker contact with families. Since the baseline review, an additional four individuals were referred to this program, with a total of 31 individuals in the referral process at the time of the review. The Facility also had developed an excellent working relationship with the Travis County Probate Court. Based on interview, once a number of petitions had been filed for guardianship, and the necessary review process had occurred, the Facility worked with the Court to set up a "Guardianship Day." On the designated day, the Court came to AUSSLC, and held the guardianship hearings on-site. This made it more convenient for family members, as well as for the individuals who needed to attend the hearings. At the time of the most recent review, a guardianship day was being planned, and it was estimated that approximately nine guardianships would be ready to be processed. The Facility also was tracking guardianship dates in an effort to maintain current guardianships. Each year, the current guardian was required to submit an annual report to the Court. By tracking these dates, the Facility was able to offer assistance to guardians, as needed, to complete the annual report, thereby ensuring that the guardianship did not lapse. 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	

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		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. As the State finalizes its policy on consent and guardianship, it should define the potential roles of SSLC staff in the process.	

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; 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, AUSSLC should develop a policy on guardianship to reflect the State policy.
4. Based on any additional information provided in the State policy regarding prioritization for guardianship, AUSSLC should review the list that identifies individuals who need the support of a guardian, and re-prioritize the list, as needed.
5. AUSSLC should identify additional resources for guardians, particularly for those individuals who do not have current family interest in pursuing guardianship, and are not eligible for participation in the Family Eldercare program, as well as for individuals who might be on the waiting list for a guardian for a long period of time.
6. If alternative guardianship resources cannot be identified, the State should consider seeking or providing funding for another guardianship program in the Austin area that would be responsible for the identification, training, and oversight of guardians, similar to the program offered by Family Eldercare.

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 AUSSLC draft Policy entitled "Recordkeeping Practices, dated 8/31/10; o AUSSLC Summary of Client Records Coordinator Duties, updated 9/3/10; o Unit Clerk Directory as of 4/20/10; o AUSSLC Corrective Action Plan, Section V, Conversion of records to new system, undated; o Record Audit Tool summaries for the months of April through July 2010; o Active Records and Individual Notebooks for Individual #124, Individual #202, and Individual #126; o Individual Notebooks for Individual #98, Individual #26, Individual 23, and Individual #279; and o AUSSLC Table of Contents for Policy and Procedure Manual. ▪ **Interviews with**: o Gail Tigue, Client Records Coordinator; and o Tammy Snyder, Director of Quality Enhancement.
	Facility Self-Assessment: The POI indicated that the Facility was not in compliance with any of the requirements of Section V of the SA. This was consistent with the findings of the Monitoring Team. As noted below, though, substantial progress had been made, including with regard to the conversion of records to the new Table of Contents (TOC). Further refinement of the auditing process, including making modifications to the monitoring tool to encompass all of the elements of the SA, conducting analysis of information, and developing and implementing corrective action plans, is necessary to ensure that the Facility is able to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: All of the active records at the Facility had been converted to the new Table of Contents required by the State Office. At the time of the review, all but two residences on campus had Individual Notebooks for each individual. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department. Since the baseline review, a process had been implemented requiring review of policies prior to their finalization. It required that policies be sent to the leadership group for review. The group reviewed any draft policies, to ensure adherence to State Office requirements, as well as to the Settlement Agreement, and regulatory requirements. Audits were being completed of records. No action plans had been developed yet to address issues related to records. As illustrated in this report, a number of issues negatively impacting the quality and availability of records needed to be addressed through the development and implementation of action plans.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	As of September 29, 2010, AUSSLC had developed active and master records for all of the individuals at the Facility, as required by the new records guidelines. At the time of the review, staff were in the process of completing Individual Notebooks for individuals living in one and a half residences. This was a significant undertaking, and staff should be commended for the effort. Based on interview and document review, the records management staff recognized that assistance was needed to complete this task, and had worked with administration to utilize staffing available, such as reassigned staff to complete the process. The Facility was in the process of developing a policy that, while being consistent with the State Office policy, outlined procedures that were specific to the Facility. This will be important to address some issues, such as details regarding the security of the records, defining a process for signing out records, and providing more in-depth information about falsification of records. The Monitoring Team looks forward to reviewing the policy when it is finalized. Based on interview, a training process had been implemented regarding the new records. Home Supervisors were trained by the Record Department, who were then responsible for training their staff. Records Department staff met with each discipline to explain the new record format. Some issues had been identified, such as staff becoming used to the new, reverse chronological order of the records, and staff not bringing all of the records to medical appointments. As was the case during the baseline review, in reviewing records on-site, there were a number of issues related to the records identified. Issues included documents missing from the records, outdated documents, information not being available in the active record, and staff entering information into records for times that had not yet occurred. Examples of each are provided below: ▪ In conducting a review of a small sample of records, documentation was found to be missing or outdated. For example: o Individual #124's active record contained an out-of-date rights sign-off. There was nothing in the section on functional skills assessment. A draft PSP was in the record, dated 9/23/09, almost a year prior to the review. It was unclear if a final PSP was ever completed. Although observation notes were legible, the signatures were not. o Individual #126's active record contained no PSP, and the functional assessment section only contained a summary of the assessment, not the actual assessment. ▪ The Monitoring Team found a number of entries for times that had not occurred	Noncompliance

#	Provision	Assessment of Status	Compliance
		yet. With all of these, it appeared that staff were completing their end of shift paperwork prior to the end of the shift, and dating it as if it were the end of the shift. For example: o When the Monitoring Team reviewed Individual #202's record at 8:40 p.m. (20:40) on 10/6/10, an Observation Note entry already had been made for 9:00 p.m. (21:00) on 10/6/10. o Similarly, on 10/6/10, at 9:20 p.m., an entry in the Observation Notes for Individual #98 was dated at 10/6/10 at 22:05 (10:05 p.m.) o An Observation Note for Individual #26 was dated 10/6/10 at 22:30 (10:30 p.m.), when the Monitoring Team reviewed it at 9:25 p.m. ▪ As noted with regard to Section L.1 of the SA, the lack of filing information in records was another important issue that needed to be resolved quickly. The Medical Director needed to meet with Facility Administration as soon as possible to resolve this issue. The tasks of filing lab results, annual medical assessments, consult reports, etc. was not being accomplished in a timely manner. Apparently out of frustration, and in order to have access to updated information regarding individuals on their caseloads, medical staff had compiled "green" files. These were copies of labs, consult reports, etc. that the medical staff copied before sending the original to the individual's residential building. Medical staff reported that they were not certain if the lab tests or reports were filed in the records, or how long it took to accomplish this task. To circumvent this, they had created their own internal files. While on site, the Monitoring Team found issues with regard to the timely and appropriate filing of information in individuals' records. For example: o In attempting to find documents related to Individual #39, the most current annual medical evaluation in the record was dated 1/8/09. When the Monitoring Team inquired about the document, a more recent annual medical assessment had been completed on 12/23/09, which provided evidence of compliance with yearly evaluations. However, this showed that it had not yet been placed in the record, close to 10 months later. Physicians cannot be expected to complete their duties without access to accurate and up-to-date records. ▪ The Individual Notebook, or I-book system, which was put into place just recently, allowed the direct support professionals to carry a notebook in which documentation could be entered, rather than needing to go to the individual's active record. The concept being that information would be recorded when events actually occurred, making the data more reliable. There were certain benefits to the direct support professionals writing information while it was still current in their thoughts. However, at a medical staff meeting, there were serious concerns raised about the I-book system. The Medical Director should	

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		meet with Administration to resolve these issues promptly. In one instance, at a neurology clinic, there were no recorded seizures for two months, and the neurologist was considering decreasing the dosage of medication. The I-book was not available. It was learned, however, that there had actually been eleven seizures in the two months discussed. There appeared to be no system for promptly getting the information from the I-book into the permanent medical record. Further, if such information is going to be maintained in the I-books, then the I-book should be with individuals at all times, including when the individual goes to meetings and appointments. This lack of process was creating a potential for individuals to experience harm. If the neurology clinic team had not realized the information was not updated, and the neurologist had lowered the dose of medication, the outcome could have been serious. ▪ As noted with regard to Section M.1 of the SA, a review of 15 records found that the documentation from the Hospital Liaison Nurse was present in only six of the 15 records (40%). Also, Nursing Care Plans and current Nursing Quarterly Assessments were found in 10 out of the 15 records (67%). However, the Facility provided these missing documents, indicating that the Hospital Liaison and Nurse Managers had not printed them and/or they were not timely filed in the medical records. Having these documents available in the records is essential for continuity of care. In addition, one of the requirements included in Appendix D is for records to be maintained securely. Consistent with the baseline findings, at AUSSLC, different residences had different storage capacity. For example, some had locked rooms in which records could be kept, while others did not. Reportedly, some records were kept in areas such as laundry rooms, which increased the likelihood of damage or loss of records. This is an issue that the Facility should evaluate to ensure that records are maintained both confidentially and securely.	
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. On a positive note, a process had been developed to review policies as they were drafted. After policies were sent to and reviewed by the Director of Quality Enhancement, the Executive Leadership group reviewed each policy. The group reviewed any draft policies to ensure adherence to State Office requirements, as well as to the Settlement Agreement, and regulatory requirements. As appropriate, the group made recommendations to the policies' authors, and approval for policies was provided when all recommendations had been addressed. This process should be very helpful as the Facility moves through the process of finalizing the many policies currently under development or revision.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	According to the Director of Quality Enhancement, as well as documentation reviewed, the QE Department was responsible to conduct at least 10 record reviews on a monthly basis. For the months of April through July, between five and 12 records were reviewed each month. The following were some of the issues the summary reports identified: ▪ Annual medical assessments not being found in the records; ▪ Resuscitative status not being identified in the records; and ▪ Personal Support Plan Addendums not being present. The Director of Quality Enhancement honestly indicated that this data had not been analyzed thoroughly to identify trends and determine the underlying issues, and/or action plans developed to address such issues. The Facility recognized that this was the next step in the process. As was reported after the baseline review, with regard to the tool being used to audit records, it was not clear that it addressed all of the requirements of Appendix D of the SA. For example, it appeared that the tool was designed to determine the presence or absence of items, and, if such items were current. Requirements in Appendix D of the SA, such as legibility, accuracy, appropriate signatures, proper dating of entries, etc. did not appear to be considered in the audit process.	Noncompliance
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	As noted in other sections of this report, there were difficulties with staff having ready access to the records to ensure their use in clinical decision-making: ▪ At the time of the review, when a physician needed a medical record, there was no dedicated space in the various residences where the medical record could be reviewed in a quiet office setting. Consequently, the medical record was brought to the physician's office for review. Unfortunately, the campus only had one driver who had several assignments. These included taking individuals for off campus lab tests, and hospital tests, as well as delivering and picking up medical records. One PCP estimated that about 20 percent of the time, the requested medical record did not arrive in a timely manner. Further, it was not clear how nursing and other departments completed their documentation if the record was taken to the physician's office, and might not be in the residence when needed. This is an issue that requires resolution. ▪ Other issues identified with regard to Section V.1 impacted the ability of team members to use the records to make treatment decisions. These included the timely filing of information in the records, and the accuracy of such information.	Noncompliance

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

1. The Facility should finalize the development of a recordkeeping policy, and update its recordkeeping procedures to ensure consistency with the State policies, procedures, and Appendix D of the SA.
2. Taking into consideration the need to protect the privacy and security of records, the Facility should review the current record storage resources that are available in residences and day programs across campus, and make changes, as necessary.
3. 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.
4. The monitoring of records should include all of the elements of Appendix D, such as legibility, and completeness of records.
5. Monitoring of records should result in action steps/plans to address individual as well as systemic issues as they are identified. Such action plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. As the plans are implemented, they should be monitored to ensure the desired outcomes are being achieved. If not, the plans should be modified.
6. The Facility should ensure that documents are timely filed in the medical and programmatic records, so that pertinent clinical information is readily available to clinicians and others needing this information when making decisions regarding treatments and health care services. The Facility should determine if adequate staff supports are currently available to ensure the timely filing of records.
7. The issues related to staff entering information into records, and dating, and signing the entries for times that have not yet occurred, should be investigated. Once the underlying reasons for this practice are identified, appropriate actions should be taken to correct it.

List of Acronyms

Acronym/ Symbol	Meaning
°	Degrees
≥	Greater than or equal to
≤	Less than or equal to
4LPM	Four Liters per Minute
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABI	Ankle Brachial Index
ACP	Acute Care Plan
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Automatic Defibrillator
AEM	Antiepileptic medication
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ASD	Autism Spectrum Disorder
ASL	American Sign Language
AST	Austin State Hospital
AT	Assistive Technology
ATC	Active Treatment Committee
AUSSLC	Austin State Supported Living Center
BCBA	Board Certified Behavior Analyst
BID	Twice a Day
BM	Bowel Movement
BMI	Body Mass Index
BSL	Basic Life Support
BSP	Behavior Support Plan
BUN	Blood Urea Nitrogen
CBC	Complete Blood Count
cc	Cubic Centimeter
CCC	Certificate of Clinical Competence
CCSSLC	Corpus Christi State Supported Living Center
CDC	Centers for Disease Control
C-Diff	Clostridium difficile
CIRS	Crisis Intervention Restraint Summary

CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CM	Case Manager
CMP	Comprehensive Metabolic Panel
CNE	Chief Nursing Executive
COPD	Chronic Obstructive Pulmonary Disease
COTA	Certified Occupational Therapy Assistant
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTD	Competency Training and Development
CV	Curricula Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Data, Assessment, and Plan
DART	Data, Action, Response, and Treatment
DD	Developmental Disabilities
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DRO	Differential Reinforcement
DRR	Drug Regimen Reviews
DSHS	Department of State Health Services
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
E.coli	Escherichia coli
ECU	Environmental Control Unit
EEG	Electroencephalogram
EDWR	Estimated Desired Weight Range
EGDs	Esophagogaastroduodenoscopies
EKG	Electrocardiogram
EMS	Emergency Medical Services
ENT	Ear, Nose and Throat
EPS	Extrapyramidal Symptoms
ER	Emergency Room
FBA	Functional Behavior Assessment
FDA	Food and Drug Administration
FBG	Fasting Blood Glucose
FNP	Family Nurse Practitioner
FTE	Full-time Equivalent

GE	Gastroesophageal
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HRC	Human Rights Committee
HST	Health Status Team
HT	Habilitation Therapy
I-book	Individual Notebook
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facilities for Persons with Mental Retardation
ID/DD	Intellectual Disability/Developmental Disability
IDEA	Individuals with Disabilities Education Act
IDT	Interdisciplinary Team
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IPN	Integrated Progress Notes
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
mg	Milligrams
MH	Mental Health
MHMR	Mental Health Mental Retardation
MIVI	Multiply Impaired/Visually Impaired
ml	Milliliters
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MRA	Mental Retardation Assistant
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
Na	Sodium
NEO	New Employee Orientation
NM	Nutritional Management

NMT	Nutritional Management Team
NOO	Nursing Operations Officer
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OCD	Obsessive Compulsive Disorder
OIG	Office of Inspector General
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Assessment of Living Skills
PBS	Positive Behavior Support
PBSP	Positive Behavior Support Plan
PC	PNMP Coordinator
PCP	Primary Care Practitioner
PECS	Picture Exchange Communication System
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
POI	Plan of Implementation
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
P&T	Pharmacy and Therapeutics
PTA	Physical Therapist Aide
PTSD	Post Traumatic Stress Disorder
PFW	Personal Focus Worksheet
q	Every
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QID	Four times a day
QMRP	Qualified Mental Retardation Professional

RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
R/O	Rule Out
ROM	Range of Motion
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAMT	Settlement Agreement Monitoring Team
SAO	Skill Acquisition Objective
SAMS	Self-Administration of Medications
SFAR	Structural and Functional Assessment Report
SFBA	Structural and Functional Behavior Assessment
SGA	Second-generation Antipsychotic
SGD	Speech Generated Device
SIB	Self-Injurious Behavior
SL	Speech Language
SLP	Speech and Language Pathologist
SO	State Office
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
TB	Tuberculosis
TED	Thrombo Embolic Deterrent
TID	Three times a day
TIMA	Texas Implementation of Medical Algorithms
TIVA	Total Intravenous Anesthesia
TMAP	Texas Medical Algorithm Project
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UA	Urinalysis
UGI	Upper Gastrointestinal
UNT	University of North Texas
USDHHS	United State Department of Health and Human Services
USPSTF	United States Preventive Services Task Force
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulators
VR	Verbal Reinforcement
VRI	Viral Respiratory Infection

VS	Vital Signs
WBC	White Blood Count