United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

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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, 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 Settlement Agreement. This report provides the results of a compliance review of Austin State Supported Living Center (AUSSLC).

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 AUSSLC, 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 Settlement Agreement.

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

(a) **Onsite review** – During the week of May 9th through 13th, 2011, 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 onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about Facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans

(PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans (CLDPs), and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, 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 Settlement Agreement 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 Settlement Agreement 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 Settlement Agreement. 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 Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
(d) **Assessment of Status:** As appropriate based on the requirements of the Settlement Agreement, 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 Settlement Agreement 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 Settlement Agreement identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. 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 Settlement Agreement. The recommendation sections for some provisions include a subsection of additional suggestions for the Facility. These are presented in an effort to assist the Facility in prioritizing activities as the Facility staff work towards achieving substantial compliance with the provision.

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

Given the number of issues identified during the baseline review, as well as the first compliance review, it was expected that some of the change processes would take time. During this most recent review, it was clear that the staff at AUSSLC had taken a number of steps to address identified issues and to comply with the Settlement Agreement. In a number of areas progress had been made. In a number of other areas, the foundation has been laid for change, and in others, concerted efforts should be made over the next six months to make the necessary changes.

Many of the staff at AUSSLC, particularly the Director and Assistant Directors, recognized the significant work still needed to comply fully with the Settlement Agreement, and, most importantly, to improve the protections, supports, and services being offered to individuals living at the Facility. One of the major challenges continued to be stabilizing the direct support professional workforce, and ensuring that these staff were competent in all of the many areas in which their provision of supports and services directly impacted the individuals the Facility served. The Management Team was very aware of this need, and viewed it as a priority.

The Monitoring Team encourages the Facility to continue to address the many challenges ahead. The Facility had many dedicated staff with variety of skills and talents. Efforts should continue to build a strong team across campus. It will be essential for all disciplines to work together, and communicate with one another to develop strategic and coordinated efforts to resolve the difficult issues that remain.

As with previous reviews, the Monitoring Team would like to thank the management team, all of the staff, and the individuals who live at AUSSLC for all of 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.

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

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

- Despite the vacancy in the Incident Management Coordinator position, there was evidence that the Facility was continuing to work diligently to strengthen and improve its investigation process and findings. The Facility investigators demonstrated knowledge and commitment to the integrity of their work. The transfer of the investigation function to the Department of Quality Enhancement was viewed as a positive development.

- The daily Incident Management Meetings were noted to be productive forums for the review and discussion of incidents, and the findings from investigations. The Acting Incident Management Coordinator was well prepared for these meetings.
- The majority of DFPS investigations reviewed now documented the supervisor's approval.
- A number of the investigations contained thoughtful and relevant recommendations for additional follow-up, such as staff training and enhanced team discussion, to prevent the recurrence of similar incidents. The case files contained evidence of follow-up action in a number of investigations, including disciplinary actions.

Quality Assurance

- The staff of the Quality Enhancement (QE) Department continued to work diligently to develop and implement quality assurance strategies that contributed to the provision of active treatment, as well as to compliance with the requirements of the Settlement Agreement. Since the last site visit, the responsibility for incident management and investigation functions had been transferred to this Department.
- The QE Department had continued its practice of informal "quizzes" on the living units. These quizzes provided helpful information regarding staff knowledge about the reporting of abuse, neglect, exploitation and other serious incidents.

Integrated Protections, Services, Treatments and Supports

- Since the last review, steps had been taken to increase Qualified Mental Retardation Professionals' (QMRPs) skills with regard to the facilitation of meetings. The QMRP Coordinator and the QMRP assigned to the Physical and Nutritional Management Team (PNMT) had attended train-the-trainer sessions, and had been certified to teach a course on facilitation. The AUSSLC QMRPs had participated in a day of training on facilitation, as well as team building activities. This training was a positive step, and appeared to be thoughtfully designed to encourage collaboration amongst the QMRPs, as well as build their skills.
- It was clear that teams and, particularly QMRPs were trying to incorporate more of individuals' preferences into Personal Support Plans (PSPs), as well as to expand action plans to include more of the protections, supports, and services individuals required. However, PSPs still did not adequately integrate protections, supports and services. This remained a work in progress.

Minimum Common Elements of Clinical Care

- The process of formalizing Medical Department policies had begun. Dental had completed a number of departmental policies.

At-Risk Individuals

- Using the at-risk process defined in DADS Policy #006, the Facility had completed risk ratings on each individual residing at AUSSLC. It was clear there was a learning curve for the different PSTs, and continual improvement was needed in this area.

Psychiatric Care and Services

- At the time of the last review, the Facility recently had added two full-time Staff Psychiatrists, which brought the number of full-time Psychiatrists to three, plus the continuation of a Child Psychiatrist's weekly three-hour consultation time. Those individuals now had been fully integrated into the Department.
- During the current onsite review, the Monitoring Team observed a Psychiatric Clinic of each of the four Psychiatrists. These observations indicated that there was ample time for discussion, which included a thorough review of behavioral, psychiatric, medical, and environmental considerations.

Psychological Care and Services

- The Psychology Department had increased the number of Board Certified Behavior Analysts on staff, and the majority of those not yet certified were enrolled in graduate courses. The Director of Behavioral Services had pursued affiliations with local universities to recruit practicum students.
- An internal peer review committee had been established, the function of which was to provide clinical oversight of Positive Behavior Support Plan development and the functional behavior assessment process. Issues related to staff's openness to engage in a constructive, but critical review still needed to be addressed. Additionally, contact had been initiated with staff from the Lubbock State Supported Living Center who were providing external peer review. This was in its earliest stages.

Medical Care

- The Medical Department had developed a morning medical meeting, at which significant medical concerns that had occurred during the prior 24 hours, as well as current hospitalizations were reviewed. It was well attended by PCPs, psychiatry staff, and nursing staff. Rounds in the Infirmary followed it. This was one of the essential building blocks of ensuring quality care.
- With regard to routine care at the Facility, annual medical assessments were uniformly excellent, and provided a rich compendium of information concisely organized. However, timeliness of these assessments was problematic. The Medical Department should focus on ensuring timely completion of annual medical assessments and physical exams within a 365-day time period from the last annual medical assessment and physical exam.

Nursing Care

- Effective May 1, 2011, the Facility had stopped using Agency nurses, and had restructured the work schedules of many of the Registered Nurses (RNs). AUSSLC had spent a significant amount of time building a much-needed infrastructure regarding the scheduling and tracking of nursing staffing. Since the last review, due to the clinical intensity that was needed for those individuals who were admitted to the Infirmary for acute medical issues, the Facility had changed the nursing staffing of the Infirmary to include only RNs. Also, the Facility had established minimum nursing staffing ratios for each building. At the time of the review, the restructuring process of the Nursing Department was still underway with additional interventions yet to be implemented.

- The competency-based nursing skills training program provided by the State's Nurse Practitioner Consulting group recently had been conducted at AUSSLC with the RN Case Managers and Nurse Educators.
- Although there continued to be serious problematic issues regarding the medication administration and medication variance systems at AUSSLC, the Facility had implemented some very promising systematic processes and infrastructures regarding the medication administration system. Of special note were the Facility's new Medication Error Trend reports, which included the raw data, graphs, and pie charts for medication errors by nurse, residence, agency/facility staff, severity index, contributing factors, and type of error. These were especially impressive in that trends for a specific month, as well as trends over the course of several months could be identified easily.

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

- The pharmacy completed an ambitious project to ensure that all medications dispensed were compatible with the texture and thickened liquids prescribed for individuals. This required collaboration with many departments, and appeared to be highly effective with excellent positive impact.
- The adverse drug reaction reporting system had not been finalized, but there was a draft presented at the latest Pharmacy and Therapeutics Committee meeting, which appeared to be a final draft document.

<u>Physical and Nutritional Supports</u>

- As of 3/1/11, the Facility established a fully dedicated Physical and Nutritional Management Team (PNMT), which included an Occupational Therapist, Physical Therapist, and Speech Language Pathologist. Members of the PNMT reported that the Medical Director had made positive contributions to the team's work, and a constructive working relationship had been developed. The Facility Administration, in collaboration with Habilitation Therapies Director, were to be applauded for realigning resources to form a dedicated PNMT, as well as adding a QMRP and Physical and Nutritional Management Plan Coordinator (PNMPC) to the dedicated PNMT.
- Two respiratory therapists had been hired, and provided valuable support not only to individuals with significant respiratory challenges, but to the PNMT members as well.
- Within a short period of time, the dedicated PNMT had developed and implemented a comprehensive PNMT action plan format, as well as individual-specific monitoring forms to document implementation of the action plan. During the onsite review, the PNMT was initiating the assessment process with an individual who was currently hospitalized. The PNMT developed a transition plan for this individual, which identified action steps to be completed during her hospitalization, upon discharge from the hospital on the day of her return, and subsequent days. In the process of assessing individuals, the PNMT had identified systemic issues that needed resolution. The PNMT was to be commended for their approach to identifying and resolving systemic issues, and should continue to seek the support of Facility Administration to resolve these issues as they arise.

Dental Services

- The Dental Department continued to provide quality dental care, and thorough documentation of dental care and follow-up. However, many of the challenges outlined in the Settlement Agreement remained.
- A successful suction tooth-brushing program was started and was in the second phase of expansion.

Communication

- The Speech Pathologists were to be commended for their focus on competency-based training and completion of staff performance check-offs. The next major initiative should be the incorporation of these communication devices into multiple formal skill acquisition programs, and informal daily activities in multiple environments.

Habilitation, Training, Education, and Skill Acquisition Programs

- Generic training in active treatment had been developed, introduced to New Employee Orientation, and expanded to already existing staff. Additional training in working with individuals with developmental disabilities had been provided to Active Treatment Staff and PNMP Coordinators. An associate psychologist had been recruited to train QMRP and Active Treatment Staff in writing behavioral objectives.
- The checklist originally designed to assess engagement had been greatly expanded, and was being used by members of the QA Department.
- Materials had been purchased for use in the residences, although it was recognized that the scope and quantity of materials remained limited. New day treatment programs had been identified and begun. Lastly, the policy for community trips had been amended, making it easier to travel greater distances without specialized staff (i.e., nursing). Data was also initiated to track opportunities for training in the community.

Most Integrated Setting

- AUSSLC held a community provider fair in March 2011. Due to extensive outreach efforts, attendance of individuals and staff was very good. Family and guardian involvement was minimal, but the Facility was following up with a survey to determine if another day and time, or format would be more appealing to this group. Individuals were assisted to ask questions about community options that were available, which increased the educational value of the event.
- The CLDPs reviewed included essential and non-essential supports, and significant progress had been made in better defining more of the protections, supports, and services individuals need. However, teams still 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

- AUSSLC had developed a draft document entitled: "Guardianship Priority Rating Tool." The draft tool appeared to provide a structured mechanism to identify the factors that might prioritize one individual over another for guardianship. It used some objective measures, such as the number of high risk areas the individual had been assessed as having through the at-risk screening process, use of a PBSP and/or SPCI, and a past history of a need

for frequent medical concerns, fractures, or surgical interventions. The Facility's effort to draft a tool for this purpose was commendable.

- DADS recently had issued a new guardianship booklet, entitled "A Texas Guide to Adult Guardianship," which the Facilities could use as an educational resource. Review of the booklet showed that it provided a basic overview of guardianship, as well as alternatives to guardianship, and answered a number of common questions about guardianship, and the guardianship process.

Recordkeeping and General Plan Implementation

- As indicated in the last report, 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 this most recent review, all 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.
- Audits were being completed of records. These audits were identifying a number of issues related to the completeness and quality of the records.

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

Restraints

- During the onsite review, after careful review of the documentation provided and after discussion with the Director of Behavioral Services, the Monitoring Team determined that the data regarding the use of restraint was seriously flawed. Incomplete and lost restraint forms, despite the designation of mailboxes for their placement, were cited as problems by the Facility itself. The Monitoring Team also discovered inconsistencies in the compilation of restraint data. As a result, it is not possible to fully evaluate the Facility's use of restraint with any degree of confidence at this time. The Director of Quality Enhancement is urged to work with the Director of Behavioral Services to establish a timely, comprehensive and reliable system for the reporting the use of restraint.
- In addition, procedures for monitoring restraint and the concurrent analysis of restraint data require extensive review and remedial action. At the time of the site visit, it was not clear that the Behavioral Services Department had the capacity to monitor and analyze the use of restraint in a reliable manner. Based on the evidence reviewed for this section, safeguards for the use of restraint were seriously lacking, and there was no meaningful assurance that the least restrictive alternative was being utilized on a consistent basis.

Abuse, Neglect and Incident Management

- Improvement was needed in the timeliness of incident reporting, and the timely completion of the investigation report itself.

- While it is unquestioned that the Facility's leadership had a strong commitment to ensure that abuse and neglect were not tolerated and that individuals were protected from harm, during the monitoring visit, it was again noted that there were environmental and programmatic constraints that impeded these important efforts. Frequent instance were noted of individuals unengaged in meaningful activity, and/or engaging in target behaviors without consistent staff intervention. It was not clear from the limited analysis of incidents the Facility was completing that the individualized needs of people served were being adequately addressed to prevent harm to the extent possible, such as individuals' needs for a quiet environment, adequate space, and consistent involvement in activities that were of interest to them. Some of these issues would need to be addressed on an individual level, but many also would require a more systemic approach.

Quality Assurance

- The QE Department provided documentation on injuries by individual, living unit and type of injury. This included valuable information that could be utilized to develop and implement corrective action plans to protect individuals from harm. However, it was not evident that this information was being used in a comprehensive and continuous manner for improvement across the Facility. The QE Director reported that the Facility had concentrated its efforts on identifying data, and that corrective action plans had not been implemented yet.
- The Quality Assurance/Quality Improvement (QA/QI) Council held weekly meetings. This forum would benefit from greater discussion and analysis of the information available to the QE Department. The QE Department had begun to use the monitoring tools mandated by the State Office.

Integrated Protections, Services, Treatments and Supports

- Often, members of individuals' teams, who should have been present based on the individuals' needs, did not participate in annual meetings. 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. Even when assessments were present, the information and recommendations were not integrated adequately into individuals' PSPs.
- The objectives and training contained in the PSPs lacked intensity, and failed to relate to the longer-term goals/preferences of the individuals reviewed. Another area where all plans reviewed could have benefitted from additional attention was with regard to "community participation."
- Action plans within PSPs often did not identify the person responsible for regularly reviewing implementation efforts and results to determine the continued efficacy of the plan. Monthly and quarterly review reports were not consistently being completed.
- AUSSLC continued to be at the beginning stages of developing and implementing quality assurance mechanisms to ensure compliance with Section F of the Settlement Agreement. The Facility's Plan of Improvement included one corrective action plan for Section F. It addressed the need for facilitation training to be provided to QMRPs. As is discussed above, this action plan was in the process of being implemented.

Integrated Clinical Services

- There were a number of improvements in integrating clinical services, but many of these were at the beginning or early stages of development, and needed further refinement. Some of these efforts included the morning medical meeting, and the creation of the Physical and Nutritional Management Team (PNMT). A number of collaborative efforts continued, including the Pharmacy and Therapeutics Committee (P&T Committee), and a committee addressing pre-treatment sedation and restraints. The Pharmacy Department had collaborated with the Nursing Department in assisting to resolve the medication error concerns.
- For follow-up of consultation reports by PCPs was inconsistent. There should be a formalized system with documentation on a standardized form or through a dictated note. The note should summarize briefly the content of the consult report and acknowledge agreement or not. There should be a brief comment regarding the next step. If there is disagreement, evidence for rationale should be presented, and an alternate option provided. The form should be signed (not initialed), and dated.

Minimum Common Elements of Clinical Care

- There remained need for improvement in completing assessments or evaluations in the Medical, Pharmacy, and Dental Departments. Preventive care remained a challenge in the Medical Department, but steps were being taken to improve compliance.
- Identification, assessment, and treatment of changes in health status remained challenging. Recurrent hospitalizations and ER visits for the same medical problems also remained a concern.
- AUSSLC remained without an adequate medical quality improvement program. The infrastructure had not been developed, such as quality and comprehensive database systems. Clinical indicators in most cases awaited the completion of the clinical guidelines/pathways. However, use of current selected data that appeared valid was not analyzed and optimally used to guide the Medical Department.

At-Risk Individuals

- In reviewing recently completed risk screening documentation, some individuals' risk ratings were consistent with the State Office risk guidelines, and others were not. Teams were providing rationales for their decisions, although sufficient detail was not always recorded. For the teams to make quality decisions concerning risk ratings, and to develop action plans, the various team members will need to complete considerable preparatory work, and provide quality information to the teams.
- Additionally, teams need to think critically concerning preventing risk and reducing risk for those categories for which individuals are identified as being at highest risk. Each high-risk category should lead to a discussion of what other assessments and treatment options are available to reduce the risk. Currently, there were action plans developed without the recognition of the need for further assessment.

Psychiatric Care and Services

- The Facility recently had completed a new version of the form that is used at the Quarterly Psychiatric Reviews. In addition to basic medication and behavioral data, this revised format included space for information to

document the symptoms that justify the psychiatric diagnosis, the status of side effect monitoring, evidence of the efficacy of the prescribed medications, and a section on risk-benefit analysis, which included actual, as well as potential side effects that could then be empirically weighed against the demonstrated efficacy of each medication. The information that will be included in this documentation should address many of the provisions of the Settlement Agreement that are related to the rational use of psychotropic medication for individuals with developmental disabilities. As this new documentation had just been developed, its implementation could not be assessed during this review.

- At the time of the last review, a significant advance in the evolution of the format for the Comprehensive Psychiatric Evaluations (CPEs) was noted. These newly formatted documents were reviewed, and were found to be comprehensive and thorough. Unfortunately, the Facility only had been able to complete 21 of these CPEs, and there were 170 individuals receiving psychotropic medication. Thus, a major challenge confronting the Facility was the development of a mechanism to complete these documents in a more efficient manner, without compromising their quality.
- Psychiatry was the lead discipline for the initiative to implement Pre-treatment Sedation Desensitization Plans. The final format for the basic assessment form upon which these Plans would be developed had just been finalized and, thus, documentation related to that process would not be available for analysis until the next review cycle.

Psychological Care and Services

- Efforts to address data collection problems were being addressed. A new system just recently had been introduced with selected staff trained on its use. However, based on observation and document review, the accuracy and reliability of collected data remained problematic. Staff are encouraged to continue their focus on designing systems that are manageable and valid.
- Since the last visit, only five Structural and Functional Assessment Reports had been completed. As the information gleaned from these assessments is critical in developing appropriate and effective Positive Behavior Support Plans, this activity should be a priority.
- The Positive Behavior Support Plans currently developed for the individuals at the Facility provided a range of very helpful and specific guidelines for staff. Future plans should include a greater emphasis on identifying appropriate replacement behaviors, with guidelines for teaching these behaviors throughout the day. Considerable changes to these plans also should be made to ensure that appropriate reinforcers are identified, differential reinforcement is applied, and schedules of reinforcement are dense enough to effect positive behavior change.

Medical Care

- Morning medical meetings should be the forum for critical thinking, especially concerning how to prevent recurrences of hospitalizations and emergency room visits, but they were not yet used in this manner. In addition, documentation of the morning meetings was nonexistent. Such documentation should identify clinical

concerns requiring closure, for which follow-up information should be recorded. At the time of this review, there was no formal process for follow-up of clinical concerns needing closure.

- Acute care had numerous challenges needing attention, not all of which the Medical Department could resolve without the assistance of other departments. Additionally, once the acute illness had resolved, in many cases, there was little documentation of additional assessments or treatments to attempt to prevent repeat visits to the ER or hospitalizations.
- The Medical Department was lacking an adequate information technology system. There were several databases, which did not agree in content, and many appeared to be incomplete. The Medical Department should maintain complete and accurate data from which to determine trends. This was a significant barrier to any medical quality improvement program. However, the Medical Department was not using data to which it already had access to further analyze information, and develop corrective action plans.
- Non-facility medical peer review had been started, with an initial visit in April 2011. The results appeared pragmatic and helpful. However, there was no documentation of the visit.

Nursing Care

- Consistent with the findings from the previous reviews, 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. The problematic areas continued to be related to the lack of adequate documented nursing assessments when the individual began showing symptoms of a change in status, and the lack of nursing assessments prior to the transfer to an off-site medical center, as well as upon return to the Facility. The problems in this area reflected the significant need for nursing to develop and implement Facility protocols and procedures that would guide nursing practices regarding conducting adequate and regular clinical assessments, and to clearly outline the criteria for nursing documentation, and physician notification regarding status changes.
- There was no improvement found in the quality of the Comprehensive Nursing Assessments and the Health Management Plans.

Pharmacy Services and Safe Medication Practices

- The completion of QDRRs was not possible after March 2011, although the process had been developed. This was due to staffing issues, and it was unclear when the process would resume.
- There remained difficulty in the identification and tracking of "stat" medication orders used as chemical restraints, with lack of pharmacy review and guidance.
- Medication errors remained problematic, but the Pharmacy Department had been aggressive in providing medication room sweeps, in-service training to nurses, and implementing other action steps, which should have a positive impact in reducing medication errors as the system moves forward.

Physical and Nutritional Supports

- It did not appear that PST members understood the criteria for referral to the PNMT and/or the PNMT process. As a result, appropriate referrals were not being made.
- As the PNMT processes continue to evolve, the PNMT will need to focus on clearly documenting the PNMT evaluation and action plans, including when the referral was received for an individual and the PNMT action plan development and implementation date; ensuring documentation of staff competency-based training and check-offs for all areas identified on the action plan; ensuring individual-specific monitoring is completed per the action plan; implementing a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan and/or make modifications to the plan; and establishing a review process to determine the efficacy of individuals' strategies, resulting in the attainment of identified recommendations and measurable outcomes.
- The Habilitation Therapies Department was to be commended for her leadership in the development and implementation of procedures for competency-based training. Although efforts had begun to provide competency-based training on individuals' PNMPs, this initiative was at the initial stages of implementation, and considerable additional training was needed. This was illustrated through the significant issues the Monitoring Team noted with regard to the implementation of individuals' PNMPs, which had the potential to place individuals at risk.

Physical and Occupational Therapy

- A number of concerns continued to be noted with regard to the provision of OT/PT supports. Direct and indirect therapy interventions should be analyzed, during the assessment and/or update process, as well as in clinical progress notes to determine if progress is being made and/or if changes need to be instituted. Justification for therapy interventions should be outlined in the analysis of findings section to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies. Therapy plans should be integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. These supports should be defined in an individual's PSP. Monthly documentation should justify the initiation, continuation or discontinuation of assessment recommendations, and provide a status on the achievement of measurable outcomes. Quarterly documentation should be provided for the provision of indirect supports. There should be a formal process for implementing changes in an individual's supports, when progress is made and/or a lack of progress is noted, including a timeframe for re-evaluation.

Dental Services

- The development of baseline information concerning oral hygiene ratings across the campus was an important first step. The challenge will be improvement in those rating scores over time. Half the campus had poor or very poor oral rating scores, needing urgent attention. However, dental hygienist training and mentoring in the residences was not part of the current dental services, but it is recommended that such a program be implemented.

- The need for effective desensitization programs remained, because otherwise the Dental Department was dependent on the use of IV sedation and oral sedation to attain the necessary cooperation to provide dental care.
- There remained concerns related to monitoring in the residences after oral sedation was administered, and before the dental visit occurred.
- There was much improved tracking of the missed appointments. However, the challenge will be to reduce the percentage of missed appointments, which will require the collaboration of a number of different departments.

Communication

- Staffing was potentially one factor that resulted in the inadequate provision of speech and communication supports to individuals at AUSSLC. In sum, therapists were not active members of the PSTs, as evidenced by the SLP's absence from annual PSP meetings, insufficient time to provide direct therapy, lack of development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the insufficient development of informal strategies to reinforce assessment recommendations and measurable outcomes.

Habilitation, Training, Education, and Skill Acquisition Programs

- While the PSP process had expanded and improved in recognizing individual preferences and identifying risks, the objectives identified remained quite limited and inadequate in their scope. Teaching opportunities remained infrequent, methodologies were compromised by a lack of clarity and consistency, and data used to assess progress was below standard.
- Comprehensive assessment of an individual's strengths, needs, and preferences remained an area that required improvement. Adaptive behavior across skill domains was not consistently assessed, resulting in training programs that were severely limited. Further, preference assessments were not routinely completed.
- The activities available to the individuals served at AUSSLC were also quite limited. Work presented was often repetitive and non-functional, with very little variety offered. Opportunities for engagement in the residences were compromised by the lack of age-appropriate, and individualized activities and materials.

Most Integrated Setting

- 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.
- PSTs had made little progress in identifying obstacles to community placement, and/or developing plans to overcome them. The Facility was not yet aggregating or analyzing information related to obstacles/barriers to community transition.
- Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. Each of the items on the checklists had been addressed. Efforts clearly were being made to add information regarding the interviews conducted, the documents reviewed, and the observations made. As noted in the previous report, the biggest difficulty the Monitoring Team noted was with regard to the standards

used to monitor. During this most recent review, questions arose with regard to the stringency of monitoring standards being used to evaluate community providers.

Consent

- AUSSLC indicated in a written statement that the "Instrument to determine Functional Capacity regarding consent has not yet been approved by the state office. When it is approved, curricula for training of select staff will be written." It was anticipated that the State Office policy, which had not yet been issued, would provide guidance with regard to the instrument/processes to be used in determining functional capacity. However, at the time of the review, 123 of the 361 individuals the Facility served did not have guardians.
- AUSSLC continued its efforts to obtain guardians for individuals who were thought to need them, but this remained a slow process. Since the last review, no additional individuals had obtained guardians. Of the 123 individuals without guardians, a total of 30 had been referred to Family Eldercare, a nonprofit guardianship agency. With the infusion of grant money, it was anticipated that seven would be coming off of the lengthy waiting list. Another 28 individuals had been referred to the Guardianship Assistance Program that the County Court operated. An additional private guardianship was being processed.

Recordkeeping and General Plan Implementation

- The quality of the records was significantly lacking. The Facility had just begun the process of identifying the underlying issues that were resulting in documents not being filed in a timely and accurate manner.
- Policy development was in different stages, both at the State and Facility-level, and, in some cases, the Facility was awaiting new or revised policies from the State before revising or developing its own policies.
- 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 The complete restraint records, including restraint checklist form, face-to-face form, the debriefing form, review documentation, and, where available, the individual's Safety Plan for Sample #C.1, including Individual #56, Individual #98, Individual #283, Individual #360, Individual #395, Individual #406 and Individual #445. o The training transcripts and signed forms acknowledging the obligation to report abuse, neglect, and exploitation for 25 randomly selected AUSSLC employees (Sample #C.2.); o Prevention and Management of Aggressive Behavior (PMAB) training curriculum; o List of Individuals Restrained, from 11/10 through 4/11; o List of individuals restrained off campus by AUSSLC employee; o List of employees delinquent in PMAB Basic training, abuse, and neglect training and unusual incident training; o List of Restraints by Resident and Type, from 12/1/10 through 5/9/11; o Observation notes for 5/11 for Individual #103; o Last three incidents of dental restraint for Individual #92, Individual #215, and Individual #212; o Human Rights Committee Meeting minutes from 10/28/11 to 2/24/11; o Restraint Reduction Committee Meeting Minutes, from 2/15/11 through 4/4/11; o Restraint Trend Report, Quarters 1 and 2, for FY11; o List of Individuals with a Safety Plan, dated 3/28/11; o Do Not Restrain List with the names of 45 Individuals, dated 4/1/11; o PSP, BSP, and Safety Plan for Individual #406 and Individual #360; o Policy regarding Restraint Monitor Duties, dated 8/10; o Pre-Treatment Sedation Committee meeting minutes; o Restraint documentation for the following 10 individuals for a total of 91 Restraints: Individual #445, Individual #406, Individual #421, Individual #283, Individual #395, Individual #74, Individual #360, Individual #56, Individual #139, and Individual #98; o Personal Support Plans for: Individual #445, Individual #406, Individual #421, Individual #283, Individual #395, Individual #320, Individual #74, Individual #360, Individual #56, Individual #139, and Individual #98; o Quarterly Reviews for: Individual #390, Individual #347, Individual #268, and Individual #456; o Monthly Reviews for: Individual #347 and Individual #310; o Specific Program Objectives for: Individual #347 and Individual #268; o Data Sheets for: Individual #390, Individual #268, Individual #408, Individual #452, Individual #115, Individual #310, Individual #79, Individual #223, and Individual #456; o Structural and Functional Assessment Reports for: Individual #283, Individual #320, and

	Individual #56; o Functional Analysis Reports for: Individual #395, Individual #74, Individual #360, and Individual #139; o Functional Assessment Reports for: Individual #98; o Staffing Summary minutes, PSP addenda, Reviews for: Individual #445, Individual #406, Individual #421, Individual #283, Individual #395, Individual #320, Individual #74, Individual #360, Individual #56, Individual #139, and Individual #98; o Positive Behavior Support Plans for: Individual #445, Individual #406, Individual #421, Individual #283, Individual #395, Individual #320, Individual #74, Individual #360, Individual #56, Individual #139, and Individual #98; and o Safety Plan for Crisis Interventions for: Individual #445, Individual #406, Individual #421, Individual #283, Individual #395, Individual #74, Individual #360, Individual #56, Individual #139, and Individual #98. ▪ **Interviews with**: o Vira Benson, Facility Director; o Jose Levy, Director of Behavioral Services; o Cristy Pierce, Assistant Director of Behavioral Services; o Bruce Weinheimer, State Coordinator for Psychological Services; o Jo Ann Villasana, Human Rights Officer; and o Tammy Snyder, Director of Quality Enhancement. ▪ **Observations of**: o Incident Management Meetings, on 5/9/11 through 5/11/11; o Restraint Reduction Committee Meeting, on 5/9/11; o Individual #103 in her residence; o Human Rights Committee Meeting, on 5/12/11; o Site visits to all residences 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 potentially problematic behavior, and informal discussions with employees, as well as some of the individuals.
	Facility Self-Assessment: The Facility's Plan of Improvement (POI) was dated 4/27/11. The POI cited difficulty in thoroughly reviewing the use of restraint due to incomplete or missing documents. The Facility assessed a finding of noncompliance for each of the provisions in Section C. Corrective actions were to be implemented by the end of 5/11. The Monitoring Team concurs with this self-assessment.
	Summary of Monitor's Assessment: During the onsite review, after careful review of the documentation provided and after discussion with the Director of Behavioral Services, the Monitoring Team determined that the data regarding the use of restraint was seriously flawed. Incomplete and lost restraint forms, despite the designation of mailboxes for their placement, were cited as problems by the Facility itself. The Monitoring Team also discovered inconsistencies in the compilation of restraint data. As a result, it is not possible to fully evaluate the Facility's use of restraint with any degree of confidence at this time. The

	Director of Quality Enhancement is urged to work with the Director of Behavioral Services to establish a timely, comprehensive and reliable system for the reporting the use of restraint. In addition, procedures for monitoring restraint and the concurrent analysis of restraint data require extensive review and remedial action. At the time of the site visit, it was not clear that the Behavioral Services Department had the capacity to monitor and analyze the use of restraint in a reliable manner. Based on the evidence reviewed for this section, safeguards for the use of restraint were seriously lacking, and there was no meaningful assurance that the least restrictive alternative was being utilized on a consistent basis.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	During the onsite review, the Monitoring Team was unable to obtain reliable data regarding the use of restraint. The information provided in the discrete lists of restraint usage contained multiple inconsistencies regarding the number of individuals restrained, and the number of episodes of restraint. Furthermore, the Director of Behavioral Services acknowledged serious deficiencies in the completion and timely submission of restraint documentation. The Facility's Plan of Improvement stated that: "available documentation has not allowed for thorough review as documents were incomplete or not in the record." In addition, injuries that occurred during a restraint episode were not tracked. This was a general problem and not limited to a single episode of restraint. Reportedly, there was no effort to summarize or analyze any information about injuries that occurred during restraint episodes across the Facility. The Director of Quality Enhancement and the Director of Behavioral Services were urged to work together to develop a reliable, accurate, and consistent method for obtaining data regarding the use of restraint at AUSSLC prior to the next onsite review. There had been no changes in the Facility's policy since the last monitoring visit. Although as noted previously, the lists the Facility provided were flawed, a sample, referred to as Sample #C.1, was selected based on the information available. This included seven individuals, representing 20% of the 35 individuals restrained over the last six-month period. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample included: Individual #56, Individual #98, Individual #283, Individual #360, Individual #395, Individual #406, and Individual #445. Individual #360 and Individual #406 were two of the five individuals with the highest restraint use in the last six months. For each of the seven individuals in the sample, 20% of the documented restraint episodes were reviewed for a total of 22 restraints. The review of Individual #56 included six restraint episodes (12/25/10, two on 4/11/11, two on 5/2/11, and 5/9/11). Individual #406 had five episodes reviewed (10/6/10, 11/22/10, 2/24/11, 2/25/11, and 4/30/11), as did	Noncompliance

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		Individual #360 (2/9/11, 2/20/11, 2/21/11, 2/28/11, and 3/1/11). There were three restraint episodes reviewed for Individual #395 (11/2/10, 12/9/10, and 3/11/11). For the remaining three individuals, one restraint each was reviewed: Individual #283 (5/2/11), Individual #445 (5/4/11), and Individual #98 (4/16/11). <u>Prone Restraint</u> The Facility's policy governing the use of restraint prohibited the use of prone restraint, and physical restraint where the individual was supine. Based on a review of the restraint records for individuals in Sample #C.1 involving seven individuals, none (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> 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. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. Not all requisite records were available for each restraint. For example, as indicated below, there were numerous debriefing forms missing from the records the Facility provided to the Monitoring Team. Based on the records available, the following are the results of this review: ▪ In 19 of the 22 records (86%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Examples of where this was the case included: o Individual #283 picked up a rock and broke a window; o Individual #445 started to bite her hand and hit her head; o Individual #395 threw a plate and a glass of water; bit a staff person on the hand and grabbed a peer's t-shirt. She refused to calm down or go to her room. Examples where this was not the case included:	

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		o It was not evident from the documentation that Individual #406 required restraint after he "threw his plate and staff re-direct (sic) to his room." o Individual #360 was described as not wanting "pulled" staff on 2/20/11. Her behavior was not clearly described on 3/1/11. ▪ The narrative describing the use of restraint was very brief for all episodes reviewed. However, there was no evidence in any instance that restraints were being used for the convenience of staff, or as punishment. ▪ In 15 of the 22 records (68%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Examples where this was the case included: o Individual #98 displayed aggression towards staff and began banging her head; o Individual #445 could not be redirected while she was crying and banging her head and biting her hand; Examples where this was not the case included: o Although it was documented that Individual #283 had picked up a rock, there was no description of attempts to verbally calm him, or of any other alternative to restraint; o Individual #56 did pose an immediate threat to himself and others when he engaged in self-injurious behavior (hand-biting) and attempting to hit staff or peers. However, in five out of six episodes, staff did not implement his PBSP as written. He was told to "stop," but only once was offered an opportunity to engage in another activity. o The less restrictive alternatives for Individual #360 were not clearly described on 2/20/11 and 2/27/11. Facility policies identified a list of approved restraints. ▪ Based on the review of 22 restraints, involving seven individuals, all (100%) were approved restraints. As is discussed in greater detail with regard to Section C.7.e, a sample of 11 individuals who had been restrained more than three times in a 30-day rolling period was reviewed, including an in-depth review of their PBSPs. Although all of them had PBSPs, a number of concerns were noted with regard to the adequacy of these plans. Examples of these concerns are provided below. As a result, it could not be confirmed that for these individuals, restraint was not applied in the absence of or as an alternative to treatment.	
C2	Effective immediately, restraints shall be terminated as soon as the	The restraint records involving the seven individuals in Sample #C.1 were reviewed. Of these, two of the individuals (Individual #406 and Individual #360) had Safety Plans that	Noncompliance

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	individual is no longer a danger to him/herself or others.	defined the use of restraint. The findings with regard to these two individuals were: ▪ In reviewing Individual #406's restraint documentation, he was released from restraint when calm, which was an inappropriate release standard, or when no longer a danger to himself or others. ▪ The Safety Plan for Individual #360 specified that no restraint could last more than 30 minutes. This instruction was not followed. On 2/9/11, this Individual was restrained for 43 minutes, and on 2/20/11, she was restrained for 41 minutes. For the other five individuals where Safety Plans were either not present or provided, in 11 out of 12 (92%), the criterion for release was clear. Safety Plans are discussed in further detail with regard to Section C.7.e. The one incident in which it was not clear (due to the codes transcribed) involved Individual #56 on 5/2/11.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. Review of the Facility's PMAB training curricula revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. The Director of Behavioral Services reported that, since the last onsite review, new employee orientation had been expanded to include competency-based training regarding the use of reinforcement rather than restraint. However, this training had not been provided yet to residential staff. Unit psychologists also planned to provide additional training to replace the current use of didactic quizzes about the use of restraint. Sample #C.2 was selected randomly from a current list of staff. The training transcripts and signed forms acknowledging the obligation to report abuse, neglect and exploitation were reviewed for 25 AUSSLC employees. Based on the review of Sample #C.2, all (100%) staff had been properly trained on restraint and its related topics. Two acknowledgement forms were missing but documentation of participation in the training (the training rosters) was included for both of these employees. However, the Facility also provided lists of employees that were delinquent in required	Noncompliance

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		annual refresher training. There were 34 employees delinquent in Basic PMAB training. As noted above with regard to Section C.1 of the Settlement Agreement, 86% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Staff did document where redirection and verbal prompts were attempted prior to restraint use. This finding, however, must be qualified by the observation that increased staff knowledge and experience with alternatives to restraint would most likely show a reduction in overall restraint use. The techniques documented to demonstrate an avoidance of restraint were not particularly individualized, creative or effective. For example, repeating: "stop" without any other attempt to engage the individual appeared to have a negligible effect. The failure to effectively engage an individual as she demonstrated self-injurious behavior was evident in the prolonged observation of Individual #103 during the onsite review. Although restraint was not employed, staff did little to intervene in her constant face slapping except a verbal command to "stop." At one point, the Monitoring Team Member recommended further staff intervention. As noted with regard to Section K.9 of the Settlement Agreement, which addresses the quality of PBSPs, strategies applied when targeted problem behavior occurred were very similar across all 45 plans reviewed. In 33 of the 45 plans (73%), the individual was told to stop engaging in the behavior. Additional steps often called for separating the individual from others, and then providing praise when the individual calmed. While there might be similarity across 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. As with all aspects of a PSBP, consequences should be individualized to ensure an outcome of positive behavior change.	
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	A review of 11 Positive Behavior Support Plans (PBSP) revealed no case in which there was evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). Staff at the Facility had been meeting since 7/10 to review pre-treatment sedation used for routine medical and dental care. A review of the minutes from seven meetings indicated that psychology staff were present for two (29%) of these meetings. Given that psychology staff developed the assessment tool to address this matter and their expertise should be applied to shaping behavior change, it is highly recommended that psychology actively participate in all desensitization planning and implementation efforts. As is discussed with regard to Section J.4 of the Settlement Agreement, the Lead Psychiatrist indicated that the committee recently had completed a new format for the individual assessments upon which the individual Desensitization Plans would be	Noncompliance

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	eliminate the need for restraint.	developed. The Plans that had previously been developed had been abandoned, because it was felt that they were too formulaic in nature and lacking in strategies that were specific to the individual. However, at the time of the Monitoring Team's review, no plans had been developed using the new assessment process. The Monitoring Team looks forward to reviewing such plans during future reviews. The following documents were provided as evidence of dental desensitization planning: PSPs, quarterly reviews, monthly reviews, specific program objectives, and/or data sheets. In total, plans for 18 individuals were reviewed. Tooth brushing programs, implemented at a minimum of twice daily, were identified for 11 individuals. Two others had plans for tooth brushing daily. Two individuals had objectives to have their gums brushed or cleaned twice daily. Four individuals were to have their gums/teeth swabbed twice daily, and four others were scheduled to have this done once per day. Tooth and/or gum care should be part of every individual's daily schedule, and, as appropriate, part of formal programming. It should be implemented no less than twice daily. Of the 18 individuals reviewed, only five (28%) were scheduled to make visits to the dental clinic. However, four of these five were to visit once monthly. The fifth individual was scheduled to make weekly visits. Without more frequent exposure to the dental clinic, it is unlikely that these individuals will learn to tolerate dental exams. There were three examples provided of restraint initiated during dental procedures for Individual #92, Individual #215, and Individual #212. The documents provided to the Monitoring Team did not reference any alternatives to restraint or the implementation of a desensitization plan to reduce the discomfort/fear of these individuals. At the time of the onsite review, the Facility reported that it did not track the use of restraint for medical purposes. Therefore, there was no information available for review by the Monitoring Team. The Director of Quality Enhancement was urged to work with the relevant clinical disciplines to establish a timely and comprehensive process for the tracking and analysis of restraint authorized for medical procedures. Based on a review of the "Do Not Restrain" list, none of the individuals included in the sample were on the list.	
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	Review of Facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Based on the review of training records, dated 4/6/11 to 4/8/11, there were 19 employees at the Facility who successfully completed the training to allow them to	Noncompliance

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	assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	conduct face-to-face assessment of individuals in restraint. As noted throughout this section, however, during the majority of restraint episodes reviewed, there was no restraint monitor present to exercise the responsibilities described in the Facility's policy entitled "Restraint Monitor Duties," promulgated in 8/10. Based on a review of 22 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ In seven out of 22 incidents of restraint (32%) by an adequately trained staff member. Records that did not contain documentation of this included: o A restraint monitor was not present for any of the five restraint episodes reviewed involving Individual #406. It was of serious concern that debriefing and face-to-face assessment forms were completed after the fact and were not based on first-hand evidence by a restraint monitor. o There was no restraint monitor present for the episode involving Individual #98, on 4/16/11. o A restraint monitor was not documented as present in four out of six restraint episodes involving Individual #56 (4/11/11, two on 5/2/11, and 5/9/11). o A restraint monitor was not present for two out of three episodes (11/2/10, 3/11/10) reviewed regarding Individual #395. o A monitor was not present for three out of five restraints for Individual #360. Monitors were present for her on 2/20/11 and 3/1/11. o A monitor was present for the two incidents involving Individual #283 and Individual #445. ▪ In two out of 22 instances (9%), it could be confirmed that the restraint monitor arrived within 15 minutes to begin the assessment. As noted above, there was no restraint monitor present for numerous restraint episodes. In the other incidents where a monitor was present, the time of arrival was not recorded in the documentation. ▪ In seven out of 22 instances (32%), the documentation showed that an assessment was completed of the application of the restraint. ▪ In seven out of 22 instances (32%), the documentation showed that an assessment was completed of the circumstances of the restraint. The Facility did not provide any information regarding the use of alternative monitoring schedules. A sample of individuals was selected based on the list provided of individuals who had been restrained since the last review. The available restraint documentation for these individuals within this time period was reviewed to determine if nursing staff had adhered to the requirements. Based on a review of 91 restraint records for 10	

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		individuals for restraints that occurred at the Facility (Individual #445, Individual #406, Individual #421, Individual #283, Individual #395, Individual #74, Individual #360, Individual #56, Individual #139, and Individual #98), there was documentation that a licensed health care professional: o Conducted monitoring at least every 30 minutes from the initiation of the restraint in 30 (33%) of the instance of restraint. Records that did not contain timely documentation of this included: Individual #445, 11/1/10, and 5/4/11; Individual #406, 10/15/10, 11/20/10, 11/22/10, 12/4/10, 12/9/10, 12/11/10, 12/20/10, 12/23/10, 12/25/10, 2/10/11, 2/15/11, 3/4/11, 3/10/11, and 4/10/11; Individual #421, 12/1/10, 12/4/10, 12/5/10, 12/6/10, 1/4/11, 1/6/11, 1/14/11, 1/14/11, 1/24/11, 2/9/11, and 2/10/11; Individual #283, 1/11/10, and 2/3/11; Individual #395, 11/9/10, 12/1/10, 12/9/10, 1/12/11, and 1/24/11; Individual #74, 11/2/10, and 12/11/10; Individual #360, 11/4/10, 11/14/10, 11/24/10, and 11/29/10; Individual #56, 1/11/11, 2/11/11, 2/25/11, 3/6/11, 3/16/11, 4/11/11, 4/11/11, 5/2/11, 5/2/11, and 5/9/11; Individual #139, 10/3/10, 10/5/10, 11/2/10, 11/14/10, 11/21/10, and 12/13/10; Individual #98, 2/26/11, 3/24/11, 3/25/11, 4/4/11, and 4/16/11. o Monitored and documented vital signs in 62 (68%). Records that did not contain documentation of this included: Individual #406, 11/22/10, 12/25/10, 2/15/11, 2/24/11, and 4/10/11; Individual #421, 12/4/10, 12/5/10, 12/6/10, and 1/4/11; Individual #283, 2/3/11; Individual #395, 11/9/10, and 1/24/11; Individual #74, 12/11/10; Individual #360, 11/11/10, and 11/14/10; Individual #56, 2/11/11, 2/25/11, 3/6/11, 3/16/11, 4/11/11, 4/11/11, 5/2/11, 5/2/11, and 5/9/11; Individual #139, 10/3/10, 11/2/10, 11/10/10, and 11/21/10; Individual #98, 2/26/11. o Monitored and documented mental status in 80 (88%). Records that did not contain documentation of this included: Individual #395, 11/9/10, and 1/24/11; Individual #360, 11/14/10; Individual #56, 2/11/11, 2/25/11, 3/6/11, 3/16/11, 4/11/11, 5/2/11, and 5/2/11; Individual #139, 10/3/10. The inadequate documentation found in the records included nurses' statements that an individual's mental status was "stable," which was not an appropriate assessment and description of mental status. The Facility reported that it did not track the use of medical restraint and, therefore, could not provide documentation to the Monitoring Team. The Director of Quality Enhancement is urged to work with the appropriate clinical staff to develop and implement a reliable, timely, and comprehensive process for the monitoring of medical restraint.	
C6	Effective immediately, every	A sample (Sample #C.1) of 22 Restraint Checklists for individuals in non-medical	Noncompliance

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	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.	restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ In 16 out of 22 restraint episodes (73%), continuous one-to-one supervision could be confirmed as provided. The level of supervision was not documented for the episode on 11/22/10 involving Individual #406, or for three episodes involving Individual #56. Despite observation notes, the supervision for Individual #395 was documented as routine, during a restraint on 11/2/10. It was unclear whether supervision was continuous or intermittent. On 2/9/11, the level of supervision was not indicated for Individual #360. ▪ In 22 out of 22 episodes (100%), the date and time restraint was begun; ▪ In 22 out of 22 episodes (100%), the location of the restraint was documented; ▪ In 22 out of 22 episodes (100%), information about what happened before, including the change in the behavior that led to the use of restraint, was described. However, the quality of this documentation was extremely cursory in virtually all cases. ▪ In 22 out of 22 episodes (100%), the actions taken by staff prior to the use of restraint were described. In some instances, the description was very limited and provided very little detail. Although the reason for restraint use was evident, the description was sparse. ▪ In 22 out of 22 episodes (100%), the specific reasons for the use of the restraint were indicated in the checkboxes. ▪ In 22 out of 22 episodes (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was checked on the form; ▪ In 22 out of 22 episodes (100%), the names of staff involved in the restraint episode were included; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o In 20 out of 22 episodes (91%), the observations were documented every 15 minutes and at release. The exceptions were the restraint episode on 3/11/11 involving Individual #395, where documentation was 20 minutes apart, and the restraint episode on 4/11/11 for Individual #56, which was also 20 minutes apart; and o In 22 out of 22 episodes (100%), the specific behaviors of the individual that required continuing restraint were noted; ▪ In the majority of episodes, the care provided by staff during the restraint, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bedpan was not documented. This was most likely related to the brief duration of the restraint episode. In one episode, Individual #283 was offered water after the conclusion of the restraint; and ▪ In 22 out of 22 episodes (100%), the date and time the individual was released	

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		from restraint was included. In 64 of the 91 records reviewed (70%) related to nursing, the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were documented. Records that did not contain this documentation or inadequate descriptions of injuries included: Individual #445, 2/3/11; Individual #406, 10/6/10, 10/25/10, 2/15/11, 2/24/11, 4/10/11, and 4/30/11; Individual #421, 12/4/10, 12/6/10, and 2/9/11; Individual #395, 12/9/10, 1/2/11, and 1/24/11; Individual #74, 12/11/10; Individual #360, 11/11/10, and 11/14/10; Individual #56, 2/25/11, 3/6/11, 3/16/11, 4/11/11, 5/2/11, and 5/2/11; Individual #139, 10/3/10, 11/2/10, 11/10/10, 11/14/10, and 11/21/10. In a sample of 22 records (Sample #C.1), restraint-debriefing forms had been completed for 16 episodes (73%). However, as noted above, a restraint monitor, who was not present in five out of five episodes for Individual #406, in one out of one episodes for Individual #98, and in two out of three episodes for Individual #395, completed the restraint debriefing forms. There were no debriefing forms provided at all for the restraint episodes involving Individual #56 twice on 4/11/11, twice on 5/2/11, and 5/9/11, or for Individual #445's episode on 5/4/11. There were no uses of chemical restraint in the 22 restraint episodes reviewed. Given the problems with the restraint data experienced during the onsite review and described above, a specific sample was not drawn. A specific sample will be drawn during the next visit, if reliable information is available to the Monitoring Team. However, as is noted with regard to Section N.3, the Facility's data with regard to chemical restraints made it difficult to even determine how many had occurred. The Pharmacy was not conducting the reviews it should have been. Additionally, one individual (Individual #425 on 10/9/10) received a chemical restraint (intramuscular Zyprexa) that might have been intended for another individual. These serious issues related to the use of chemical restraints should be addressed as soon as possible.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical,	A sample of 11 individuals who had been placed in restraint more than three times in any rolling thirty-day period was selected for review to determine whether the requirements	Noncompliance

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	psychosocial factors;	of the Settlement Agreement were met. This included: Individual #445, Individual #406, Individual #421, Individual #283, Individual #395, Individual #320, Individual #74, Individual #360, Individual #56, Individual #139, and Individual #98. The following documents were reviewed for each individual: Positive Behavior Support Plan, Staffing Summary minutes, PSP Addenda, and/or Quarterly Reviews since 11/10, and Personal Support Plan. For 10 of the individuals, the Safety Plan for Crisis Intervention was also reviewed. The Safety Plan for Individual #320 had been discontinued. For all of the 11 individuals reviewed (100%), there was evidence that the individuals' teams had met to discuss the use of restraints. For all of the individuals reviewed (100%), individuals' teams reviewed areas of adaptive behavior. However, these reviews were not comprehensive, and did not always result in changes to habilitation services. The following is an example of an individual for whom consideration of adaptive behavior needs resulted in changes to his program: ▪ Individual #406: The team recognized his limited communication skills. This resulted in initiation of speech therapy services and expansion of communication supports within his living environment. The following are examples where teams failed to address adaptive behavior needs: ▪ Individual #395: This individual was refusing to go to workshop. Although the team acknowledged that: "she is very smart and needs to be challenged," there were no plans to expand her work skills. ▪ Individual #74: This individual was noted to have social skill deficits, but there were no plans to teach specific social skills. ▪ Individual #139: The team noted that this individual often tried to communicate with her peers, but she was usually "rebuffed." Again, there were no recommendations to implement social skill training with this individual and her peers. For all of the individuals reviewed (100%), individuals' teams reviewed the biological, medical, and psychosocial factors. However, these reviews were not consistently adequate. The following are examples of individuals for whom this was done appropriately: ▪ Individual #445: This individual was noted to display problem behavior prior to visits from her mother and holidays. Recommendations were made to increase structure during these times. ▪ Individual #406: The speech therapist provided a review of the individual's communication system and necessary supports, because she had observed that problem behaviors were less likely in his previous home where these had been employed. The team also recommended noise-dampening earmuffs/headphones to address the individual's aversion to loud environments.	

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		▪ Individual #421: It was noted that this individual had difficulty adjusting to her return to AUSSLC following extended home visits. A recommendation was made to increase her schedule of reinforcement following these visits. ▪ Individual #395: When the team noted that the individual's contact with her father had been reduced, counseling was recommended. ▪ Individual #320: This individual began to experience deterioration in her behavior after exploring community placement. Counseling sessions were initiated, and a Therapeutic Safety Contract was developed with the individual. As this individual's Safety Plan for Crisis Intervention had been discontinued, staff should have reinstated the plan and trained staff accordingly. ▪ Individual #360: Time spent with a preferred staff member had been identified as a strong reinforcer for this individual. Therefore, it was recommended that when restraint was necessary, preferred staff should not be involved to the extent possible. A plan also was initiated to give the individual the opportunity to choose the staff member with whom she would work for two hours each day. ▪ Individual #139: Staff attention was identified as a strong reinforcer for this individual. It was noted that staff training had been provided to try to minimize attention following problem behavior. ▪ Individual #98: Several factors were identified as contributing to problem behavior. Treatment for allergy symptoms was recommended. Data on sleep patterns was advised. Lastly, it was recommended that whenever possible, familiar staff be assigned to the individual. The following are examples where teams failed to do this adequately: ▪ Individual #421: An incident was reviewed where staff required the individual to remain in her room for two hours following problem behavior. The individual repeatedly asked to leave her room. When she was eventually released from her room, she flipped tables, and engaged in self-injury and aggression. Although there were reports that the staff had had additional in-service training, further feedback should have been provided, including on-the-job competency-based training, with accompanying changes made to the PBSP. ▪ Individual #283: This individual was noted to experience increases in problem behavior prior to and following a holiday visit home, yet there were no recommended changes suggested to help address these matters in the future. ▪ Individual #395: It was reported over several months that the individual was increasingly refusing to go to work or leave her bed. While changes were recommended in meetings held in 1/11, it was unclear whether any of these recommendations had been implemented. Although these problems continued and were worsening, no changes were recommended at meetings held on 4/26/11 or 5/2/11. ▪ Individual #74: The meeting held on 1/5/11 included a report of a diagnosis of	

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		narcolepsy made the previous month following a sleep study conducted at the Austin Sleep Disorder Clinic. The medication Nuvigil was recommended. It was reported that due to funding issues, the pharmacy at AUSSLC could not purchase this medication. While an alternative medication, Provigil, was recommended, it was unclear whether a dialogue had taken place between staff at the Facility and the physician at the clinic to obtain approval for this alternative. ▪ Individual #139: During a staff meeting, the issue of the individual's vomiting was discussed. The psychologist noted that a request to rule out an eating disorder would be raised with the psychiatrist. This issue was not referenced in later meetings, and, therefore, the outcome was unknown. No recommendations were made regarding the individual's reported behavior of eating large amounts of food. ▪ Individual #98: Staff reported that this individual often wanted a second serving of meat at meals. If he did not obtain this, he often displayed problem behavior. As a result, on 5/20/10, a physician's order was written for a second serving of meat at all meals. However this was not implemented until 12/13/10. This simple intervention should not have required almost seven months to implement.	
	(b) review possibly contributing environmental conditions;	For all of the individuals reviewed (100%), individuals' teams reviewed the possibly contributing environmental conditions. However, this was not done thoroughly for individuals in the sample. The following are examples of individuals for whom this was done appropriately: ▪ Individual #445: This individual was noted to become upset when her snack was not provided as scheduled. The team identified alternative availability of snack items when the canteen was closed. ▪ Individual #406: To enrich the individual's daily schedule, the team recommended increasing opportunities for engagement and active treatment. ▪ Individual#74: Staff recognized that a reinforcement schedule of once daily might have been too lean to promote positive behavior change. While still a thin schedule, reinforcement was increased to twice daily. ▪ Individual #98: Opportunities for daily exercise were recommended. The following are examples of where the teams failed to do this adequately: ▪ Individual #406: The team recognized that many of the individual's difficulties occurred in relation to meals and snacks. Several recommendations were made on 12/16/10, including: a) move him to a different table during meals; b) gather a list of food preferences; c) change snacks to offer greater variety; d) provide an opportunity to eat lunch off campus or at the canteen each week contingent upon appropriate behavior; e) provide the home with a cooler so that water was readily available at all times; f) change the dining room tables to reduce	Noncompliance

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		crowding; and g) consider using a timer to help the individual eat more slowly. While these were all good suggestions, the plan was to introduce these in the order presented. This resulted in the completion of only the first recommendation in a timely manner. This same list was reviewed eight additional times, with only the second recommendation completed by 2/25/11. The recommendations were not reviewed again after this date. Many of these were simple interventions that should have been implemented in a timely manner. ▪ Individual #283: This individual had several problem behaviors that resulted in restraint (physical and chemical) after exiting the home by crawling out a window. Although discussion took place regarding modifications to the windows, there was no indication that changes had been made. ▪ Individual #56: The team repeatedly recommended an exploration of items that were "calming" to the individual. This recommendation was first made on 12/23/10, and was still a recommendation on 4/15/11. To ensure implementation of any recommendation, a responsible staff member and recommended timeline should be identified. Reports also repeatedly referenced preventative measures that had been discussed previously. The psychologist should have ensured that these measures are clearly outlined in the PBSP.	
	(c) review or perform structural assessments of the behavior provoking restraints;	A Structural and Functional Assessment Report or a Functional Analysis Report was available for eight of the 11 individuals whose records were reviewed (73%). However, in a number of cases, the quality of these assessments, as well as the timeliness were of concern. The Monitoring Team reviewed two of these reports (Individual #320 and Individual #139) in the last report. The following are examples of individuals for whom this was done appropriately: ▪ Individual #283: The report for this individual was completed on 8/27/08. Information was gathered through indirect methods, including staff responses to behavior rating scales and interview, and direct observation. Setting events, antecedent conditions, and maintaining consequences were summarized. As this assessment was completed nearly three years ago, it is highly recommended that the assessment be updated with expanded recommendations provided regarding the PBSP. ▪ Individual #56: The report for this individual was completed on 2/28/08. Information was gained through indirect methods, including staff responses to behavior rating scales and interview, and direct observation. Setting events, antecedent conditions, and maintaining consequences were summarized. As this assessment was completed over three years ago, it is highly recommended that the assessment be updated with expanded recommendations made regarding the PBSP.	Noncompliance

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		The following are examples where teams failed to do this adequately. ▪ Individual #395: The report submitted was completed on 8/20/07. The report contained a brief introduction including historical information, but the remainder of the report was incomplete. Staff should complete a full assessment, as soon as possible. ▪ Individual #74: The report submitted was completed on 8/29/07, less than one month after the individual had been admitted to AUSSLC. At this time, only one occurrence of problem behavior had been observed. The circumstances for this individual had changed over the past three plus years. An updated assessment should be completed, as soon as possible. It should be noted that during a meeting held on 5/11/11, the psychologist indicated that a functional behavior assessment and preference assessment would be completed for this individual. ▪ Individual #360: The report submitted was completed on 12/12/07. Much of the report was based on historical information. An updated assessment should be completed. ▪ Individual #98: The report submitted was completed on 12/10/07, less than one month after the individual had been admitted to AUSSLC. The findings were inconclusive. An updated assessment should have been completed. ▪ Individual #421: The team recognized that a functional behavior assessment had not been completed for this individual. However, there was no recommendation or timeline identified for its completion. ▪ Individual #360: At a staff meeting held on 2/3/11, a plan for completion of a functional behavior assessment by 4/11 was made. At the time of the Monitoring Team's visit, this had not yet been completed. ▪ Individual #139: The assessment for this individual was completed on 7/5/07. As it was over three years old, it should be updated. This was recognized at a meeting held on 2/16/11, and reportedly, plans were to begin collecting information.	
	(d) review or perform functional assessments of the behavior provoking restraints;	Refer to Section C.7(c) above.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to	For 11 of the individuals reviewed (100%), a Positive Behavior Support Plan had been developed. A review of these plans resulted in the following: ▪ Every plan (100%) specified the objectively defined behavior(s) to be treated that led to the use of restraint. These same definitions were not included in the safety plans. ▪ Every plan (100%) identified a hypothesized function for the behavior(s) targeted for reduction. ▪ Seven of the 11 plans (64%) provided an operational definition of the	Noncompliance

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	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;	replacement behavior. ▪ Ten of the 11 plans (91%) included strategies to address antecedent and preventative measures. ▪ Six of the 11 plans (55%) included adequate positive reinforcement strategies to strengthen adaptive behavior. ▪ Every plan (100%) included a description of the intervention to be applied contingent upon the occurrence of the target behavior(s). ▪ Ten of the 11 plans (91%) identified the author, but none (0%) were signed. The following are examples of individuals for whom adequate PBSPs were in place: ▪ Individual #406: This draft plan included some important information specific to this individual, including his preference for consistent routines, his use of a daily picture schedule, his use of noise reducing headphones, and his preferences related to meals and snacks. ▪ Individual #421: A primary function of this individual's target behavior(s) had been identified as attention seeking. Within her plan, there were guidelines for providing positive attention at least once every five minutes. This was an enriched schedule of reinforcement designed to minimize the individual's need to engage in problem behaviors. ▪ Individual #283: This individual's plan included several appropriate replacement behaviors including asking for a break, seeking interactions with staff, requesting preferred items/activities, and practicing alternative coping skills. The plan identified three forms of reinforcement for appropriate behaviors. Increasing the opportunities to practice the identified replacement behaviors (listed as twice daily), and creating an enriched schedule of reinforcement (contracts were identified for every two to five days, and "behavior money" was identified for every seven days) would strengthen this plan. ▪ Individual #320: The description provided regarding the teaching of replacement behavior was specific and comprehensive. Preferred activities were clearly identified, and two forms of reinforcement were noted. Again, provision of an enriched schedule of reinforcement would strengthen this plan. ▪ Individual #74: This plan included several clearly written and individual specific guidelines for antecedent management. These included dietary considerations, specific prompting strategies, sleep management, and other environmental factors. ▪ Individual #139: Staff were advised to provide positive attention at least once every five minutes. This was an appropriate intervention, because problem behaviors were considered attention-seeking responses. One interesting note included in this plan was a reference to reduced problem behavior when at home with her family as she "has access to a wide range of novel stimuli not found	

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		within this facility." This would suggest that access to a greater variety of activities would be an appropriate component of this PBSP. The following are examples of individuals for whom the PBSPs were inadequate: ▪ Individual #445: There was a note that aggression might occur when her personal space was "violated." As this individual was legally blind, there should have been specific guidelines for initiating interactions. While the plan identified a possible attention-seeking function of the problem behavior, the replacement behavior was for this individual to practice appropriate coping skills. There was no plan for teaching appropriate means of seeking attention, nor was a reinforcement schedule defined for providing attention contingent upon appropriate behavior. Lastly, if this individual began to display self-injurious or aggressive behavior, she was to be offered the opportunity to listen to music, after being told to cease the behavior. Access to this preferred activity might strengthen the very behaviors targeted for reduction. ▪ Individual #395: The plan included a note that restraints tended to be more frequent around the onset of her menses. There was no indication that medication was provided to help manage resulting pain or discomfort. The schedule of reinforcement was also very lean, as it appeared that access to the reinforcer was contingent upon 60 days without restraint. ▪ Individual #74: While a variety of replacement behaviors were identified, including seeking attention and asking for a break, the schedule for teaching these behaviors was noted to be "at least once per shift." This did not provide sufficient opportunities for teaching alternative behavior. ▪ Individual #56: Teaching the replacement behavior of asking for something he wanted and learning to wait were identified to occur three times each week. This teaching schedule afforded limited opportunities for learning to occur. Further, concerns were raised regarding a note in which staff were advised to provide a requested snack, even if problem behavior was exhibited during the "waiting period." This risked a strengthening of the problem behavior. The Safety Plans of 10 of the 11 individuals in the sample were reviewed. The following represents the results: ▪ In 10 out of 10 Safety Plans reviewed (100%), the type of restraint authorized was delineated. ▪ In all 10 (100%), the maximum duration of restraint authorized was specified. In every case there was an indication that restraint could not exceed 30 minutes. ▪ In all 10 (100%), the designated approved restraint situation was specified. The situation was consistently described as one in which other strategies had been attempted, but had failed, and/or the person's behavior posed an immediate and serious risk of harm to self or others.	

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		▪ In nine of the 10 plans (90%), the criterion for terminating the use of the restraint was specified. However, as discussed below, there was concern about some of the criteria. In two plans, the staff were directed to begin a gradual release once the individual was no longer struggling. In seven plans, there was an identified time criterion during which the individual was no longer struggling, vocalizing, or displaying identified problem behavior. This time ranged from two consecutive minutes to seven consecutive minutes. Once the individual met this criterion, he/she should be released from the restraint. Some of these time constraints might be too long, and adequate justification for these time frames was not provided. One plan (Individual #360) did not include a clear criterion for terminating the restraint. ▪ In every plan, staff were instructed to provide the individual with an explanation regarding the need for restraint. As the function of identified problem behaviors for many of these individuals was hypothesized to be attention seeking, it would appear that any verbal behavior on the part of staff could potentially serve as a reinforcer. It was appropriate that the guidelines for restraint did indicate that other individuals should be removed from the area when possible. Additionally, guidelines indicated that the number of staff involved and present should be sufficient to ensure safety while minimizing excessive attention. ▪ Seven of the plans (70%) were dated, including one that was a draft. The author was identified in six of the plans (60%), but none of the plans were signed. The Facility was not yet in compliance with this section. PBSPs continued to need to be improved, and concerns related to Safety Plans addressed.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	The Facility was not collecting measures of treatment integrity at the time of the visit. While a monitoring tool had been developed and was being used to gather information regarding staff interactions with the individuals served, this instrument did not allow for assessment of appropriate application of a specific Positive Behavior Support Plan.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Although a change in the reinforcement program for Individual #74 was recommended, this change was not made to the PBSP. No other changes were recommended during the meetings where restraint matters were discussed. As noted above, there were additional indications that changes should have been made to individuals' plans (e.g., Individual #56, Individual #406, Individual #421, Individual #283, and Individual #98), but these did not occur.	Noncompliance

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C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	A sample of documentation related to 22 incidents of non-medical restraint was reviewed (Sample #C.1), including any debriefing forms provided, any attached PSP addenda, any notations of unit review, and any notations of Incident Management meeting. This documentation showed that: ▪ In 14 out of 22 restraint episodes (64%), it could be confirmed that a reliably informed review occurred within three days of the restraint episode. Debriefing notes alone were not considered reliable, a restraint monitor, who was not present, completed them. ▪ In 14 out of 22 restraint episodes (64%), there was evidence that the circumstances under which it was used was determined; ▪ In none of the documentation for the 22 restraint episodes was there evidence that a restraint monitor was present, that debriefing forms were completed, that a unit review occurred in a timely manner, that a PST was convened, and that a discussion ensued at the next Incident Management meeting. Each of these steps is critical to a thorough review of these restrictive practices. For example: o Observation of the Incident Management meetings conducted during the onsite review indicated that restraint episodes were discussed. Although this was the stated intent at AUSSLC, the documentation provided and reviewed about individual restraints did not confirm these discussions. o The notations regarding the Unit's review of two restraint episodes for Individual #406, on 10/6/11 and 11/22/10, indicated that the reviews occurred seven and eight days later than the actual episode. There was documentation, however, that the PST had met the day following each of the three other episodes. o There was no indication of a Unit review for the restraint episode on 4/16/11 involving Individual #98, or for the episode on 5/4/11 involving Individual #445. o Debriefing forms completed for Individual #406 and for Individual #98 were completed without the direct observation of the restraint monitor. The restraint monitor was not present for these episodes. o The Unit review of an incident on 12/25/11 for Individual #56 took place on 2/10/11. o The PST met promptly to review the three incidents for Individual #395. In the report from the meeting on 3/11/11, the team stated: "[Individual #395] does not appear to be making progress at AUSSLC. She does not participate in programs that are created for her and is noncompliant… If [Individual #395] is no longer appropriate for the AUSSLC, the team will look into community options."	Noncompliance

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		The Facility is commended for initiating administrative review of individuals who contact restraint frequently through its Restraint Reduction Committee. A few changes to this meeting format are recommended. First, it would enhance the functional outcome of this meeting if the Director of Behavioral Services had a copy of the PBSP for the individual(s) under review. A graph depicting current levels of problem behavior also would be helpful. It also would enhance the efficiency of this meeting, if an analysis of the situations under which restraint had occurred was completed in advance. This might focus the discussion on changes that could be implemented to minimize future use of restraint. Interview of staff should take place soon after the restraint occurred. Further, it will be important to support the direct support professionals who are called to this meeting by giving them an advanced understanding of the meeting's purpose.	

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

1. If the Facility is to monitor reliably and responsibly the use of restraint, the restraint documentation must be complete, accurate, and timely. The Director of Behavioral Services and the Director of Quality Enhancement should work together to review the procedures and current practice for the reporting and documenting restraint use. Such data should be analyzed and as issues are identified, corrective action plans should be developed and implemented to correct them. (Section C.1)
2. The ongoing failure of staff to submit documentation that complies with the provisions of the Settlement Agreement should be addressed. (Section C.1)
3. Psychology staff should be routinely involved in all review, planning, and implementation related to dental and medical desensitization programs. (Section C.4)
4. The Director of Quality Enhancement should work with the appropriate clinical staff to develop a process for tracking the use of medical restraint. (Sections C.4 and C.5)
5. The issue of restraint monitors not being present during restraints, and not completing the related documentation thoroughly should be addressed as soon as possible. (Sections C.5 and C.6)
6. The Facility should ensure that a licensed health care professional monitors and appropriately documents vital signs and the 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. (Section C.5)
7. The Facility should ensure that nursing staff assess and appropriately document any restraint-related injury. (Section C.6)
8. Nursing should develop and implement a monitoring tool addressing the requirements for nursing documentation regarding restraint use. (Sections C.5 and C.6)
9. The Facility should improve its tracking, monitoring, and review of the use of chemical restraints. As is recommended with regard to Section N.3, the incident in which an individual potentially received a chemical restraint intended for another individual should be reviewed thoroughly, and actions taken, as appropriate, to ensure such incidents do not recur. (Section C.6)
10. For those individuals who experience high rates of restraint, as defined as greater than three occurrences within a rolling 30-day period, a current (within 12 months) functional behavior assessment should be completed. (Section C.7.c)
11. For those same individuals, review of circumstances leading to restraint should result in recommended changes to the individual's PBSP. Staff should carefully review identified replacement behaviors, antecedent management strategies, and enriched schedules of reinforcement. (Sections C.7.e and C.7.g)

12. Amended PBSPs should be written and distributed in a timely manner, with staff trained in the recommended changes. (Sections C.7.e and C.7.g)
13. All administrative staff are encouraged to increase their visits to the homes and day programs where individuals are served. This will provide a degree of support for the direct support professionals, and will also allow for ongoing supervision in the implementation of PBSPs, as well as the use of restraint. (Section C.7).
14. The Director of Behavioral Services should have information related to the individual's PBSP and the use of restraint at the Restraint Reduction Committee meeting. (Section C.8)
15. Interview of staff regarding use of restraint should take place soon after the restraint occurred. Staff should be informed of the purpose of the Restraint Reduction Committee prior to being called to a meeting with administrative personnel. (Section C.8)

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #002.2: "Incident Management," and DADS Policy #021.1: "Protection from Harm – Abuse, Neglect and Explanation," dated 5/11/11; o Interagency Memorandum of Understanding (MOU) Regarding Investigations of Abuse and Neglect in State Supported Living Centers, dated 5/28/10; o Presentation Book for Section D; o Rights Poster and examples of Right of the Month; o Training records/transcripts for Facility investigators; o Training records/transcripts for Department of Family and Protective Services (DFPS) investigators; o Training module regarding the AUSSLC Abuse, Neglect/Incident Management Policy; o Abuse and Neglect Procedures Quiz; o Results of the Abuse/Neglect Procedures Quiz, for 1/11 through 4/11; o Trend Analysis Reports for Quarters 1 through 3 FY 11; o Background Check documentation; o List of all investigations completed by the Facility, since the last onsite review; o List of all investigations completed by DFPS, since the last onsite review. o Report listing all abuse, neglect and exploitation investigations commenced within the last six months, including individual, date of incident, type of incident, date investigation began, alleged perpetrator, and outcome of investigation; o List of individuals (25) requiring one-to-one supervision at the time of the monitoring visit; o List of individuals (27) with a Safety Plan, as of 3/28/11; o List of all incidents or injuries by individuals, living areas and types of incidents; o List of DFPS investigators; o Training transcripts and signed forms acknowledging obligation to report abuse, neglect, and exploitation for 25 randomly selected employees; o Signed forms acknowledging obligation to report abuse, neglect, and exploitation for 14 staff hired two months prior to the onsite review; o List of employees delinquent in PMAB basic training, abuse and neglect training, and unusual incident training; o Human Rights Committee Meeting minutes, from 10/28/10 to 2/24/11; o PSPs for Individual #230, Individual #96, Individual#430, and Individual #374; and o Investigation Reports reviewed included the following for DFPS: 38474564, 38552755, 38619389, 38924753, 38681073, 38704152, 38514730, 38483182, 38483194, and 38543904; and for the Facility: 111104, 111219, 111112, 111017, 111015, 110113, 111018, 110204, 111123, 110307, 111110, 110203, 110218 and 110206. These

	investigation reports involved a total of 16 individuals and constituted a sample of 20%. ▪ **Interviews with**: o Vira Benson, Facility Director; o Tammy Snyder, Director of Quality Enhancement; o Aubrey Johnson, Investigator and Acting Incident Management Coordinator; o Adrian Watson, Investigator; o Yesenia Barrera, Investigator; o Jo Ann Villasana, Human Rights Officer; o Jose Levy, Director of Behavioral Services; o Individual #320; and o Individual #283. ▪ **Observations of**: o Site visits to all residences and day programs. 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 individuals. o Incident Management Meetings, held on 5/9/11, 5/10/11 and 5/11/11; o Quality Assurance/Quality Improvement Council Meeting, on 5/11/11; o Human Rights Committee Meeting, on 5/12/11; and o Individual #103 in her living unit.
	Facility Self-Assessment: In its Plan of Improvement, dated 4/27/11, the Facility stated that it was in substantial compliance with most of the provisions of this Section, with the exception of D.2.a, D.3.e. D.3.f, D.3.g, and D.3.h. These provisions refer to the timely reporting of incidents, the timely completion of reports or the timely request of extensions, the content of the investigation reports, and the supervision of the Facility's investigations. The findings of the Monitoring Team were consistent with the Facility's assessment of noncompliance for these requirements. However, for both these provisions, as well as those in which it stated substantial compliance had been achieved, the Facility failed to provide any data to substantiate its findings. As the Facility progresses with its self-evaluation process, it will be important to utilize the information gained through its auditing process and other data sources to substantiate compliance, as well as to identify areas in which improvement is needed, and to incorporate such information into the Plan of Improvement document.
	Summary of Monitor's Assessment: Despite the vacancy in the Incident Management Coordinator position, there was evidence that the Facility was continuing to work diligently to strengthen and improve its investigation process and findings. The Facility investigators demonstrated knowledge and commitment to the integrity of their work. The transfer of the investigation function to the Department of Quality Enhancement was viewed as a positive development. Staff hoped that the new supervisory structure would result in a reaffirmation of the purpose of the Incident Management unit.

	The daily Incident Management Meetings were noted to be productive forums for the review and discussion of incidents, and the findings from investigations. The Acting Incident Management Coordinator was well prepared for these meetings. The majority of DFPS investigations reviewed now documented the supervisor's approval. A number of the investigations contained thoughtful and relevant recommendations for additional follow-up, such as staff training and enhanced team discussion, to prevent the recurrence of similar incidents. The case files contained evidence of follow-up action in a number of investigations, including disciplinary actions. Improvement was needed in the timeliness of incident reporting, and the timely completion of the investigation report itself. While it is unquestioned that the Facility's leadership had a strong commitment to ensure that abuse and neglect were not tolerated and that individuals were protected from harm, during the monitoring visit, it was again noted that there were environmental and programmatic constraints that impeded these important efforts. Although staffing had been stabilized, agency nurses discontinued, and new programs implemented, there continued to be evidence of a serious lack of active treatment. Repeatedly, individuals such as those living in 732D were observed to be unengaged for extended periods of time, or, as documented through observation of Individual #78, Individual #103, Individual #73 and an individual in Residence 785, whose name was not known by pulled staff on duty, displaying self-injurious behavior, such as slapping their face or the side of their head. Staff did not always intervene to stop this behavior. Furthermore, the residential space was crowded, sometimes disorganized, and there was a definite lack of privacy and individualization. It was not clear from the limited analysis of incidents the Facility was completing that the individualized needs of people served were being adequately addressed to prevent harm to the extent possible, such as individuals' needs for a quiet environment, adequate space, and consistent involvement in activities that were of interest to them. Some of these issues would need to be addressed on an individual level, but many also would require a more systemic approach. The efforts of the Human Rights Officer to support a vibrant and rewarding self-advocacy initiative were to be commended. In addition to the monthly meetings, the members of the Self-Advocacy Group conducted meetings in the residences, so that more individuals could participate in discussions about their rights. These ongoing outreach activities served as an effective complement to the teaching about rights and responsibilities noted during the Monitoring Team's evening visits to some of the residences.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The Facility was required to comply with DADS Policy #021. A Draft policy #021.1, dated 5/11/11, was shared with the Monitoring Team. During the onsite review, it was reported that this policy had been revised, but the changes had not yet been approved. Changes in local policy were to be made once the DADS policy was finalized. The Monitoring Team learned after the onsite review that the DADS policy had been approved on 5/11/11. Any changes in local policy will need to be reviewed during the next site visit. The Presentation Book for Section D contained copies of policies regarding protection from harm from Corpus Christi State Supported Living Center. It	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		was unclear whether AUSSLC intended these policies to be its own, and whether new documents would be issued referring to practices at AUSSLC. With that caveat, the policies and procedures provided by the State and, thus, the Facility included a commitment that abuse and neglect of individuals would not be tolerated. All personnel were required to report abuse and/or neglect, and the reverse side of the identification badge that each employee wore contained this directive. In practice, the Facility's commitment to ensure that abuse and neglect of individuals was not tolerated was illustrated by the disciplinary action taken against employees confirmed of having committed such unacceptable practices. The Facility reported that 12 employees had been terminated from employment in the last six months, as a result of confirmed abuse or neglect during the course of their duties. Other disciplinary action also had been taken. For example, as a result of a DFPS investigation (38543904) into the alleged neglect of Individual #358 and Individual #119, who were left unsupervised, an employee was terminated. An investigation (38424288) into the abuse and neglect of Individual #220, who was picked up and placed in a van against her expressed wishes, led to the termination of two employees. Two nurses were reported to the Board of Nursing after they failed to protect Individual #358 from harm, when he choked and was hospitalized in critical condition as a result of their intentional disregard. Criminal action was found with regard to this investigation (38552755.) At the same time, as the Facility itself recognized, it was of serious concern that incidents were not reported consistently in a timely manner. Repeatedly, the review of investigations conducted for this site visit documented that incidents were not reported within the requisite time frame. For example, although staff was aware that Individual #220 was placed forcibly into a van during the morning, the incident was not reported until after 7 p.m. that night. Similarly, the injuries experienced by Individual #358 and Individual #119 were not reported until the next day. This is addressed in further detail with regard to SectionD.2.a. The Facility remained in Substantial Compliance with this provision. It had the State policy in place, which required timely reporting of incidents of abuse and neglect, and had demonstrated a commitment to not tolerate abuse or neglect. To remain in compliance with this provision, the Facility Administration will need to continue to address issues identified in relation to abuse and neglect, which impact individuals' protection from harm.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year,		

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	each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	AUSSLC policy and practice was based on DADS Policy #021, which required staff to report immediately any allegation of abuse, neglect and/or exploitation. The Facility provided an accounting of all allegations of abuse from 1/1/11 to the present (interpreted as 4/11, the date the information was submitted). The information provided indicated that between 1/1/11 and the present (April), there were a total of 88 allegations of abuse. Of these, two were substantiated, 70 were unsubstantiated, and 16 were inconclusive. Within the same time period, it was reported that there were 64 allegations of neglect. Of these, eight were substantiated, 56 were unsubstantiated, and none were inconclusive. The Monitoring Team requested information related to the total number of serious incidents in other categories, as defined by Facility policy. For example, the Facility should be maintaining information on serious injuries, individuals leaving campus without authorization, hospitalizations, etc. The Facility did not submit a request that was responsive to the Monitoring Team's request. What AUSSLC submitted was a document that showed that since 1/1/11, six serious injuries had occurred, 10 unusual incidents had occurred, and no credible suicide threats had occurred. This was not an adequate breakdown of serious incidents, because, for example, it did not provide clear definition of "unusual incidents," and did not include categories such as leaving campus without authorization, hospitalizations, etc., which clearly would be considered "serious." Based on informal discussions with 12 staff, 10 were able to describe the reporting procedures for abuse, neglect, exploitation, or other serious incidents. However, two direct support professionals were hesitant or incorrect, when asked about the timeframe for reporting. None of these staff feared retaliation. When queried, the Facility investigators stated that they would seek to reassure a fearful employee, but would be clear that reporting must occur. Individual #320 and Individual #283 were conversant about their rights, and were able to describe the process for reporting an allegation of abuse, neglect or exploitation. Both	Noncompliance

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		were active members of the self-advocacy group Two samples of investigations were selected for review. These included: ▪ Sample #D.1, which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. This sample included the following investigation numbers: 38474564, 38552755, 38619389, 38924753, 38681073, 38704152, 38514730, 38483182, 38483194, and 38543904. ▪ Sample #D.2, which included a sample of Facility investigations. Some of these were investigations that had been referred to the Facility by DFPS, while others were investigations the Facility completed related to serious incidents. This sample included the following investigations: 111104, 111219, 111112, 111017, 111015, 110113, 111018, 110204, 111123, 110307, 111110, 110203, 110218 and 110206. These two samples involved 16 individuals and, according to the information provided during the site visit, approximately 20% of all completed investigations. In addition to the investigation reports contained in Sample #D.1 and D.2, two additional investigations were selected for inclusion in this report. Both of these Facility investigations (1112IR02 and 16433) raised concerns about restrictive practices used to address challenging behaviors. The first investigation involved Individual #246. The second involved Individual #217. Based on a review of the 24 investigation reports included in both Sample #D.1 and Sample #D.2: ▪ Six (25%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. For example, the incidents related to the following investigations were not reported within one hour: 38619389, 38924753, 111112 and 111017. ▪ Twenty-four (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. The Facility had a standardized reporting format. This format was comprehensive, and included reference to all of the criteria required by the Settlement Agreement.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take	It was evident through the review of all investigation reports that alleged perpetrators were removed promptly from contact with any individuals until the allegation was resolved. Documentation to this effect was included in the case files, and discussions with the Facility Director and investigators confirmed that this was standard practice. Letters permitting an alleged perpetrator to return to work once cleared of any	Substantial Compliance

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	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.	accusations were included in the case files reviewed. The Facility Director or her designee signed these letters. In addition to the prompt reassignment of the alleged perpetrator, all investigation files contained documentation that appropriate clinical staff treated suspected or actual injuries. In one case, there was concern noted in the investigation report that the physician's response was not timely. However, this appeared to be an exception.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	According to the policies followed at AUSSLC, all employees were obligated to attend competency-based training on preventing abuse and neglect during new employee orientation, and every 12 months thereafter. All required training had to be appropriately documented by certification and by date of completion. Supervisors were to periodically assess employee knowledge and provide additional training as needed. AUSSLC used quizzes to test the knowledge of staff working in the living units. Program Monitors for the Department of Quality Enhancement tracked the results of the quizzes. This was consistent with the requirements of the Settlement Agreement. The Trend Analysis reports indicated overall compliance rates of 92% for 2/11, 98.3% for 3/11, and 98.3% for 4/11. The Director of Quality Enhancement indicated that she intended to continue the quizzes, and to introduce additional probes to test additional areas of staff knowledge and competency. Review of 25 randomly selected staff records showed that all had been properly trained within the requisite timeframe. However, the Facility provided a list of staff delinquent in completing their annual refresher training. It was documented that 31 employees were delinquent in abuse and neglect training, and that 142 employees had not completed the requisite training in the reporting of unusual incidents.	Noncompliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement	During orientation and every 12 months thereafter, all staff were required to sign a statement acknowledging zero tolerance for abuse, neglect, and exploitation of individuals, and their obligations for reporting any suspected abuse, neglect, or exploitation. AUSSLC was to maintain copies of these signed forms. A sample of 25 employees was selected randomly to determine if annual statements had been signed. Based on a review of these forms, the requirement of the Settlement Agreement had been met.	Substantial Compliance

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	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.	In addition, the roster of staff hired in the two months prior to the onsite review was reviewed. An acknowledgement form was included for each of those new employees. The Facility was asked for a list of staff identified as having failed to report abuse and/or neglect. It was reported that no process was in place at this time to track this information. However, a lack of a tracking system did not appear to be preventing the Facility from taking "appropriate action in response to any mandatory reporter's failure to report abuse or neglect." In the Monitoring Team's review of investigations files, due to DFPS's policy of not identifying the reporter, it could not be determined whether or not staff made the allegations, or individuals, visitors, or family members. This also made it impossible for the Monitoring Team or the Facility to determine if staff who witnessed an incident had, in fact, reported it. Anonymity in reporting is standard practice, and is necessary to encourage reporting. However, it makes assessment of whether or not mandated reporters have fulfilled their obligations difficult.	
	(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.	Personal Support Teams and the annual Personal Support Plan meeting were used to educate individuals and their primary correspondent or Legally Appointed Representative (LAR) about their rights, and about the mechanisms to identify and report unusual incidents, including allegations of abuse, neglect and exploitation. In reviewing a small sample of PSPs, the sharing of this information with both the individual, and, as appropriate, the LAR was documented in one out of four (25%) cases. More specifically: ▪ The PSP document reviewed for Individual #230 contained a notation that the "Recognizing Signs of Abuse Resource Guide" was provided to the guardian. ▪ Individual #96 received this booklet, but it was not evident that a copy was provided to her primary correspondent. ▪ There was no documentation that the booklet was provided to the guardians of Individual #430 or #374. The materials used for this purpose were evaluated during a previous monitoring visit, and they were found to be satisfactory. If it is not done already, a brief discussion of reporting, and a longer discussion of all investigations and incidents related to the individual should be an integral part of each PSP meeting. Although not a requirement of 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 the investigations reviewed. No omissions were noted in these samples.	Noncompliance

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		The Facility provided a list of serious incidents or allegations that were reported by someone (not staff) significantly involved in the individual's life. The family of Individual #152 alleged that he was not cared for properly by a staff person (unnamed) assigned to his living unit. The complaint was investigated, and staff was to be re-trained regarding cleanliness and the proper repair of clothing. However, there was no information provided to confirm that training had occurred. The complaint was forwarded to the Assistant Independent Ombudsman for review. The Assistant Independent Ombudsman position was vacant during the onsite review. There was no information available regarding her review of this issue, if it did occur.	
	(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 residence and day program area to determine whether a "rights" poster was posted in a visibly accessible area. The Facility had decided that each poster should be close to a telephone so that rights violations could be reported easily. The Facility's own excellent expectation was not met. However, in compliance with the wording in the Settlement Agreement, there were posters evident in each of the residences, and several were displayed in the workshop and day program areas. It was notable that the Monitoring Team's suggestion about the rights poster in 729 was implemented. The poster had been laminated, so that it could not be torn and digested, and it was placed at the appropriate height for the men to view it. However, the rights poster in the Infirmary was still located behind the oxygen tank in the dining room. A review was completed of the posting the Facility used. It was attractive and included a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. The actions that the Facility and the Human Rights Officer had taken, in particular, to promote self-advocacy and a deeper understanding of civil rights were to be commended. The Right of the Month materials were informative, and some of the staff in the residences described them as more useful than the posters. The initiation of Self-Advocacy Group meetings in some of the residences was especially encouraging, because it resulted in more participation by individuals with physical or medical complications. The position of the Assistant Independent Ombudsman was vacant at the time of the onsite review. It was anticipated that this position would be filled by the time of the next monitoring visit.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law	The process and procedures for the notification of the police and/or the Office of the Inspector General (OIG) were mandated by State policy, which required that if an allegation might involve criminal activity, the Director or her designee were to notify	Substantial Compliance

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	enforcement.	DFPS who was then responsible for notifying law enforcement agencies. Based on the review of investigations and discussions with the Director and the Facility investigators, there was compliance with these obligations. It was evident that the Facility had developed a productive and positive relationship with law enforcement officials. All investigations reviewed were referred, if appropriate, to law enforcement. It was noted that the correspondence, generally emails, from the OIG was included in the investigation files. This had been a recommendation that the Monitoring Team made. The inclusion of such information was helpful, and the Facility's responsiveness was appreciated.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	Both State and Facility policy prohibited retaliation. This prohibition was stressed in new employee orientation, and in the refresher courses. The Facility Director's strong commitment to the prevention and redress of retaliation was evident. The staff interviewed during the onsite review did not express any fear of retaliation for reporting abuse, neglect, or any serious incidents. The Facility investigators stated that they would be supportive and reassuring if staff were to be fearful. However, they would require reporting to be done in a full and timely manner. The Facility provided the name of one employee who had expressed fear of retaliation for reporting in good faith. The names of three employees who were disciplined for retaliation also were provided. However, it was not clear if these four employees were involved in the same incident investigation. Individual #320 and Individual #283 were asked if they feared retaliation, if they reported abuse, neglect, or any harm. Both stated that they were not afraid to report. DFPS investigation 38483182 concluded that an employee who had been terminated from AUSSLC had filed the allegation of abuse and neglect in retaliation was. Given that the employee already had been terminated, the Facility did not need to take any further disciplinary action.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Trend Analysis Reports for the 1st and 2nd Quarters, FY 2011 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. In its response to the Monitoring Team's draft report, the State indicated that: "AuSSLC's	Not Rated

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		practice is for the program auditors and the unified records clerks to complete approximately 20 chart audits a month - these audits include a review of the observation and integrated progress notes for unreported injuries. The program auditors have been doing this for about two years." However, the Facility did not provide this information during the review, and documentation was not requested to confirm it. The Monitoring Team will request such information during the next review, but has chosen not to rate this provision for this review. In addition, as indicated in the Monitoring Team's draft report: "The Director of Behavioral Services reported that injuries during restraint were not tracked. This was a critical problem that required prompt and thorough attention." In its response, the State indicated: "The report by the Director of Behavioral Services that injuries during restraint were not tracked is inaccurate. State-wide all injuries regardless of source are tracked in the Client Work System (aka CWS) as the Client Injury Report has a prompt especially for restraints. In addition, state-wide all serious injures resulting from a restraint require an Unusual Incident Report." During the next onsite visit, the Monitoring Team will attempt to gain a better understanding of this significant discrepancy.	
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	DADS Policy Number 002.2: Incident Management, dated 6/18/10, governed the investigation of abuse, neglect, exploitation, theft, serious injury, and other serious incidents involving individuals residing in State Supported Living Centers. DADS Policy Number 012: Protection from Harm-Abuse, Neglect and Exploitation, dated 5/11/11, established procedures for the identification, reporting, trending, analysis of incidents, and prevention of abuse, neglect and exploitation at State Supported Living Centers. DADS Policy Number 002.2 specified the training required for investigators, and the expectation that they not be in the direct line of supervision of an alleged perpetrator. The curricula for the Facility and the DFPS investigators had been reviewed and generally determined to be adequate. As indicated in previous reports for other	Substantial Compliance

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	perpetrator.	Facilities, with regard to the DFPS training, what was not as clear was whether the training included instruction on how to complete the DFPS report, how to review and use information from past investigations, and how to determine when recommendations would be warranted and develop appropriate recommendations. Although the training covered the basics of investigations, ongoing training should cover additional topics, such as these listed. The specific requirements regarding the conduct of investigations for incidents involving individuals with an intellectual or developmental disability had been specified. The training requirements showed an evolution of curricula over the past decade. Training transcripts for some investigators at DFPS reflected the changes in instructional materials over time. The training transcripts for all DFPS investigators were reviewed. Each investigator's transcript documented completion of the requisite training modules regarding work on behalf of individuals with an intellectual or developmental disability. The Facility investigators had remained constant since the last monitoring visit. They had completed the training cited as lacking in the last monitoring report. All now had been trained in the conduct of root cause analysis, and certificates were provided as part of the response to the document request. These investigators had been trained as stipulated by the provisions of the Settlement Agreement. The Facility has achieved substantial compliance with this obligation	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	As described above, State and Facility policy required cooperation and coordination with law enforcement officials. The Facility had met this obligation. There was evidence of a positive and productive working relationship. The review of investigation files confirmed that incidents and allegations were referred appropriately to law enforcement, especially the Office of the Inspector General. Furthermore, in most relevant investigations, Facility staff at all levels cooperated with DFPS investigators. One investigation included a report of a staff person's resistance to cooperate. The investigator insisted on her cooperation, and she complied. Any disciplinary action taken or retraining on this obligation was not documented in the case filed.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such	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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	investigations.	Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 10 investigation records from DFPS (Sample #D.1), six had been referred to law enforcement agencies, including 38552755, 38619389, 38474564, 38704152, 38543904, and 38924753. For all of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the 14 investigation records from the Facility (Sample #D.2), five had been referred to law enforcement agencies, including 111104, 111112, 110203, 110204, and 111017. For all of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations.	
	(d) Provide for the safeguarding of evidence.	The investigations reviewed for this monitoring report did not require a safeguarding of physical evidence. Discussion with the Acting Incident Management Coordinator indicated that physical evidence would be safeguarded in a secure location in his office, until transferred to the proper authorities. Although the specific place for storage of physical evidence was not observed during this monitoring visit, the Incident Management unit's office is the repository of investigation documents and is secure. No one is permitted to enter this area without permission. The use of videotape footage continued to be an important aid to investigators. Its use was referenced in several investigations (e.g., 38681073) involving allegations of physical abuse and/or neglect.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants	Based on the above State and Facility policies, investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were	Noncompliance

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	a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Three out of 10 (30%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following are examples of investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: o 38552755, 38619389 and 38483182. The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary: o 38474564, 38924753, 38681073, 38704152, 38514730, 38483194, and 38543904. o For example, in Investigation #38543904, Individual #358 was bitten by another individual and suffered a laceration to his right eyebrow, when he was left without staff supervision in the van. The incident occurred on 1/13/11, and the investigation began on 1/17/11. o Individual # 450 experienced a fractured ankle on 3/5/11. An allegation of neglect was filed, but the investigation did not begin until 3/8/11. Based on the Monitoring Panel's discussion with DFPS in December 2010, DFPS developed a policy to guide better documentation of activities that occur within the first 24 hours of the investigation. The three Monitoring Teams recently provided comments on the draft policy, which DFPS took under consideration in developing a revised draft. The Monitoring Teams will provide comments on the revised draft in the coming weeks. The Monitoring Team looks forward to reviewing such additional information during upcoming reviews. ▪ One out of 10 (10%) was completed within 10 calendar days of the incident, including sign-off by the supervisor; and one was completed within 10 days, but not signed by the supervisor; ▪ For the eight that were not completed within 10 days, four (50%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ Ten (100%) resulted in a written report that included a summary of the	

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		investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In seven of the investigations reviewed (70%), recommendations for corrective action were included. In each of these investigations (100%), the recommendations were adequate to address the findings of the investigation. The following are examples of investigations that included appropriate recommendations: o In-service training was recommended and implemented with regard to Investigation #38704152, after Individual #450's ankle was fractured; and o Training was recommended and completed on transferring responsibility for an individual following the incident investigated in #38543904. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Three out of 14 (21%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. The following are examples of investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: o 111219, 111015 and 111110 The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary: o 111104, 111112, 111017, 110113, 111018, 110204, 111123, 110307, 110203, 110218 and 110206. ▪ One out of 14 (7%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; ▪ For the 13 that were not completed within 10 days, one (8%) had documentation of a written extension request that had been approved by the Facility Director, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ All 14 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In 11 of the investigations reviewed (78%), recommendations for corrective action were included. In 10 of the 11 investigations (91%), the	

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		recommendations were adequate to address the findings of the investigation. The following are examples of investigations that included appropriate recommendations: o After Investigation #111017 was completed, staff training was conducted regarding a timely response to an individual's need for attention after an injury. The agency nurse involved in the incident was barred from AUSSLC, because she did not return the call for assistance in a timely manner. The following was an investigation for which concerns were noted with regard to the adequacy of the recommendations: o In Investigation #110307, it was documented that Individual #107's nails were not trimmed properly and bleeding occurred. This incident was initially reviewed by DFPS, and referred back to the Facility as a staff performance issue. The DFPS investigator recommended that the Facility evaluate the alleged perpetrator's attitude and demeanor to ensure that they were appropriate for working with individuals who require assistance. The Facility investigator spoke with the alleged perpetrator, and, in that interview, was not concerned about his attitude. However, there was no evidence that further discussions about the employee's attitude or demeanor were conducted with his supervisor or co-workers, or that the need for sensitivity training was considered. As was recommended in the investigation report, training was completed on the proper procedure.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a	Based on a review of previously cited State and Facility policy, the policy required that: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion; ▪ The report utilize a standardized format that sets forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses; o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o 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; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o The investigator's findings; and o The investigator's reasons for his/her conclusions.	Noncompliance

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	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.	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. Both the Facility and DFPS reports addressed common elements. The reporting formats were clear, well organized and permitted sufficient information to be included for follow-up. However, a specific section of the reports should be designated for a description of the history of allegations, if any, documented for the alleged perpetrator. This information was not readily located within the investigation report formats. However, the history of allegations for the victim was in a clearly identified section of the reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In all of the investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In all (100%), each serious incident or allegations of wrongdoing; o In all (100%), the name(s) of all witnesses; o In all (100%), the name(s) of all alleged victims and perpetrators; o In all (100%), the names of all persons interviewed during the investigation; o In all (100%), 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; o In all (100%), all documents reviewed during the investigation; o It could not be determined whether all sources of evidence were considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In all (100%), the investigator's findings; and o In all (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In all of the investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The report utilized a standardized format that set forth explicitly and separately: o In all (100%), each serious incident or allegations of wrongdoing;	

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		o In all (100%), the name(s) of all witnesses; o In all (100%), the name(s) of all alleged victims and perpetrators; o In all (100%), the names of all persons interviewed during the investigation; o In all (100%), 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; o In all (100%), all documents reviewed during the investigation; o It could not be determined whether all sources of evidence were considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In all (100%), the investigator's findings; and o In all (100%), the investigator's reasons for his/her conclusions.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Based on review of the above cited State and Facility policy, it required that staff supervising the investigations review each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete and coherent. The policy required that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In six out of 10 investigation files reviewed (60%), there was evidence that the supervisor had conducted a review of the investigation report. The four that did not include this review were: 38474564, 38681073, 38483182, and 38483194. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 13 out of 14 investigation files reviewed (93%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ For those reports that had received a supervisory review, there were no revisions noted to be needed.	Noncompliance
	(h) Require that each Facility shall	The Facility's compliance with the completion of investigations for serious incidents is	Noncompliance

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	also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	discussed in detail with regard to Section D.3.f.	
	(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.	According to the State and Facility policy cited above, disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was to be taken promptly and thoroughly. In addition, the Facility was to have a system for tracking and documenting such actions and the corresponding outcomes. The Facility reported that 12 employees had been terminated from employment in the last six months, as a result of confirmed abuse or neglect during the course of their duties. Other disciplinary action also had been taken. For example, as a result of a DFPS investigation (38543904) into the alleged neglect of Individual #358 and Individual #119, who were left unsupervised, an employee was terminated. An investigation (38424288) into the abuse and neglect of Individual #220, who was picked up and placed in a van against her expressed wishes, led to the termination of two employees. Two nurses were reported to the Board of Nursing after they failed to protect Individual #358 from harm, when he choked and was hospitalized in critical condition as a result of their intentional disregard. Criminal action was found with regard to this investigation (38552755.) Although there was evidence of disciplinary action, there did not appear to be systematic process to track and analyze those actions. In order to determine compliance with this provision of the Settlement Agreement, each of the investigation files and other supporting documentation was reviewed for evidence that follow-up to any recommendations had occurred. This task was expedited by the Facility's practice of including any follow-up information in the investigation file. Most frequently, the information focused on staff training or disciplinary action that had been taken against the alleged perpetrator. As noted above, 70% of the DFPS investigations reviewed recommended follow-up or remedial action, as did 78% of the Facility investigations reviewed. At its daily meeting, the Acting Incident Management Coordinator informed the Incident Management Review Team of the investigations' findings and any recommendations. However, as noted above, the analysis of recommendations on a Facility-wide basis appeared to be insufficient at the time of this monitoring visit. In particular, two investigations illustrated the concern about a lack of meaningful analysis. During the monitoring visit, the investigations of incidents involving Individual #217 were the focus of considerable examination and discussion. In a meeting with the	Noncompliance

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		Facility Director, the failure to conduct a root cause analysis of the activities leading to the individual's confinement to the local jail was discussed. Additionally, in the Monitoring Team's review of the investigation involving Individual #246, there was no indication that her segregation from all peers had been the subject of a root cause analysis. Both of these investigations raised serious concern about the protection of individual rights. It also was not clear from the limited analysis of incidents being completed that the individualized needs of people served were being adequately addressed to prevent harm to the extent possible, such as individuals' needs for a quiet environment, adequate space, and consistent involvement in activities that were of interest to them. Some of these issues would need to be addressed on an individual level, but many also would require a more systemic approach. The Facility has been found in noncompliance with this provision because it was not adequately identifying the programmatic action necessary to correct the situation and/or prevent recurrence, and, therefore, not implementing such actions. In order to accomplish this, the Facility should review more thoroughly the potential causes of incidents on an individual, as well as systemic level, and develop, implement, and monitor corrective programmatic actions to address them.	
	(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.	Based on review of the above cited State and Facility policy, records of every investigation were to be maintained in a manner that permitted investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, current records were maintained in the office of the Incident Management Coordinator. Records older than five years were stored in a secure, off campus site to which Investigators had access, if necessary. With regard to DFPS, no information was available.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the	The Facility tracked the following: ▪ 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.	Noncompliance

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	incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	However, trending has not been well developed. The Facility has concentrated on collecting data and has not focused on developing and implementing corrective action plans. On April 1, 2011, the QE Director assumed supervisory responsibility for the Incident Management responsibilities, including the investigation of serious incidents and allegations of abuse, neglect and exploitation. Interviews were scheduled for the vacancy in the Incident Management Coordinator position. The appointment was anticipated by June 1, 2011. The Monitoring Team recommended that the new Incident Management Coordinator demonstrate competency and experience in system analysis, so that the data from the review of incidents and from the investigation findings could be analyzed, and as necessary, translated into corrective action plans and strategies for Facility-wide improvement.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Once the fingerprints were entered into the system, the Facility received a "rap-back," which provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In	Substantial Compliance

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		each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility.	

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

1. In addition to increased efforts to remind staff of their responsibilities with regard to the timely reporting of abuse and neglect, ongoing in-service training should reinforce with staff their responsibilities to report these allegations. (Section D.2.a)
2. If it is not done already, a brief discussion of reporting, and a longer discussion of all investigations and incidents related to the individual should be an integral part of each PSP meeting. (Section D.2.e)
3. The Director of Quality Enhancement should work with the Director of Behavioral Services to ensure the tracking and trending of injuries during restraint. (Section D.2.i)
4. In-depth analysis about previous incidents involving both the victim and the alleged perpetrator should be completed to the formulation of conclusions and the development of recommendations. (Section D.3.f)
5. As appropriate, the Facility should conduct root cause analyses to determine whether or not appropriate actions have been taken to adequately protect individuals, particularly for serious incidents that result in significantly negative outcomes, such as the incarceration of an individual. (Section D.3.i)
6. Corrective actions should not focus solely on the individual who was injured, or the victim of abuse and neglect. It is critical that environmental and peer-related risks be examined, and that reliable remedial actions be instituted as quickly as possible. (Section D.3.i and D.4)
7. The Facility should continue its efforts to finalize a tracking and trending system. (Section D.4)
8. The Facility should conduct critical analyses of the trend data collected to determine if any actions should be taken, or action plans developed to address any underlying causes of trends identified. This should be a priority for the Facility. (Section D.4)
9. The data from the review of incidents and from the investigation findings should be analyzed, and as necessary, translated into corrective action plans and strategies for Facility-wide improvement. (Section D.4)

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book, Section E; o Plan of Improvement, dated 4/27/11; o Centers for Medicare and Medicaid (CMS) report of survey, completed on 3/11/11; o Active Treatment Quarterly Review for Q2FY11; o Results of the Abuse/ Neglect Procedures Quiz, for 1/11 through 4/11; o Results from the Notification Response Quiz, for 2/11 through 4/11; o DADS Policy #003: "Quality Assurance," (undated draft); o Quality Enhancement Manual, pending revision; o Trend Analysis Reports for Quarters 1 through 3, FY11; o Active Treatment monitoring reports, for 3/11 through 4/11; o "Quality Assurance and Quality Improvement Council (QA/QI)" Policy, dated 3/11; o AUSSLC Policy #004: "Personal Support Plan Process," dated 4/4/11; o Quality Assurance/Quality Improvement Council Meeting Minutes, for 3/9/11 through 4/13/11; o Human Rights Committee Meeting Minutes, from 10/28 through 2/24/11; and o Lists of all incidents or injuries by individuals, living areas and types of incidents. ▪ **Interviews with:** o Vira Benson, Facility Director; o Tammy Snyder, Director of Quality Enhancement; o Jose Levy, Director of Behavioral Services; o Aubrey Robinson, Acting Incident Management Coordinator; and o Jo Ann Villasana, Human Rights Officer. ▪ **Observations of**: o Quality Assurance/Quality Improvement Council Meeting, on 5/11/11; o Incident Management Meetings, held on 5/9/11, 5/10/11, and 5/11/11; o Human Rights Committee Meeting, on 5/11/11; 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: The Facility's Plan of Improvement/Self-Assessment was dated 4/27/11. For Section E of the Settlement Agreement, there were no areas determined to be in substantial compliance with the requirements of the Settlement Agreement. The Facility provided a brief narrative description of some of the action steps being taken to achieve compliance with the provisions in this section. These descriptions were helpful, but as the self-assessment process progresses, the Facility also should incorporate data to substantiate its findings of compliance or noncompliance.

	Summary of Monitor's Assessment: The staff of the Quality Enhancement (QE) Department continued to work diligently to develop and implement quality assurance strategies that contributed to the provision of active treatment, as well as to compliance with the requirements of the Settlement Agreement. Since the last site visit, the responsibility for incident management and investigation functions had been transferred to this Department. The QE Department had continued its practice of informal "quizzes" on the living units. These quizzes provided helpful information regarding staff knowledge about the reporting of abuse, neglect, exploitation and other serious incidents. The QE Department provided documentation on injuries by individual, living unit and type of injury. This included valuable information that could be utilized to develop and implement corrective action plans to protect individuals from harm. However, it was not evident that this information was being used in a comprehensive and continuous manner for improvement across the Facility. The QE Director reported that the Facility had concentrated its efforts on identifying data, and that corrective action plans had not been implemented yet. The Quality Assurance/Quality Improvement (QA/QI) Council held weekly meetings. This forum would benefit from greater discussion and analysis of the information available to the QE Department. The QE Department had begun to use the monitoring tools mandated by the State Office. Although the Monitoring found noncompliance with the provisions of Section E, improvement was evident.

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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.	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 review of monitoring data, but also collection and analysis of key indicators or outcome measures. Although the Facility had begun to collect some data, for example, data related to incidents and allegations, it had not yet developed a set of key indicators. This is important for a few reasons, including providing the Facility with the ability to identify objectively the 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 homes, day programs, and/or departments that require improvement, as well as to identify a wide array of potential systemic issues. Throughout this report, there are references made to data that should be incorporated into such a system. For example, data needs to be incorporated into the system regarding at-risk individuals; medical, psychiatric, and nursing issues; infection control; physical and nutritional supports; and outcomes related to transition to the most integrated setting. This is not an all-inclusive list, but is meant to provide the Facility	Noncompliance

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		with ideas about the type of indicators or outcome measures that should be included in such a system. At the time of the site visit, the Facility had not yet completed a Quality Improvement Plan. According to the QE Director, the draft of the revised QE Policy from DADS was received on 4/13/11. The Facility's Plan was to be revised to include personnel updates, and the recent transfer of Incident Management to the Department. As it revises its Plan, the Facility should consider the inclusion of a monitoring matrix used to designate the various responsibilities for monitoring throughout the Facility. The audit tool, the frequency of review, and sample size should be identified. The results of these monitoring efforts should be analyzed to identify areas of strength and weakness; corrective action plans should be developed as appropriate. Findings from these reviews should be presented at the Quality Assurance/Quality Improvement Council meetings, now held weekly. In addition, as indicated by the QE Director, steps needed to be taken to ensure inter-rater reliability for any current or future monitoring activities. The work done by the Facility to compile data on the occurrence of injuries and other serious incidents was noted during the review of documents and during the interview with the QE Director. She indicated that a pilot project had been initiated to permit the electronic entry of this data. It was expected that this pilot would be effective in improving the timeliness and accuracy of the information. Information about injuries and serious incidents was discussed at the daily Incident Management meetings, and at the weekly QA/QI Council meetings. Individual concerns were to be addressed. However, corrective action plans were not yet being implemented. The QE Director recognized the importance of implementing a reliable process for the development of corrective action plans that were Facility-wide in scope. At the time of the review, AUSSLC had begun using eight of the newly adopted Settlement Agreement review tools required by the State Office. In the various sections of this report, the Monitoring Team has provided comments, as appropriate, with regard to the monitoring tools and the Facility's implementation of them. The five Program Auditors who work in the QE Department, along with other Facility staff such as the Human Rights Officer, had conducted quizzes on the living units to determine the extent of staff knowledge on the reporting of abuse, neglect, exploitation and other serious incidents. A sample of restraints and PSP meetings also were to be monitored. Reportedly, these efforts had not been consistent to the extent anticipated. Although the results of the quizzes were to be discussed at the QA/QI Council meetings, it was not clear how the findings were to be utilized in the development of corrective action plans.	

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		On April 1, 2011, the QE Director assumed supervisory responsibility for the Incident Management responsibilities, including the investigation of serious incidents and allegations of abuse, neglect and exploitation. Interviews were scheduled for the vacancy in the Incident Management Coordinator position. The appointment was anticipated by June 1, 2011. The Monitoring Team recommended that the new Incident Management Coordinator demonstrate competency and experience in system analysis, so that the data from the review of incidents and from the investigation findings could be analyzed, and as necessary, translated into corrective action plans and strategies for Facility-wide improvement. During the site visit, it was reported that medical restraint was not tracked on a continuous basis. It was recommended that the QE Department institute a procedure for this information to be documented. As indicated in the Facility's Plan of Improvement, the Facility was not in substantial compliance with the requirements of this subsection. However, there was clearly progress and evidence of creative initiatives for evaluating staff knowledge and performance.	
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.	Although the Settlement Agreement did not anticipate full compliance with this provision until 6/26/12, some data were already being analyzed regularly. The identification of trends was found to be limited. However, examples of data analysis regarding injuries, and the use of restraint were examined and discussed during the site visit. There was valuable information available to the Facility on the occurrence of injuries. The Trend Analysis reports were thoughtfully prepared and were informative. However, although action might be taken on individual cases, there was no evidence of a systemic approach to the development and implementation of corrective action plans or proactive strategies. The QE Director reported that the focus had been on identifying data and not on the development of corrective action plans. During the site visit, the data on restraint use was found to be incomplete and, therefore, unreliable. In addition, it was reported that the use of medical restraint was not tracked or analyzed at the Facility. During the last monitoring visit, the Performance Improvement Committee was meeting regularly, and was the focal point for presentation and discussion of data. Since that time, the Quality Assurance/Quality Improvement Council had replaced the Performance Improvement Committee. Based on a review of the minutes of the QA/QI Council as well as the Monitoring Team's observation of a Council meeting during the onsite review, progress was being made in the Council's development. The meetings were being held weekly, and the agendas were focused on new developments at both the State and	Noncompliance

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		Facility levels, as well as on discrete areas of monitoring required by the Settlement Agreement. Department heads were scheduled to report on the progress being made in their areas of responsibility, and also were expected to identify areas of concern. In its discussions, the Quality Assurance/Quality Improvement Council should broaden its focus from that of the Settlement Agreement requirements to one that is centered on expected, and even, best practices in the field. For example, focusing on broader areas such as eliminating risk in the environment or ensuring individuals have opportunities for growth and development could lead to proactive strategies regarding more individualized programming, the expansion of community-based options for active treatment, such as supported/competitive employment, and the redesign of the residential units. Discussions about restraint use, injuries, incidents, etc. would then be linked more clearly and forcefully to the Facility's overall goals. The Quality Assurance/Quality Improvement Council would benefit from the inclusion of a direct support professional and self-advocate as members. This individual could provide an important perspective about the development and implementation of quality assurance/improvement strategies at the individual and residential/day/vocational levels.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The QE Director reported that the Facility had concentrated its efforts on the identification of data, and that corrective action plans had not been implemented. At the time of the site visit, there was not a centralized system for the dissemination or tracking of corrective action plans. The Plan of Improvement stated that this was under development and was anticipated to be in place by 5/1/11. This issue will be reviewed and monitored during the next site visit.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	As noted above, the Facility has concentrated its efforts on the identification of data. This will be reviewed further during future monitoring visits, when corrective action plans are available and are being implemented.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	As with Section E.4 of the Settlement Agreement, this will be reviewed during future monitoring visits.	Noncompliance

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

1. The Facility should develop and implement a tracking system that allows identification of issues across many components of protections, supports and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection

and analysis of key indicators or outcome measures. Throughout this report, there are references made to data that should be incorporated into such a system. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system. (Section E.1)

2. The data referenced in #1 should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports. (Sections E.1 and E.2)
3. The QE Director should work with the Director of Behavioral Services to review the documentation of restraint data to ensure its reliability, accuracy and thoroughness. The use of medical restraint should be tracked and analyzed. (Sections E.1 and E.2)
4. As recommended in previous reports, the valuable information already being collected through monitoring, trending and tracking, and other quality enhancement efforts should be used more rigorously to actually eliminate potential risk still evident for individuals served by AUSSLC. The information the QE Department gathers should be analyzed to identify problematic trends, and action plans should be developed and implemented to address issues identified. Such action plans should include actions, person(s) responsible, timeframes for completion, and definition of the desired outcome(s). (Section E.2)
5. The Quality Assurance/Quality Improvement Council would benefit from the inclusion of a direct support professional representative as a member. This individual could provide an important perspective about the development and implementation of quality assurance/improvement strategies at the individual and residential/day/vocational levels. (Section E.2)
6. In its discussions, the Quality Assurance/Quality Improvement Council should broaden its focus from that of the Settlement Agreement requirements to one that is centered on expected, and even, best practices in the field. For example, focusing on broader areas such as eliminating risk in the environment or ensuring individuals have opportunities for growth and development could lead to proactive strategies regarding more individualized programming, the expansion of community-based options for active treatment, such as supported/competitive employment, and the redesign of the residential units. Discussions about restraint use, injuries, incidents, etc. would then be linked more clearly and forcefully to the Facility's overall goals. (Section E.2)
7. Once action plans are developed, they need to be monitored to ensure their completion, as well as to ensure they are effective in addressing issues identified. If they are not, they should be modified appropriately. (Sections E.4 and E.5)
8. As the Facility moves forward in developing its self-assessment processes, in addition to the important narrative information included in the POI, the Facility should include data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance. This data would potentially come from a variety of sources, including, for example, the results of monitoring activities, as well as outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature. This data should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors and revises, as appropriate, to effectuate positive changes in the lives of the individuals the Facility supports. (All of Section E, and Facility Self-Assessment)
9. The Incident Management Coordinator vacancy is an opportunity to restructure and strengthen the work of the incident management and investigation functions. Expertise in the systemic analysis of data and the development of corrective action plans would be useful in implementing these responsibilities. (Section E.1 and E.2)

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 AUSSLC Policy: Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports); o Presentation Book for Section F; o Blank monitoring forms, including: ▪ AUSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 9/1/10; ▪ PSP Review and Recommendations, undated; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section F; and ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section F, with guideline, revised 12/10; o Active Employee Course Participation Report, from 8/1/10 to 5/31/11, for Supporting Visions: Personal Support Planning Introduction; o Writing Measurable Objectives PowerPoint Presentation, undated, with training roster; o Austin SSLC Training on Living Options Agenda, dated 3/28/11, with training roster; o "Q Construction: Facilitating for Success" Lesson Plan and Content, dated 4/7/11, with sign-in sheet; o Draft Personal Support Planning training, undated; o QMRP Information, last updated 5/3/11; o "Current Residents and Staffing Dates," dated 3/30/11; o Training roster and materials for Individual #168's service and training objectives, dated 4/14/11 and 4/15/11; o PSPs for Individual #142, and Individual #299; o Personal Support Plans, related assessments, and sign in sheets for: Individual #109, Individual #168, Individual #323, Individual #199, and Individual #365; and o Personal Support Plans, related assessments, Personal Focus Assessments (PFA), sign in sheets, monthly/quarterly reviews, PSP Addendums (PSPAs), and skill acquisition programs for Individual #272, Individual #19, Individual #74, Individual #350, Individual #244, Individual #339, Individual #301, Individual #434, Individual #227, Individual #195, Individual #96, Individual #230, Individual #358, Individual #374, and Individual #430. ▪ **Interviews with**: o Tom Cochran, Coordinator of QMRP Services, and Sarah Knowles, Director of Active Treatment; o Tammy Snyder, Director of Quality Enhancement; and o Meetings with the teams of Individual #72 and Individual #74 to discuss the at-risk screening and plan development process.

	▪ **Observations of**: o PSP annual review meeting for Individual #107; o Discussion of Section F led by Tom Cochran, during the Quality Assurance/Quality Improvement Council meeting, on 5/11/11; o Individual #430 in her residence; o Site visits to all residences 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: The Facility's Plan of Improvement provided a narrative description of steps that had been taken to meet the requirements of the Settlement Agreement. The narrative was limited in scope, and often repeated information from one cell to the next without individualizing the information to discuss specific steps that the Facility had taken to address the various components of Section F. The Facility also did not provide any data gained from any formal monitoring. As the Facility expands its self-assessment processes, it will be important for such data to be included in the POI to substantiate findings of substantial compliance and/or noncompliance. In its POI, the Facility identified itself as being in compliance with Section F.1.a, which requires that the interdisciplinary team "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." The Facility indicated in the narrative that QMRPs were facilitating every Personal Support Team (PST), and that: "Ongoing training and monitoring will be conducted by the QE department and QMRP Coordinator to ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports." As the Monitoring Team has stated in its reports, the QMRPs' successful facilitation of teams and team meetings is key to compliance with this requirement of the Settlement Agreement. At the time of the review, QMRPs were not consistently demonstrating the ability to adequately facilitate team members' participation "in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports." The Monitoring Team found the Facility out of compliance with this provision. The Facility also indicated that it was in compliance with F.2.f, which requires that: "the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension." The Facility provided no data to support this finding. As noted below with regard to Section F.2.f, the QMRP Coordinator indicated that no tracking system was yet available to ensure that PSPs were completed and put into effect within 30 days. It is unclear how the Facility determined it was in compliance with this provision, when mechanisms for measuring compliance had not yet been developed or implemented. The Facility's finding was inconsistent with that of the Monitoring Team.

	Summary of Monitor's Assessment: Since the last review, steps had been taken to increase QMRPs' skills with regard to the facilitation of meetings. The QMRP Coordinator and the QMRP assigned to the Physical and Nutritional Management Team (PNMT) had attended train-the-trainer sessions, and had been certified to teach a course on facilitation. The AUSSLC QMRPs had participated in a day of training on facilitation, as well as team building activities. This training was a positive step, and appeared to be thoughtfully designed to encourage collaboration amongst the QMRPs, as well as build their skills. Often, members of individuals' teams, who should have been present based on the individuals' needs, did not participate in annual meetings. 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. Even when assessments were present, the information and recommendations were not integrated adequately into individuals' PSPs. The objectives and training tasks contained in the PSPs lacked intensity, and failed to relate to the longer-term goals/preferences of the individuals reviewed. 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, none of the plans reviewed 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. It was clear that teams and, particularly QMRPs were trying to incorporate more of individuals' preferences into PSPs, as well as to expand action plans to include more of the protections, supports, and services individuals required. However, PSPs still did not adequately integrate protections, supports and services. This remained a work in progress. Action plans often did not identify the person responsible for regularly reviewing implementation efforts and results to determine the continued efficacy of the plan. Monthly and quarterly review reports were not consistently being completed. AUSSLC continued to be at the beginning stages of developing and implementing quality assurance mechanisms to ensure compliance with Section F of the Settlement Agreement. The Facility's Plan of Improvement included one corrective action plan for Section F. It addressed the need for facilitation training to be provided to QMRPs. As is discussed above, this action plan was in the process of being implemented.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two		

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	years, the IDT for each individual shall:		
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.	The DADS policy for this section was issued on 7/30/10. The DADS Personal Support Plan Process policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the use of the Personal Focus Assessment, and required the team to identify the necessary assessments at the PFA meeting. The policy addressed PSP monitoring, staff training and quality assurance. AUSSLC had issued a companion policy, which appeared to be a replication of the DADS policy. It was dated 4/14/11. The Facility policy did not provide any further guidance or procedures to tailor the State policy for implementation at the Facility. For example, the DADS policy required competency-based training of staff, but did not define the methodology for assessing competency. No Facility policy was presented that identified the criteria for measuring staff competency. Likewise, the DADS policy required monitoring to be completed, but provided few specifics. There was no Facility policy or procedure further defining the monitoring process that would be completed at AUSSLC. These provide just a few examples of areas in which it would be appropriate for the Facility to develop facility-specific policies and procedures to assist in ensuring full and consistent implementation of the State policy. In order to review this section of the Settlement Agreement, a sample of PSPs was requested, along with related assessments, sign-in sheets, PSPAs, skill acquisition programs, and monthly and/or quarterly reviews. Although not all of these documents were provided for all of the individuals in the sample, the sample included: Individual #272, Individual #19, Individual #74, Individual #350, Individual #244, Individual #339, Individual #301, Individual #434, Individual #227, Individual #195, Individual #96, Individual #230, Individual #358, Individual #374, and Individual #430. The Facility also provided the PSPs, related assessments, and sign-in sheets for some of the most recently completed PSPs, including those for Individual #109, Individual #168, Individual #323, Individual #199, and Individual #365. To assess compliance with the Settlement Agreement, an in-depth review was conducted of 12 plans, including Individual #230, Individual #374, Individual #430, Individual #358, Individual #96, Individual #350, Individual #244, Individual #301, Individual #434, Individual #227, Individual #195, and Individual #365. While on site, the Monitoring Team observed a number of PSP meetings, and also met with two teams to discuss the at-risk screening process, and the integration of plans to address risk factors into the PSPs. The Monitoring Team met with the teams for Individual #74, and Individual #72.	Noncompliance

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		DADS Policy #004 indicated that the QMRP would plan and facilitate the PSP meeting. As noted above, the Facility policy was a replication of the DADS policy. The QMRP Coordinator confirmed that QMRPs facilitated the teams, including team meetings. During the on-site review, QMRPs facilitated the meetings that the Monitoring Team attended. Since the last review, steps had been taken to increase QMRPs' skills with regard to the facilitation of meetings. The QMRP Coordinator and the QMRP assigned to the Physical and Nutritional Management Team had attended train-the-trainer sessions, and had been certified to teach a course on facilitation. The QMRP Coordinator indicated that the work group that had developed the Supporting Visions training on the new PSP process also had developed the facilitation training. The AUSSLC QMRPs had participated in a day of training on facilitation, as well as team building activities. All but two of the 26 QMRPs had participated in this training, and this was due to the need to be out on leave. This training was a positive step, and appeared to be thoughtfully designed to encourage collaboration amongst the QMRPs, who previously had been supervised by the Unit Directors. One of the goals of the day of training was to assist in the development of a more cohesive group that shared resources and experience. The QMRP Coordinator indicated that these training efforts also were needed to reinforce the QMRPs' role as a leader in the team process, and to teach QMRPs the skills necessary to assertively solicit ideas, as well as data from various team members. He correctly identified the need to reduce the subjectivity in team meetings, and substitute this with data-driven decision-making. However, based on review of PSPs, observation of PSP meetings held the week of the onsite review, as well as meetings with teams regarding the at-risk screening and plan development process, 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. The role of the QMRP in facilitating this process is a key requirement to achieve compliance with this component of the Settlement Agreement. Based on observations while the Monitoring Team was onsite, the following illustrated examples of good facilitation of meetings: ▪ For Individual #107, the QMRP did a nice job of soliciting the individual's preferences, likes, and dislikes. She wrote these on white boards and posted them in a place that team members could see. At a number of points during the meeting, references were made to them. In addition, the QMRP facilitated a discussion of Individual #107's Optimistic Living Options. She kept the team focused on what would be best for and most preferred by Individual #107. For	

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		example, the team decided he liked quiet environments, and a setting with three to six people would be appropriate. The team discussed that although he might like a room of his own, ongoing interaction also was important to him. They discussed his preferences for stimulating, but calming environments, and specifically mentioned a water fountain, proximity to a park for walks, a large television with an extra large remote, music, concerts, and an environment that would keep him healthy and safe. The following were examples of missed opportunities with regard to adequate facilitation to ensure integrated development of plans that addressed the full set of protections, supports, and services needed by an individual: ▪ As noted above, Individual #107's QMRP demonstrated some good facilitation skills. However, there were portions of the annual PSP meeting during which more robust facilitation would have resulted in more focused team discussion and planning. It should be noted that the QMRP Coordinator was present at the meeting in a monitoring role. As times, he appropriately intervened to provide the team and the QMRP with guidance. It also is important to note that the QMRP was extremely new to her position, and this was only the second PSP meeting that she had responsibility for conducting on her own. The following are a couple of examples of areas in which facilitation could have been improved: o As the QMRP Coordinator pointed out during the meeting, the team had discussed a number of action steps to address identified risk issues. However, often they were broad and not measurable, and monitoring was not defined. The QMRP was encouraged to solicit this information from the team. The team continued, though, to be vague about completion dates, which team member was to do what, and how the team would know when the action item was completed or the outcome achieved. o The team talked about a number of topics multiple times during the meeting. For example, as the QMRP Coordinator identified during the meeting, the team had discussed Individual #107's resistance to dental care and his poor oral hygiene several times, but had not yet developed a plan. The QMRP Coordinator suggested to the team that they develop a plan to ensure this important service need was not overlooked. This discussion was further hindered, though, because, as discussed with regard to Section F.1.b of the Settlement Agreement, all of the necessary team members were not present, including the dentist/dental hygienist. ▪ As noted with regard to Section I.1 of the Settlement Agreement, QMRP kept the team focused for one (33%) of the PSPs/PSP addendum meetings observed (for Individual #107, Individual #102 and, Individual #82). The individuals' PSPs/PSP addendum meetings where the facilitator did not keep the team focused	

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		included: Individual #107, and Individual #82. For these PSPs, the facilitator did not guide the teams to use specific clinical data and the Risk Guidelines to support the risk levels that the teams assigned to the individuals' health indicators. In addition, they did not keep the teams on track in addressing individual-specific issues succinctly, and ensuring that all team recommendations were adequately and clearly defined to facilitate follow-up. The facilitators for these PSPs did not appear to have a structured process for conducting the team meetings. Part of the skill of facilitating a meeting is to ensure that as topics come up, they are either fully discussed, or they are tabled until an appropriate time during the meeting. This would greatly reduce the length of the meetings, which would in turn encourage full participation of all team members. Although it was important to ensure that all teams fully discussed individuals' risks, what it appeared teams were doing was discussing the risk ratings at the beginning of the meetings, and then moving through other portions of the PSP format, many of which addressed areas in which risks could naturally be discussed. For example, teams discussed risks, then discussed the supports individuals needed to achieve their optimistic living options, and then discussed action plans. Teams appeared to be under the impression that fully setting forth action plans was an activity reserved for the end of the meeting, as opposed to one that could occur during the various discussions throughout the meeting. This often resulted in topics being partially discussed at various times during the meetings, or discussed multiple times without fully being addressed through action plans. Over time, consideration should be given to incorporating the risk discussions into the overall PSP annual meeting agenda, and potentially revising the format of the PSP document to encourage teams to discuss issues fully and develop complete action plans at naturally occurring times during the meeting. As was noted in the last report, at the time of the baseline review, it was reported that there were 16 QMRPs supporting individuals living in 28 residential sites on campus. At the time of the first compliance review, 10 QMRPs had been hired, increasing the number to 26. At the time of the most recent review, this staffing had been maintained. One QMRP had been assigned to the PNMT, which was a very positive step, and should assist in ensuring that appropriate supports are provided to individuals the PNMT reviews. The remaining 25 QMRPs served the 361 individuals residing at AUSSLC at the time of the review. This resulted in an average caseload of approximately 14 individuals. The QMRP Coordinator continued to supervise all 26 QMRPs, and a QMRP Educator had been hired. It was anticipated that the QMRP Educator would assume some of the responsibilities of the QMRP Coordinator in relation to training and mentoring the QMRPs. Although the addition of this staff member was a positive step, the span of control of the QMRP Coordinator was still significant, and likely had a negative impact on the completion of tasks related to compliance with the Settlement Agreement. For	

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		example, the QMRP Coordinator was able to complete limited monitoring of PSP meetings, and the development and implementation of tracking systems that would be helpful in identifying gaps in team members' attendance at meetings and/or the timely completion of assessments had been put on hold due to a lack of available time. Reportedly, efforts had been made to identify positions for lead QMRPs. However, issues related to the categorization of the positions and the associated need for increased funding had been a barrier, which at the time of the review, had not been overcome. Based on observations as well as a review of PSPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and 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 (PST) as including the individual, the Legally Authorized Representative (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. As noted earlier, the Facility had adopted this policy. In discussing team membership with the QMRP Coordinator and the Director of Active Treatment, the impression was that for the months after the Supporting Visions training, attendance had increased at PSP meetings, but that since then, attendance had begun to not be consistent. At the time of the review, the Facility did not yet have a mechanism in place to aggregate information about attendance at PST annual or quarterly meetings, or for PSPA meetings. However, the sign-in sheets reviewed generally now showed who was present for the entire meeting or part of the meeting, who was not present, and/or if presence of a particular discipline was not applicable to the individual. The QMRP Coordinator indicated he was encouraging the QMRPs to use the PFA meetings to define who needed to be in attendance at the annual PSP meeting. Because these meetings occurred approximately a month prior to the annual meeting, team members could then be provided adequate notice of meeting dates and times. In reviewing PSP sign-in sheets, QMRPs were present at the annual meetings. The individual was present sometimes. Examples of individuals who were not present, included, Individual #230, Individual #374, and Individual #430. Others participating included, at times, nurses, direct support professionals, Legally Authorized Representatives, psychologists, Occupational Therapists (OTs), and other disciplines, depending on the individual's circumstances. Physicians often attended part of the meetings, and psychiatrists rarely attended. Dentists or dental hygienists infrequently attended. Often, an OT, but PTs, SLPs, and dieticians infrequently attended, even in	Noncompliance

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		situations in which an individual had related needs. Residential supervisors only sporadically attended. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. For the subsample of 12 PSPs reviewed, two did not contain sign-in sheets, but for none of the remaining 10 (0%) did it appear that a duly constituted team was in attendance. For example: ▪ Members of the Monitoring Team observed the annual PSP meeting for Individual #107. His team identified him as being at high risk for aspiration, respiratory compromise, urinary tract infections, and dental. He was at medium risk in most other areas, such as weight, constipation, osteoporosis, seizures, and skin integrity. He was fed through a feeding tube. However, the following team members were not present: MD/PCP, dentist/dental hygienist, Speech Language Pathologist, dietician, or Physical Therapist. There were a number of times during the meeting that the team deferred a decision, because input was needed from one of these team members, particularly the PCP. For example, the team believed that the PNMP needed to be revised to add a length of time he needed to remain upright after tube feeding. This seemed particularly relevant due to two recent hospitalizations for emesis. However, the team deferred the decision in order to obtain input from the PCP. Similarly, the team required the input of the dietician with regard to his intake of water and formula, but the QMRP indicated she would need to obtain the dietician's input later in the day. Individual #107 was extremely resistant to dental care, and had "very sore gums." However, no one from the Dental Department was present, and, as a result, instead of developing a plan to address these issues specifically, the team's action step was to "follow up with dental." ▪ The sign-in sheet for Individual #301's annual PSP meeting did not include a communication/speech therapist, dietician/nutritionist, a physical therapist, or a psychiatrist. Individual #301 had complex physical and nutritional management needs, had been diagnosed with dementia, was having difficulty being understood by those closest to him, including his brother/guardian, and over the course of the previous six months, had been identified as being at high risk due to weight. ▪ Individual #227 was having difficulty remaining on task at the workshop, and a different day program was discussed at her annual PSP meeting. No representative was present from vocational services or day programs. In addition, no direct support professionals or other residential representatives were present. She needed a specialized diet, but the dietician was not present. Individual #227 did not communicate verbally, but no communication or speech therapist was present. ▪ Individual #350 had a PBSP to address significant aggressive, self-injurious, and	

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		sexually inappropriate behavior. No psychologist was in attendance at her annual PSP meeting, and it did not appear that a psychological assessment was submitted for the team's use in developing the PSP. ▪ Individual #96 did not attend any day programming, partially due to her expressed resistance. The music therapist evaluated her, and recommended that music therapy be offered as an inducement to participation in sensory activities. However, despite the inclusion of her report, the music therapist did not attend the PSP meeting to discuss her findings and recommendations. PFAs did not consistently set forth which team members needed to be in attendance at individuals' PSP meetings. It was a positive step that efforts were being made on the sign-in sheets to document who was present for all or part of the meeting, and which team members were absent. It will be important for the Facility to develop and implement a system to aggregate the data being collected at team meetings regarding attendance. This data should be analyzed, and, if problematic trends are identified, they should be addressed.	
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 previously reported, 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 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 Settlement Agreement.	Noncompliance

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		Most of the PSPs reviewed contained assessments of health, psychological evaluations or updates, speech, OT/PT, nutrition, audiological screening, community living options, vocational or day evaluations, and other assessments based on specific needs. However, the quality of these assessments was of concern, and, at times, the timeliness of assessments was a concern (e.g., speech and language assessments that were over 10 years old). In addition, there were few, if any, dental or psychiatric assessments included as part of the assessments teams had used in developing PSPs. 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. It also should be noted that at times, assessments were not signed, or included other individuals' names or information in them. In one of the 12 PSP included in the subsample (8%), adequate assessments were present (i.e., for Individual #358). Often the narrative sections of individuals' PSPs identified issues of concerns for which assessments were not found. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. The following provide examples of PSPs in which concerns related to assessments were noted: ▪ Individual #301's Personal Focus Assessment was completed approximately two months before his PSP meeting. However, it was not complete, and did not include a listing of assessments to be completed. The Speech and Language Evaluation included in Individual #301's PSP packet was dated 2/22/00. It indicated that: "He speaks in complete sentences and is also able to respond to greetings, comment, and answer yes/no questions… [Individual #301's] speech is intelligible to an unfamiliar listener." On the first page of his most recent PSP, it stated: "Throughout the discussion [Individual #301] kept his head down most of the time. When his brother spoke to him, he would respond back with a smile and speak in short phrases that his brother found difficult to understand." The team included a goal for him to respond to staff's greetings upon arrival at his day program. Based on the 2/22/00 Speech and Language Evaluation, this was a skill that he already had. At different points in the PSP, a diagnosis of dementia was mentioned. It appeared that Individual	

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		#301's speech and language skills had changed or were changing. However, without a more recent Speech and Language evaluation, the team did not have the necessary information to put proper supports in place. The team also did not appear to have recommended that such an assessment be completed. Moreover, the Behavior/psychiatric section of the plan identified communication as a replacement behavior, but there was no indication that psychology staff and the SLP had integrated their supports. Individual #301's Positive Assessment of Living Skills (PALS) Assessment only had six out of 41 subsections completed. As noted above, the PFA completed for Individual #301 was incomplete, and it did not include an explanation as to why the subsections that were completed were selected, or justification for not completing those that were incomplete. Those that had been completed including bathing, dental hygiene, money management, community leisure, and community participation. Based on the limited skill acquisition goals identified for Individual #301, this assessment did not appear to be sufficient to provide the team with information necessary to develop and implement adequate active treatment programming for Individual #301. ▪ Individual #227 did not communicate verbally, but no speech/communication assessment was included in the assessments that the team used to develop the annual PSP. Based on the team deliberations documented in the PSP, it did not appear that communication techniques and/or alternative and augmentative communication (AAC) were considered. Individual #227 was not participating in her workshop program, and the team made the decision to move her to a day habilitation program. However, it appeared this was done without the benefit of a comprehensive vocational/day activities assessment or preference assessment. The assessment of her vocational skills did not meet any of the requirements for an adequate vocational assessment. Individual #227 was visually impaired, but no orientation or mobility assessment was included. Although the team identified her visual impairment as an issue that needed to be considered, for example, with regard to living options, the PSP included no supports to address the impact of her visual impairment. ▪ For Individual #195, no OT/PT evaluation was included in the PSP package, despite his experiencing a significant decline in skills. In the narrative, the PSP referenced a dementia assessment, but one was not included in packet. Of additional concern, although the team discussed the need for an updated dementia assessment to be completed, the PSP did not include a service objective to have new one completed. Despite a significant decline in skills and team discussion about the continued appropriateness of his participation in a work center, no vocational, retirement, or day habilitation assessment appeared to have been completed.	

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		▪ Individual #374 was described as having experienced "worsening" behaviors. Yet, the only behavioral assessment included in the documentation provided was a Behavior Support Plan, dated 6/23/09. ▪ Individual #230 was very interested in working and was highly motivated to attend her day program. However, there was no indication that community-based supported employment was considered, or any evidence of a comprehensive vocational assessment. ▪ Individual #430 was observed in her living unit shredding magazines, and putting the pages in the trashcan. Staff described her interest in work and her need to be occupied with interesting tasks. She attended the workshop for a total of only two and a half hours (from 9:00 to 10:15 a.m. and from 2:00 to 3:15 p.m.) each day. There was no documentation of a comprehensive assessment of her work skills to determine whether more or different engagement was warranted. Her PFA indicated the need for more challenging work projects. Yet, there was no relevant assessment contained in the documentation provided during the site visit. As discussed in further detail below with regard to Section S.2 of the Settlement Agreement, and as reported during the last visit, vocational assessment was an area in need of focused attention. The Director of Active Treatment indicated that she had taken steps to identify a better vocational assessment protocol. She had been in contact with another SSLC, which had been working on its vocational assessment processes. At the time of the review, the Director of Active Treatment reported that she had been told that the State Office was close to issuing a vocational assessment template, so she was waiting for further guidance from them. As recommended in previous reports, vocational evaluations should focus on work that is potentially interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories. Often times, for example, an individual might not be able to state what his/her interests are, due to lack of exposure to different jobs available. By using situational assessments, individuals would be provided with opportunities to try out different jobs to determine if they have or could learn the necessary skills and aptitudes, and if they are interested in pursuing such work. One assessment that would prove useful for some individuals would be an annual review of incidents, and abuse, neglect, and exploitation allegations. A comprehensive inventory/assessment of incidents and allegations was not found in any of the PSPs reviewed. However, for some individuals, it would be beneficial on an annual basis for teams to review aggregate individual data related to incidents, allegations, and restraints.	

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		This would ensure that the team considered the need to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. The intent of such a review would be to ensure that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place, and appropriately incorporated into the PSP. Furthermore, such an assessment could provide valuable information about the barriers to active treatment, and lead to the development and implementation of recommendations/objectives contained in the PSP. For example, Individual #96 was described, in the discussion about Living Options, as requiring a residence with fewer individuals so that she might benefit from enhanced staff attention. This individual presently resided in Residence 795 with 13 other women. Overall, many assessments were either not present or inadequate to guide teams properly in developing adequate PSPs. This is an area that will require the concerted efforts of all team members to resolve.	
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.	Although the new PSP process had been designed specifically to be more interactive, and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the PSPs. Based on the review of the newer plans, even when assessments were present, the connection between the assessment results and the PSP were not always clear. In none of the 12 plans (0%) were recommendations resulting from assessments adequately addressed in the PSPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. For example: ▪ Some recommendations that were not adequately addressed in Individual #301's PSP included the OT/PT and Nutritional Evaluation's recommendations that staff should feed him, unless he verbalized feeding himself. Likewise, the nursing care plan related to weight loss indicated that staff should "Assist to consume 75% of meals and snacks." These recommendations were particularly important due to the fact that the team had met a number of times during the year to address his high risk due to low weight. Similarly, Individual #301's Psychological Evaluation recommended that a dementia screening be completed "to assess current level of functioning, and report findings to PST." Although the narrative section of the PST mentioned the need for such an assessment, no service objective was included identifying the person responsible, and setting a due date. Based on a PSPA submitted for Individual #301, the assessment either had not occurred, or the team had not met to discuss it. In fact, the PSP did not include any specific supports or services to address the diagnosis of dementia, or its potential effects.	Noncompliance

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		▪ Individual #195's Speech-Language Evaluation recommended use of a picture communication book. This recommendation was not included in the PSP action plans, nor was justification provided for not including it. Although no OT/PT evaluation was available for the team in the formulation of the PSP, Individual #195's PNMP included a number of recommendation/methodologies for keeping him safe that were not reflected in the PSP. The recommendations from his medical evaluation were not included in his PSP. ▪ The Speech/Language assessment for Individual #96 recommended that staff help her make choices during her daily routines by presenting two items and letting her select one. This recommendation was not included in her PSP training objectives. ▪ The objectives in the PSP for Individual #430 did not address a recommendation, resulting from her PFA, for more social interaction experiences. Since this individual was highly motivated to work and to be engaged actively, objectives addressing more challenging work projects, another PFA recommendation, should have been included in her PSP. In addition, as discussed in previous monitoring reports, 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 Settlement Agreement.	
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

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F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004 at II.D.4 indicated that Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." As noted previously, the Facility had adopted the DADS policy as the Facility policy. As discussed in the previous report, the newer PSPs reviewed generally included more information regarding the individual's preferences and strengths. Documentation showed that the teams utilized information gained about individuals' preferences at the Personal Focus Assessment meetings that were held in the month preceding the annual PSP meeting to focus the initial discussion of the team during the PSP meeting. However, many of these preferences related to the recreational interests or food preferences of the individuals. They were not necessarily comprehensive in nature, indicating individuals' specific preferences related to living environments or jobs. Moreover, some teams had clearly included preferences in the PSPs, but it often was difficult to determine how the identified preferences of the individuals were incorporated throughout their PSPs. In the sample of 12 plans reviewed in-depth, three plans (25%) had some connection between the preferences and action plans or measurable objectives. These included the PSPs for Individual #374 (who wanted to interact more with her father), Individual #434, and Individual #227. Examples of where it was less clear how individuals' preferences were incorporated into their PSPs included: ▪ Individual #350 was able to express her preferences. Her PFA was incomplete. Many of the questions were answered with the phrase: "She didn't comment when asked." The PFA should be a team effort, so it was unclear why her team did not answer some of these questions. In addition, there was not a clear correlation between the PFA and the list of preferences, interests, and strengths	Noncompliance

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		in her PSP. In other words, the PSP did not include many of the preferences, strengths, and interests that her PFA did. Moreover, there was little, if any correlation between the action plans in her PSP and her stated preferences, interests, and strengths. The only connection appeared to be that she liked having her hair done, and this was included as a service objective. ▪ Individual #365 and his team had identified a number of his specific preferences. Some were very broad, such as "health" and "nutrition," and based on the PFA, it was unclear if these were Individual #365's preferences and interests or his team's desired outcomes for him. However, other identified preferences appeared to be more specific to Individual #365, such as farms and tractors, going for walks, listening to music, being read to, and community activities. However, little evidence was found that the team fully integrated these preferences and interests into the plan developed for Individual #365. Although the team appeared to have thoughtfully developed an optimistic living vision, which included life on a farm, a house near an airport due to his love of planes, and proximity to family, the team made the decision, largely based on his guardian's preferences, that AUSSLC was the most integrated setting for him. Moreover, the action plans included in the PSP did not address his preferences in any meaningful way. For example, the only reference to farms or tractors was that he would count toy tractors as part of a skill acquisition program. The only community objective was that he "will attend at least 2 community activities a month." ▪ Although there was not a PFA for Individual #230, at the PSP meeting, the team recognized her interests in having a pet cat in her residence. (There was a cat that was fed by the women in this residence, and it is considered a household pet.) The team also recognized her strong interest in work. However, there was no evidence that the team considered combining these interests through a volunteer or paid position in a pet store, animal shelter, etc. The only way in which her love of animals was recognized was by giving her a cat toy or can of cat food, if she visited the dental clinic as part of a desensitization program. Based on the sample of PSPs reviewed, efforts definitely had been made to document the prioritization of the individuals' needs. Many of the plans reviewed included lists of "priority needs/risks," and indicated that these were "based on the information provided through the assessments listed above." However, these often were general statements of broad categories of needs or risks, and they did not document the rationale for the prioritization, as required by the DADS policy. In addition, these statements were generally found at the beginning of the PSP document, and their connection with action plans was either unclear, or the "priorities" just appeared to be reiterations of what was included in the action plans, again, without any justification. For example: ▪ Individual #365's team identified eight "priority needs/risks," including: daily	

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		living skills, health risks, community outings, on-campus events, laundry, counting to the number 10 using objects, money management, and "SAC objectives" (it was unclear what this meant). No justification was provided for these priorities, and the only explanation for their selection was that they were "based on the information provided through the assessments listed above." Although action plans were developed to address these priorities, it remained unclear, for example, why "counting to the number 10 using object" or completing laundry were considered priorities over other skills that Individual #365 could learn. The PSP provided no explanation of what the long-term goals were that these skills would assist Individual #365 in attaining. In addition, given that these were the areas identified as priorities, many of the action plans to address them were weak. For example, community outings were identified as a priority, but only one objective was included to address this high priority area, and it read: "[Individual #365"] will attend at least 2 off campus activities a month." ▪ With encouragement from a music therapist, Individual #96 gradually began to enjoy listening to music and to be more responsive to sensory stimulation. Her PSP, dated 8/12/10, provided for her to attend sensory activities only three times a week. It was not until 5/5/11, nearly nine months later, that she was enrolled in a full day of programming. ▪ Individual #358 was noted to love social activities such as parties, dances and festivals. His PSP stated: "he likes to participate in these events when they are held on campus…but he really loves to go out into the community." He is also described as a very active person who enjoys exercise. His PSP objectives were limited to three off campus activities a month, and four social activities a month on the campus. Careful delineation of barriers to addressing needs generally was not found. For example, although based on interview, it appeared that transportation continued to be an issue to including more community-based skill acquisition programs, and that staffing was sometimes a concern in relation to providing more individualized active treatment, none of the PSPs reviewed identified these as barriers. 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, none of the plans reviewed 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.	

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		Of the sample of 12 PSPs, none (0%) had skill acquisition programs that targeted implementation within a community setting. 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 #350 was in the process of transitioning to the community, and this was clearly a stated priority for her. The only goal that she had related to participation in the community was: "[Individual #350] will participate in an off-campus activity four times per month." No direction was provided with regard to the types of activities, and no skill acquisition program was associated with this objective. She had an objective to "go to the Beauty Salon on campus and have her hair styled once a month." This easily could have been completed in the community, and would have provided her experience that would have been helpful in her transition to the community. She also had an objective to deposit money in a pretend bank. The objective read: "With modeling [Individual #350] will put money she earns into a 'bank' (given to Social Worker to deposit in TF [Trust Fund]) to be saved to purchase a desired item…" This was an activity that could have occurred in an actual bank in a community setting. ▪ Individual #358 desired and was very capable of increased independence. His PSP objectives included developing his money management skills. An objective called for him to put coins into the soda machine at the Facility. Although he had independent mobility skills, and enjoyed taking walks with staff, there was no consideration of the staff teaching this individual about the use of public transportation with supervision. ▪ Individual #230 was motivated to work and to help others. Her training objectives included setting the table in her residence. There was no evidence her team considered supported employment, or a volunteer position instead of the on-campus activity.	
	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	As noted in the last monitoring report, PSPs generally included some individualized and measurable goals/objectives, treatment strategies and supports. However, generally, a full array of individualized, observable and/or measurable objectives had not been delineated in the PSP, and/or the treatments or strategies to be employed or necessary supports were not stated specifically. As is discussed in other sections of this report, specific, individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of essential plans, such as nursing plans, psychiatric treatment plans, and physical and nutritional support plans. For example, in order to provide health care supports to individuals served, direct support professionals as well as nursing staff need to provide	Noncompliance

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	appropriate to his/her needs;	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. In addition, PSPs should include measurable, observable objectives to determine the efficacy of these plans. In other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. As is discussed elsewhere in this report, deficits in plans specific disciplines had developed prevented the team from fully identifying the full array of the measurable objectives necessary for the team to provide needed supports and services, and measure the outcomes of those supports. For example, PNMPs did not include measurable objectives, and nursing assessments often did not include individualized objectives. Based on this most recent review of plans, efforts clearly were being made to incorporate objectives, particularly service objectives and strategies, into individuals' PSPs to ensure that needs were met. In many instances, objectives and strategies were incorporated into individuals' PSPs from other documents or plans that had been developed by specific disciplines. Although work was needed to ensure that PSPs included a full complement of specific individualized, observable and/or measurable goals/objectives, this was a significant improvement. The following provide some examples of these efforts: ▪ Individual #227's plan included a number of action plans to address her areas of risk. Within these action plans, strategies from, for example, her PNMP and nursing care plans, were incorporated. Although refinement of the action plans was necessary, this was a positive step and assisted in providing a fuller picture of the supports she needed. ▪ Individual #430 developed pneumonia in 4/09, and was hospitalized. It was determined that she had silent vestibular penetration with mild aspiration. This required the placement of a G-tube. The PSP noted that her PNMP was revised three times in the past year. During the At-Risk discussion, it was determined that this individual had a medium risk of aspiration, respiratory compromise and other health concerns. Her team and her nurse practitioner reviewed her progress in these medium risk areas every 180 days. There were service objectives for each of the risks. The team had monitored her progress, and continued to evaluate her ability to tolerate meals by mouth. In 3/11, she was determined to no longer require a G-tube, and the transition to meals by mouth was initiated under close supervision. None of the 12 plans (0%) included a full complement of measurable goals or objectives to address the full array of supports and services the individual required. This negatively impacted the intensity of individuals' active treatment, the supports they were provided, and the teams' ability to measure progress, or lack thereof. Some examples of the ways in which PSPs failed to define measurable objectives included:	

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		▪ Although as noted above, Individual #227's team clearly had made efforts to include objectives in her plan for the various disciplines providing supports, many continued to be missing. For example, none of the medical supports identified in the medical assessment had been included in the PSP. Some of the strategies from the PNMP had been included in the PSP, but due to the format of the action plans used for at-risk issues, it was unclear who was responsible for implementing the supports that were identified, and some of the supports/strategies were not included in action plans, such as the use of the shower chair, which had become necessary to ensure safety. ▪ Individual #301's PSP included a number of measurable objectives. These included both skill acquisition objectives, and service objectives. Although his team had clearly made significant effort to include measurable objectives related to the various plans that contributed to the PSP (e.g., the PBSP, and PNMP), the objectives were not consistently written in measurable terms, and many were missing. As a result, the team had not set forth a full set of measurable objectives/outcomes to assist in determining if Individual #301 was progressing, stable, or regressing, and to ensure that appropriate protections, supports and services were provided. Some problematic examples included: o Individual #301 only had two objectives to address day programming. The overall desired outcome was incomplete, because it read: "[Individual #301] will". The two related objectives would be difficult to measure. The first read that: "When greeted by staff, [Individual #301] will respond verbally…" It was unclear what this meant. As noted previously, his most recent Speech and Language Evaluation was over 10 years old, but indicated that he greeted people. Given what appeared to be a regression in skills, the team should have specifically defined what a "verbal response" meant. The second objective was equally vague. It read: "With verbal prompts, [Individual #301] will participate in a group activity for 6 consecutive months by 2/11/12." It was unclear what "participation" would entail, and it also was unclear how often each month, it was expected he would participate. o Again, although it was positive that attempts had been made to incorporate several of the discipline-specific plans into the PSP, steps from the PNMP were listed, but adequate measurable, functional objectives were not included to assist the team in evaluating the efficacy of the plan's implementation. For example, although an overall goal was included that he would experience no choking episodes, the PNMP appeared to be designed to assist with a number of other issues, including skin breakdown, fractures, aspiration pneumonia, etc. No objectives were included to measure the efficacy of the plan in addressing these areas of need.	

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		○ The body of the PSP mentioned that: "Decrease of Lexapro started in August 2010, but decision to keep [Individual #301] at 5 mg [milligrams] upon reports of increased bouts of crying. As of October 2010, crying was monitored to ensure that depressive symptoms do not worsen. To date, it appears that [Individual #301] is handling the decrease of Lexapro well. If he continues to do well, then psychiatrist has indicated that discontinuation of Lexapro may occur." No objective was included to monitor Individual #301's crying, and no criteria were set forth with regard to when further medication reduction would be considered. ▪ Individual #374 had a number of identified behavioral concerns, including aggression, self-injurious behavior and disruptive behavior. Her objectives sought to reduce these undesirable behaviors, but did not specify how that would be accomplished. Rather, they were stated in such terms as "[Individual] will exhibit no more than 45 episodes of aggression per month for 12 consecutive months,' or '[Individual] will exhibit no more than 75 episodes of disruptive behavior per month for 12 consecutive months." Preventative strategies were to include keeping (her) involved in meaningful and enjoyable activities. Yet, the activities planned to accomplish these objectives were minimal, and consisted of an off-campus activity four times per month, and an on-campus activity at least four times a month, combined with three weekly walks. The intensity of these objectives was very poor, considering that this individual was served by the Facility 24 hours/day. ▪ One example in Individual #244's PSP of an area in which measurable goals should have been defined, but were not, was with regard to the action plans to address her diagnosis of diabetes, which placed her at medium risk. The desired outcome was listed as: "[Individual #244] will have minimal complications associated with type 2 diabetes." It was positive that the action steps listed some of the proactive measures that were being taken to address this, such as her diet, shoes with arch supports, regular lab work, and medication. However, the team had not developed any measurable objective(s) to determine whether or not Individual #244 was better, worse, or had remained stable with regard to her diabetes. In reviewing the health management plans, the beginnings of this were present, but needed further development, and needed to be included in the PSP. For example, the health management plan identified an acceptable blood glucose level, and indicated that her weight needed to be within "normal limits." These are the types of measures that the team should have incorporated into the PSP. The health management plan identified other measurable strategies that the team had not incorporated into the PSP, and no justification was provided. For example, the health management plan indicated Individual #244 should be encouraged to walk at least 20 minutes per day, five days per week. This was	

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		not included in her plan, nor was regular skin assessment by the RN or Licensed Vocational Nurse (LVN). 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 had made some progress in this area, but still was at the initial stages of complying with this component of the Settlement Agreement.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Numerous examples are provided throughout this report regarding how plans, supports and services were not integrated through the PSPs. PSPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires. None of the 12 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. For example, the PNMP, nursing care plans, and psychiatric treatment plans, frequently still were separate plans that were not integrated in any measurable way into the PSP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Although PBSP objectives often were included in the PSPs, which was positive, there was not evidence that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). Similarly, based on review of some of the newest plans, efforts were being made to incorporate the requirements of the PNMPs into the PSPs, and substantial effort had been made to incorporate the PNMP techniques onto the medication administration records. However, as noted above, PNMPs lacked measurable outcomes, and, as a result, these were not included in PSPs. In addition, a continued lack of integration was seen with OT/PT/SLP programs in the PSP in general, and with other disciplines, such as psychology, medical, and nursing. Examples of issues related to the lack of integration also were found between dental/medical and psychology with regard to the development and implementation of desensitization plans. The following provide some examples of where there was evidence of integration: ▪ Individual #227's team developed some skill acquisition goals to address some of the areas in which she was at risk. This showed efforts on the part of the team to look outside of medical or therapeutic interventions, and develop a more comprehensive approach to addressing her areas of risk. For example, she had been hospitalized due to an infection. The team developed a skill acquisition program to assist her in learning to use hand sanitizer, because she frequently rubbed her eyes, which could lead to infection. Likewise, the team developed a skill acquisition program to complement her PNMP, and address the risk of	Noncompliance

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		weight loss. The skill acquisition goal related to teaching her to self-initiate eating, as opposed to waiting for staff prompting The following provide a few examples of the lack of integration and/or a lack of a comprehensive set of supports: ▪ As noted above, Individual #301 had a behavior support plan, which identified verbal communication as a replacement behavior for aggression. The Speech Language Evaluation was over 10 years old, no SLP attended the PSP meeting, and no evidence was included in the PSP of collaboration between the SLP and the Psychologist. Given that Individual #301 also had a diagnosis of dementia, reassessment and the integration of these supports would appear important. ▪ Individual #244's team identified a number of support needs in the narrative section of her PSP that were not integrated into the action plan section of her plan. For example: o Individual #244 used a combination of sign language, gestures, facial expressions, and a communication book to communicate. Under the Physical and Nutritional Management Section of her PSP, the team documented: "To promote communication all staff working with [Individual #244] need to attend classes to teach more manual signs they can use to communicate with her… It is felt that if she had more people using sign with her she could better use this as a form of communication." No supports were integrated into the plan to teach her or staff additional sign language. Although her PBSP included an objective for her to use her communication book as a replacement behavior for aggression or property destruction, there was no evidence in the PSP that the psychologist had worked with an SLP to design an appropriate program. o Her PSP also indicated that she had experienced increased falls in the past year. She had a condition that was resulting in progressive visual impairment. Although it appeared that the team had some discussion about the increase in falls, and potential options, it was unclear if the team had discussed all possible options, such as obtaining a formal orientation and mobility assessment, or integrating therapeutic supports (i.e., OT, PT, psychology, nursing, residential, vocational, etc.) to assist her in accommodating the vision loss, and maintaining her independence. A page appeared to be missing from her PSP, but based on the narrative of her PSP, no integrated plans had been developed to address her falls or progressive visual loss.	
	4. Identifies the methods for implementation, time frames	DADS Policy #004.II.D.4.d included the required elements. As noted previously, the Facility had adopted the DADS policy.	Noncompliance

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	for completion, and the staff responsible;	For the goals and objectives identified, PSPs generally described the timeframes for completion, and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement. The following provide some additional examples: ▪ Individual #301's PSP included a number of service objectives, but often it was unclear the methods that would be used to ensure he was adequately supported. For example, although the nursing care plans identified specific training that staff needed to complete, no related service objective was included in the PSP. Likewise, objectives such as "Staff and nurses will monitor bowel movements daily" identified that a tracking sheet would be maintained, but not who was responsible for monitoring the tracking sheet, or taking action when certain criteria were met. ▪ Individual #195 had multiple health and physical and nutritional management issues, which his team indicated placed him at medium and high risk. The action plans in his PSP did not identify the methodologies to be used to reduce these risks, to the extent possible. For example, desired outcomes were listed as "zero fall related to unsteady gait this year," "5 or fewer episodes of constipation during the coming year," and "zero choking related injuries or illnesses in the next twelve months." No action steps were included or methodologies defined to assist Individual #195 in achieving these objectives. Although he had a PNMP and health management plans, these were not referenced in the action plans or integrated into the PSP. ▪ In Individual #434's PSP, no measurable objectives were included to address the clinical services being provided. In the narrative sections of the plan, a number of risks were identified, including high risk for osteoporosis, seizures, and polypharmacy/side effects, and medium risk for aspiration, respiratory compromise, weight, cardiac disease, circulatory, constipation/bowel obstruction, skin integrity fractures, and dental. Although the narrative section of her PSP stated objectives and methods to address some of these risk areas, the objectives were not sufficiently measurable, they were not translated into action plans, no one was identified as responsible for implementing specific actions/activities, no one was identified as responsible for monitoring their implementation, and timeframes were not established. One of the concerns was that the action plan format for at-risk issues appeared to be different from that for other action plans. This varied somewhat from PSP to PSP. However, it often was unclear who was responsible for the implementation of the at-risk action plans. However, the at-risk action plans were clear about who was responsible for monitoring them.	

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	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 identified in other sections of this report, the interventions, strategies and supports offered to individuals at AUSSLC did not consistently and effectively address individuals' needs, and many were not practical and functional at the Facility and/or in community settings. Again, such issues are discussed elsewhere in this report with regard to plans to address conditions that placed individuals' at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and PBSPs. The following provides some examples of interventions in PSPs that did not effectively address the individuals' needs, and/or were not practical and functional at the Facility and/or in community settings: ▪ One of Individual #244's preferences stated that she "likes going to work to earn money." Her specific preferences for types of work, working conditions, etc. were not identified. The narrative section of her PSP indicated that: "She did have a trial period with supported employment in the kitchen. [Individual #244] had some difficulty with this. She was moved back into a workshop." No further information was provided regarding the difficulties she had in her supported employment trial. Her vocational assessment did not meet any of the requirements for an adequate assessment. Her objectives for work included: 1) she would demonstrate to staff when she needed assistance with her work; 2) she would put her assigned work in a designated container. Based on other information in her PSP, Individual #244 had many skills and strengths that could have been built upon to assist her in obtaining more independent and competitive work. Although it could be argued that the objectives included in the PSP addressed important work skills, the strategies included in her PSP did not outline an adequate approach to provide her with more functional and independent work skills. Due to the fact that the vocational assessment was inadequate, the team likely did not have the information it needed to develop an appropriate program to address Individual #244's vocational needs. This underlines the need for assessments to be improved. ▪ Individual #434's PSP indicated that she attended day program for a half an hour in the morning, and a half an hour in the afternoon. No justification was provided for this limited schedule of day activities. ▪ Individual #430 enjoyed working and was known to be industrious. Yet, she attended the workshop for only two and a half hours per day. She was observed sitting on the floor of her residence, tearing up magazines and putting the pages into the trashcan. When asked about this meaningless activity, staff replied, "She likes to keep busy." ▪ Individual #358 desired greater independence and his team's assessments supported this goal. Yet, two of the six daily living skills objectives contained in his PSP focused on the proper use of a napkin. The other objectives involved, appropriately, the use of money, hand washing, and reporting to the medication	Noncompliance

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		room when it is time for his medication to be distributed. Although some of these goals taught functional skills, it was unclear how they were assisting Individual #358 to meet his longer-term goal of greater independence. 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 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. 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: ▪ None of the 12 PSPs reviewed (0%) included skill acquisition objectives related to cooking, or home maintenance (e.g., doing dishes, vacuuming, dusting, etc.). A few individuals had skill acquisition goals related to doing laundry or setting the table. ▪ Individual #230 liked to engage in tasks that were helpful to staff and to her housemates. She has an objective to set the table in the dining room of her residence. Apparently, no consideration was given to a volunteer position, where she could help others, or to supported employment, even though she was motivated to work.	
	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. As noted previously, the Facility had adopted the DADS policy. 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 noted above, different PSPs included slightly different action plan formats. There appeared to be two different formats: one for action plans related to at-risk issues, and another one for non-at-risk action plans. The at-risk issues action plan format identified the person responsible for monitoring, but did not clearly identify who was responsible for implementation and data collection. It appeared a column had been added to the non-at-risk action plan to identify	Noncompliance

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		specifically which team member was responsible for data review. 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., health management plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. For example: ▪ Based on a review of 30 records for individuals determined to be at risk (Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, Individual #424, Individual #423, Individual #194, Individual #124, Individual #5, Individual #339, Individual #81, and Individual #336), none of the individuals' plans (0%) included the clinical indicators to be monitored and the frequency of monitoring. ▪ As discussed above, many objectives were missing from Individual #301's PSP. Those that were present generally included how often data would be collected, and where it would be documented. Although a person(s) responsible was identified, this often included multiple people (e.g., direct support professionals and the nurse, or the psychologist). As a result, it was unclear who had been assigned responsibility for at least monthly data review. 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.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted in the 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 individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and	DADS Policy #004.II.D.4.m required the PSP to be accessible and comprehensible to staff who must implement it. As noted previously, the Facility had adopted the State policy. Copies of the PSP were being maintained in the Active Records in the residences to which staff working with the individuals had access. However, as noted with regard to Sections	Noncompliance

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	comprehensible to the staff responsible for implementing it.	V.1 and V.4 of the Settlement Agreement, major issues were noted with regard to the filing of documents, and the timely availability of documents in records. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. The majority of the PSPs reviewed were written with minimal clinical jargon. Another major issue related to comprehensibility of the PSPs reviewed was the lack of delineation of responsibility for the implementation of the plans. As a direct support professional, it would be difficult to read the PSPs as written and determine what his/her responsibilities were for the individual during the course of the 24-hour day. This, in large part, was due to the fact that the PSPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall PSP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members.	
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 Settlement Agreement. As noted previously, the Facility had adopted the State policy. The QMRP Coordinator candidly shared with the Monitoring Team that the completion of monthly and quarterly reviews of PSPs was an areas that required improvement. He explained that over the previous months, the priorities that had been set for the QMRPs were the timely completion of annual PSPs, and the development of appropriate active treatment opportunities for individuals. He indicated that in the coming months, a focus would be placed on ensuring the completion of timely and monthly reviews. The Monitoring Team's review confirmed the QMRP Coordinator's assessment. Quarterly/monthly reviews were requested for a sample of individuals. For none of the 12 individuals reviewed (0%) were consistent monthly or quarterly review reports submitted. For many one or more was submitted, but not for each month or quarter the PSP covered. The following provide examples of concerns related to the monthly/quarterly that were submitted: ▪ Individual #434 only had one quarterly review for the period of August through September 2010, and two monthly reviews for August and September 2010.	Noncompliance

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		The monthly and quarterly reviews identified numerous issues related to either data collection or objectives not being met. For example, according to the quarterly review, for nine objectives, no data had been available for one to three months. However, the quarterly review did not indicate that any action was taken to correct this deficiency by either ensuring their implementation or documentation of their completion. The quarterly review also listed a number of health related objectives. However, no information was provided regarding their status. ▪ Due to the fact that many plans, such as PNMPs, health management plans, and psychiatric medication plans, were not integrated into the PSPs, no data was provided to support the efficacy of these plans, or to indicate if changes needed to be considered. At most, a general statement was made about the individual's overall status, or appointments that had been held, hospitalizations, or assessments that had been completed. 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.	
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	DADS Policy #004.IV addressed staff training on the PSP process that generally comported with the Settlement Agreement requirements. As noted previously, the Facility had adopted the DADS policy. However, no policy was presented that further delineated how competency would be assessed. For example, no details were provided with regard to the tools that would be used, the criteria to be used in deeming competence, or the processes that would be used. For example, it was unclear what the exact competency requirements were, or what the consequences would be for QMRPs or other team members who could not demonstrate the required competencies, after training and technical assistance were provided. Supporting Visions: Personal Support Planning, dated July 2010, was the training curriculum for personal supports planning. The document designated this training as competency-based relying on two aspects of the materials, including that in developing the learning objectives, an examination had been completed of what employees needed to know on the job, and that practice events in the instruction curricula related to select learning objectives. The criteria for receiving credit for the course were attendance, participation in competency-based activity, and assessment throughout the course. This training did not meet the requirements for competency-based training. In order to	Noncompliance

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	implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	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. The course contained a variety of activities including role-playing, paper and pencil self-assessments, and videotaped demonstrations. A workbook was included so that learners could have a visual prompt and set of activities at hand. As noted above, the training instructors had special training in presenting this course, and DADS State Office had certified them to provide this training. This training course provided a good introduction to the development of PSPs, the differences between the new and the old processes, the roles of team members and the expectations for individualized and integrated plans. The training explained the "why" behind the changes, but not the "how." There will need to be additional teaching about how to then develop integrated action plans that draw together the information gathered in assessments, how to analyze that information and incorporate the individual's preferences, and how the priorities can be translated into clear directions for those working with the individual. Once the "how" of designing integrated action plans has been taught, there will need to be further training on how to link those action plans with service objectives and skill acquisition objectives, so that considerations of the individual's interests and priorities, and vision for his/her living arrangements and work will be reconciled with medical and safety needs. A number of staff from AUSSLC had been certified as trainers on the new PSP policy, including the Director of Quality Assurance and the QMRP Coordinator. It was reported that all QMRPs completed the training designed for them. At the time of the review, it was reported that the great majority of team members at AUSSLC had attended the initial training. However, training was ongoing for new staff, as well as the limited number of staff who had not yet completed it. The Facility provided a copy of the lesson plan for the training entitled: "Q Construction: Facilitating for Success." As noted with regard to Section F.1.a, all but two of the 26 QMRPs had completed the classroom portion of this training. The training content included a number of topics related to the facilitation of meetings and team activities, including characteristics of team leaders, team processes, styles of communication,	

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		asking questions to solicit input and verify information, and specific facilitation skills. The training was tailored to the PSP process, and many of the examples used and the discussion revolved around specific components of the PSPs, such as the living options discussion, and discussions about preferences, risks, and action plans. The format for the training included a number of adult-based learning concepts, including interactive activities and opportunities to practice the skills being taught. The lesson plan also identified skills that would be assessed through testing, and others that would be evaluated through an "on-the-job assessment." Although the details of the on-the-job assessment were not provided, this was a positive indication that formal competency-based assessment criteria were being established. Competency-based measures and 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.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Based on a review of a list provided by the Facility of each individual and the dates of their two most recent PSPs, it was found that of the 361 individuals supported by the Facility, 326 (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. The larger problem was related to the plans being available and in effect within 30 days. According to the QMRP Coordinator, the Facility currently had no way of tracking this indicator. 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.	Noncompliance
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	DADS Policy #004.V addressed quality assurance processes to ensure PSPs are developed and implemented consistent with the provisions of the Settlement Agreement. As noted above, the Facility had adopted the State's policy. However, the Facility's policy did not define in further detail how monitoring would be completed, and no written procedures were provided, which detailed the monitoring processes. The following monitoring tools had been adopted: ▪ AUSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 9/1/10;	Noncompliance

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	provisions of this section.	▪ PSP Review and Recommendations, undated; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section F; and ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section F, with guideline, revised 12/10; According to the QMRP Coordinator, the plan was for him to review approximately two annual PSP meetings per month, and for the Quality Assurance Department to conduct reviews of approximately five percent of the PSPs per month. However, these goals reportedly were not consistently being met. The Monitoring Team requested copies of the last six reviews the QMRP Coordinator had completed, and the last six reviews the Quality Assurance Department had completed of PSP meetings, and PSP documents. The completed review tools provided consisted mainly of the AUSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist with the exception of two completed PSP Review and Recommendations review tools. The tools showed that the Facility had identified a number of issues with regard to the PSP meeting that had been monitored. According to the QMRP Coordinator, copies of the completed forms were sent to the QMRPs, and when the QA Department completed them, the QMRP Coordinator also was provided a copy. In some cases, there were notations that a meeting had been held with the QMRP who facilitated the meeting to discuss the results. Based on the paper review the Monitoring Team conducted, there appeared to be some trends with the data. At the time of the review, it appeared the data was not yet being reviewed on an aggregate basis to identify trends. It should be noted that the QMRP Coordinator attended a number of PSP meetings. As evidenced during the week of the Monitoring Team's onsite review, he provided guidance to QMRPs and the teams to improve the planning process. It was anticipated that with the addition of a QMRP Educator that some of these responsibilities could be shared. In addition, reportedly, at the time of the review, a couple of QMRPs were completing peer reviews. In reviewing PSP meetings, the QMRP Coordinator was using the Personal Support Plan Meeting Documentation and Monitoring checklist. According to staff, this tool was in the process of being modified for use on a statewide basis. The revisions would include evaluation of the QMRPs' facilitation of the meeting. The review tool entitled Settlement Agreement Cross Referenced with ICF-MR Standards Section F: Integrated Protections Services, Treatments and Supports contained	

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		guidelines, which should be helpful in ensuring that different auditors are reviewing the same information. The QA Department used this tool to conduct its monitoring of the PSP documents. The Monitoring Team did not review the guidelines in detail. However, an overall comment would be that the guidelines did not always provide enough information to ensure that the quality of various components of the PSP process was being effectively evaluated. For example, indicator F.2.3 addressed integration of services. The guideline correctly referenced that all services and supports the individual needed should be included in the PSP, and gave an example of the need for a PNMP to be "addressed in the PSP." This did not provide sufficient guidance to ensure the integration of services and supports. For example, with a PNMP, an auditor would need to look to ensure components of the PNMP were integrated into other relevant plans, such as nursing care plans and medication administration records, and that clear objectives for the measurement of the efficacy of the PNMP had been incorporated into the PSP. Similarly, in providing guidance about the indicators related to assessments, the quality of the assessments was not addressed. As the Facility gains experience with implementing the review tools, changes should be made to these guidelines, as necessary. A copy of the document entitled PSP Review and Recommendations also was provided. This review tool appeared to target specific requirements for PSPs, such as the prioritization of preferences, strengths, interests, and needs; the Optimistic Living Vision, the need for education about living options; the identification of health risks and the need for training of staff related to these risks; integrated discussions; identification of restrictions and plans for removing them; the need for guardianship; and the development of appropriate and integrated action plans. Given the concerns outlined in this and previous reports with regard to Section F, these areas of focus appeared to be appropriate. The Facility's Plan of Improvement included one corrective action plan for Section F. It addressed the need for facilitation training to be provided to QMRPs. As is discussed above, this action plan was in the process of being implemented. AUSSLC continued to be at the beginning stages of developing and implementing quality assurance mechanisms to ensure compliance with Section F of the Settlement Agreement. The Facility remained out of compliance in this area.	

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

1. As appropriate, the Facility should develop facility-specific policies and procedures to assist in ensuring full and consistent implementation of the State policy on the Personal Support Plan process. (Section F.1)
2. The Facility and DADS State Office should reduce the span of control of the QMRP Coordinator to a reasonable level. (Section F.1.a)

3. Over time, consideration should be given to incorporating the risk discussions into the overall PSP annual meeting agenda, and potentially revising the format of the PSP document to encourage teams to discuss issues fully and develop complete action plans at naturally occurring times during the meeting. (Section F.1.a)
4. A system should be developed and implemented to aggregate the data being collected at team meetings regarding attendance. This data should be analyzed, and, if problematic trends are identified, they should be addressed. (Section F.1.b)
5. 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. (Section F.1.c)
6. Consideration should be given to adding to the PSP process an annual review of incidents, and abuse, neglect, and exploitations allegations. This would ensure that the team considered how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. (Section F.1.c)
7. 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. Behavior support plans should be integrated further with other protections, supports, and services. (Sections F.1.d, F.2.a.2, and F.2.a.3)
8. 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. Individuals' PSPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
9. The Facility should be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking, cleaning, and realistic community safety skills, become a regular part of training programs for individuals served. In addition, increased attention should be given to the development of supported employment or volunteer positions in community-based settings. (Section F.2.a.1)
10. Additional training should be provided on how to develop integrated action plans that draw together the information gathered in assessments, how to analyze that information and incorporate the individual's preferences, and how the priorities can be translated into clear directions for those working with the individual. (Sections F.2.a.2, F.2.a.3, F.2.a.4, F.2.a.5, and F.2.a.6)
11. 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. (Section F.2.c)
12. Specifically, on a monthly basis, each responsible team member should conduct a data-driven review of the assigned program(s) or support(s), take appropriate action based on this review, and document this review and any follow-up. The QMRP, as the team's facilitator, should ensure this occurs. To close the loop, the QMRP would need to take action, if any of these requirements were not met. Team meetings also might need to be held to address issues identified. (Section F.2.d)
13. 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. (Section F.2.e)
14. 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. (Section F.2.e)
15. 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. (Section F.2.f)

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Consultant reports and submitted radiologic/diagnostic test results, and integrated progress notes and other documentation commenting on consultant reports (agreement or reason for non-agreement) for the following individuals: Individual #204's Ear, Nose, and Throat (ENT) consult on 3/3/11, Individual #204's pathology report/dermatology note of 12/14/10, Individual #350's plastic surgery on 12/13/10, Individual #350's plastic surgery on 1/5/11, Individual #277's neurology consult on 1/24/11, Individual #82's for neurology consult on 4/4/11, Individual #82's neurology consult on 10/25/10, Individual #82's ENT consult on 1/20/11, Individual #82's ENT consult on 1/6/11, Individual #82's ENT consult on 12/9/10, Individual #82's ENT consult on 11/16/10 [consult report was not submitted, but Primary Care Practitioner (PCP) note confirmed consult occurred], Individual #138's neurology consult on 4/18/11, Individual #138's radiology report on 3/25/11, Individual #138's orthopedic consult on 2/28/11, Individual #138's orthopedic consult on 1/24/11 (referenced in PCP note, but no report submitted), Individual #195's neurology consult on 3/28/11, Individual #195's Electroencephalogram (EEG) report on 3/2/11, Individual #195's Computed Tomography (CT) report on 2/1/11, Individual #195's carotid Doppler and Magnetic Resonance Imaging (MRI) study on 4/13/11 (referenced in PCP note, but no report submitted), Individual #118's neurology consult on 3/28/11, Individual #118's EEG report on 2/9/11, Individual #163's surgery consult on 11/5/10 (referenced in PCP note, but no report submitted), Individual #28's neurology consult on 4/4/11, Individual #28's ENT consult on 1/6/11, Individual #28's ENT consult on 12/16/10, Individual #28's ENT consult on 2/10/11, Individual #409's ENT consult on 3/3/11, Individual #425's gastroenterology consult on 12/8/10, Individual #382's neurology consult on 12/6/10, Individual #278's eye clinic consult on 12/10/10, Individual #86's neurology consult on 1/24/11, Individual #21's neurology consult on 3/7/11, Individual #21's neurology consult on 11/13/10 (referenced in PCP note, but no report submitted), Individual #21's orthopedic consult on 10/25/10 (referenced in PCP note, but no report submitted), Individual #370's neurology consult on 12/6/10, Individual #370's neurology consult on 3/7/11, Individual #109's optometry clinic on 3/23/11, Individual #19's radiology report on 11/9/10, Individual #19's radiology report on 1/25/11, Individual #19's Electrocardiogram (EKG) report on 2/9/11 (referenced in PCP note, but no report submitted), Individual #19's radiology report on 3/21/11, Individual #50's neurology consult on 4/4/11, Individual #50's physical medicine consult on 11/2/10, Individual #453's neurology consult on 1/24/11, Individual #453's neurology consult on 11/15/10, Individual #193's neurology consult on 1/10/11, Individual #193's neurology consult on 10/25/10, Individual #297's neurology consult on 4/4/11, Individual #81's ENT consult on 3/14/11, Individual #18's neurology consult on 9/27/10, and Individual #363's neurology consult on 2/7/10;

	o Records for Individual #223, Individual #359, Individual #260, Individual #224, Individual #450, Individual #32, Individual #426, Individual #380, Individual #103, Individual #358, and Individual #1, Individual #39, Individual #254, Individual #265, and Individual # 29; and o For the last year, a list of individuals admitted to the Facility's Infirmary, length of stay, and diagnosis of Infirmary admission.
	Facility Self-Assessment: The Facility's POI included a summary of activities in which it engaged in order to comply with Section G of the Settlement Agreement. According to this document, the following activities occurred: ▪ Two state policies were implemented that provided guidance for integrated clinical services. On 7/30/10, State Policy #004 entitled Personal Support Plan Process was implemented. The first tier of training included training of professional staff on 8/23/10. A second tier was completed on 3/25/11, and included all paraprofessionals on the teams. ▪ State Policy #006 entitled At-Risk Individuals had an implementation date of 11/2/10. Training of professionals began on 12/21/10. There were two subsequent updated revisions of State Policy #006. State Policy #006.1 was created 1/1/11, and a further revision, #006.2, was created on 2/18/11. QMRPs were trained on the new integrated PSP process on 1/11/11. ▪ The Medical Director met with the QA data analyst and the Client Records Coordinator to discuss needs and challenges in these areas. ▪ A number of interdisciplinary meetings continued to meet during the past six months, such as the polypharmacy committee, the pre-treatment sedation committee, the medication error committee, and the PNMT. The PNMT continued to grow in numbers of dedicated members. ▪ Documentation of consult recommendations and PCP agreement or disagreement with these recommendations continued to be a challenge, in part due to the challenges in routing the records to the physician, as well as maintaining updated information in the records. The Facility had determined that it remained noncompliant in both sections of G, but continued to lay the foundation for future compliance. This was consistent with the Monitoring Team's findings. As the Facility expands its self-assessment processes, in addition to narrative descriptions of actions taken, it will be important to include objective data in the POI to substantiate findings of substantial compliance or noncompliance.
	Summary of Monitor's Assessment: There were a number of improvements in integrating clinical services, but many of these were at the beginning or early stages of development, and needed further refinement. Some of these efforts included the morning medical meeting, and the creation of the Physical And Nutritional Management Team. A number of collaborative efforts continued, including the Pharmacy and Therapeutics Committee (P&T Committee), and a committee addressing pre-treatment sedation and restraints. The Pharmacy Department had collaborated with the Nursing Department in assisting to resolve the medication error concerns. However, the Pharmacy, Dental, and Medical Departments had all lost staff positions, making future collaboration in many areas a challenge, as collaboration requires time in preparation and time for meetings. The Medical and Nursing Departments did not complete data collection

	on assigned tasks, resulting in the lack of a successful drug utilization evaluation program. This suggested the need for improved collaboration among departments to reach compliance with the Settlement Agreement. Follow-up of consultation reports by PCPs was inconsistent. There should be a formalized system with documentation on a standardized form or through a dictated note. The note should summarize briefly the content of the consult report and acknowledge agreement or not. There should be a brief comment regarding the next step. If there is disagreement, evidence for rationale should be presented, and an alternate option provided. The form should be signed (not initialed), and dated.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	There were many examples of integrated clinical services and collaboration. However, some of these were at the beginning or early stages of implementation, and further development was needed for full integration to occur. For example: ▪ The morning medical meeting was comprised of PCPs, psychiatrists, and nurses. A review was completed of acute care events in the past 24-hour period (or 72 hours for a weekend review), and was followed by discussion among these three disciplines. ▪ The PNMT was a multidisciplinary working group, which addressed some of the most complex health care needs of individuals. Many of these conditions could lead to rapid decline, if not addressed promptly and monitored by this group of specialists. However, the pace of the PNMT's involvement with specific individuals at highest risk, and the criteria being used to prioritize those with greatest need were not clear. ▪ In addition, based on record review of 11 individuals (Individual #223, Individual #359, Individual #260, Individual #224, Individual #450, Individual #32, Individual #426, Individual #380, Individual #103, Individual #358, and Individual #1) who had been hospitalized for acute illness, some due to aspiration pneumonia, the medication administration observations in the Infirmary, and interviews conducted with nursing staff, there was little to no collaboration between nursing, medical, and the PNMT regarding the individuals who were at high risk for aspiration. From observations during medication administration, nurses were not using the PNMPs to assess for safe positioning, when they administered medications orally or enterally. ▪ The at-risk process, which began on January 1, 2011, brought the entire PST together in a collaborative effort with each member bringing their expertise to the table. The risk determinations were dependent on the preparatory information submitted by each team member, and were based on discussion and consensus of the entire team. The discussion and results reflected quality care only if the team members had done adequate preparation for the meeting. As	Noncompliance

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		discussed with regard to Section I, teams were in a learning stage. One of the main challenges was encouraging the teams to think critically to address unresolved issues and problems, such as repeat hospitalizations. The teams at times did not appear to have the clinical background to know what areas of an individual's health needed further assessment, and whether all options in diagnostic work-up and treatment had been considered. ▪ The postoperative recovery period following dental procedures and dental anesthesia required collaboration of the Dentist and Infirmary nurses. Individuals with increased need for nursing monitoring were temporarily assigned to the Infirmary for a few hours, and, at times, overnight. In the six months prior to the Monitoring Team's visit, there were 114 admissions to the Infirmary for post-dental procedure monitoring. This represented 114/310, or 37%, of all admissions. This represented excellent collaboration and integration of dental, nursing and medical services. Additionally, a committee had been created which had begun to address the topic of pre- treatment sedation. The members represented several departments on campus. ▪ Other committees met in an interdisciplinary manner. The pharmacy and therapeutics committee was represented by pharmacy, infection control, nursing, PCPs, dental, and psychiatry. However, the minutes also indicated a need for improved collaboration in making the drug utilization evaluation program successful, in which there was resistance from the Medical and Nursing departments in assisting in collecting data. This is discussed in further detail with regard to Section N.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	Consult reports were submitted for 25 individuals. The Monitoring Team's review was based on this information. A preface to the submitted documents indicating that: "the information gathered may be incomplete due to a number of factors: filing system - filing clerks recently have been reorganized under Client Records so we are expected improved filing in the future, Record transportation is not available to bring records to PCP to write IPNs and some consults have notations by PCP in lieu of an IPN." For these individuals, there were 48 consult and test results reported. For two of these reports, there were no signatures, no dates of review recorded, and no note indicating agreement or not from the PCP. These were for Individual #82, for a neurology consult on 10/25/10, and Individual #81, for an ENT consult on 3/14/11. For Individual #425, for the GI consult, dated 12/8/10, there was a signature, but no date of signature and no note. Additionally, there were other reports for which no notes could be identified that indicated the report was reviewed, and/or whether there was agreement or disagreement with the findings and/or recommendations, if appropriate. These were, for Individual #28 for Neurology consult on 4/4/11, Individual #278 for eye clinic on	Noncompliance

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		12/10/10, Individual #50 for neurology consult on 4/4/11, and physical medicine consult on 11/2/10, and Individual #193 for neurology consult on 10/25/10. For Individual #28's ENT consult on 2/10/11, and Individual #19's radiology reports on 1/25/11 and 3/21/11, consult reports did not suggest the need for a response, other than to indicate the contents were read by the PCP. Of the 48 consult and test result reports, 45 required follow-up notes. Follow-up notes could not be found for six consultations, for a compliance rate of 37 out of 45 (82%). Additionally, there were only two PSPs or PSP addendums submitted that integrated the consultant information into the report. It was not known if PSPs were not routinely submitted in response to the document request. This either indicated a lack of submission of requested documents, or that the PSPs/addendums had not been amended/developed to include consultation report information. At times, the response of the PCP was difficult to determine. In some cases, determining the initials of the PCP was difficult, and in many cases, the agreement note was difficult to read, and briefly jotted on the actual report. (The cover page indicated the medical records were often not available to the PCP). Such an informal system should be replaced by a formal system of review, documenting on a separate form or in a standardized note (such as a dictated note), the consult being reviewed and a brief summary of the findings indicating quality review by the PCP, and notation where appropriate concerning the PCP's agreement or not. If there is disagreement, evidence for the rationale should be presented, and an alternate option provided as a next step. Follow-up then needs to be documented specifically.	

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

1. In the at-risk process for each individual, the PSTs should focus on unresolved issues and health concerns that occur repeatedly in the high and medium risk categories. (Section G.1)
2. The PST should ensure that for each high and medium risk category for an individual, these areas have been thoroughly assessed and all options considered. (Section G.1)
3. Improved collaboration in completing the drug utilization evaluations is needed. (Section G.1)
4. For follow-up of consultation reports by PCPs, there should be a formalized system with documentation on a standardized form or through a dictated note. The note should summarize briefly the content of the consult report and acknowledge agreement or not. There should be a brief comment regarding the next step. If there is disagreement, evidence for rationale should be presented, and an alternate option provided as a next step. The form should be signed (not initialed), and dated. Follow-up then needs to be documented specifically. (Section G.2)
5. As the Facility expands its self-assessment processes, in addition to narrative descriptions of actions taken, it will be important to include objective data in the POI to substantiate findings of substantial compliance or noncompliance. (Facility Self-Assessment)

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 DADS SSLC Policy #009.1: Medical Care, dated 2/16/11; o AUSSLC draft policy: Preventive Health Care Guidelines for Medical Care for the Developmentally Disabled Client, February 2011; and o 180-Day Medication Orders Procedure Corrective Action Plan, dated 4/8/11.
	Facility Self-Assessment: The Facility determined it was noncompliant with all sections of Section H, which was consistent with the findings of the Monitoring Team. The POI provided very minimal information, and for Sections H.2 through H.7 indicated that: "No action steps or initiatives have been initiated during the last six months."
	Summary of Monitor's Assessment: There remained need for improvement in completing assessments or evaluations in the Medical, Pharmacy, and Dental Departments. Preventive care remained a challenge in the Medical Department, but steps were being taken to improve compliance. The oral hygiene rating across the campus was completed as a baseline, and revealed the need to focus on preventive dental care in the residences. Identification, assessment, and treatment of changes in health status remained challenging. Recurrent hospitalizations and ER visits for the same medical problems remained a concern. AUSSLC remained without an adequate medical quality improvement program. The infrastructure had not been developed, such as quality and comprehensive database systems. Clinical indicators in most cases awaited the completion of the clinical guidelines/pathways. However, use of current selected data that appeared valid was not analyzed and optimally used to guide the Medical Department. The process of formalizing Medical Department policies had begun. Dental had completed a number of departmental policies.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals'	DADS Draft Policy #005: Minimum and Integrated Clinical Services provided the administrative structure and oversight needed to obtain compliance with Section H of the Settlement Agreement. This policy provided precise guidance concerning such areas as periodicity and timeliness of clinical assessments and evaluations. It provided expectations across a wide range of disciplines, such as quarterly reviews by nurses, annual dental examinations, regular review of drugs, annual physical exams, and periodic assessment of risk status. Changes in status had assessment expectations within 24 hours for non-urgent change, within one hour for urgent change, and immediately for emergent change. There was nothing in the policy, however, regarding assessments and	Noncompliance

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	needs.	evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). In addition, it might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H. AUSSLC did not appear to have developed any Facility-specific policies based on this draft policy. Completion of annual medical assessments had a compliance rate of 65%. Routine preventive testing and treatment had a more varied compliance rate. The compliance rate for annual thyroid testing in those with Down syndrome was 95%. For those for whom recommendations indicated a need for a screening mammography, compliance was 84 to 86%. For those for whom recommendations indicated a need for a screening colonoscopy, compliance was 42%. As noted in more detail with regard to Section L, change in health status was not identified in a timely manner, in certain cases. For example, severe weight loss was not identified and treated until serious illness occurred. In one individual, significant bruising was not identified and brought to the attention of the PCP until the Emergency Room (ER) staff discovered the bruise. In one instance, there were several days of worsening health, and there was no evidence a physician was called, or that a physician evaluated the individual prior to transfer to the ER. Individuals had repeat hospitalizations for the same condition with no further evaluation to determine underlying pathology that could be treated to improve the quality of life of the individual. In the Medical Department, there was no ability to track an individual to resolution/closure of the health concern. For the Dental Department, completion of annual dental exams had a compliance rate of 71%, during a time period of several months, with a more recent compliance rate of 86%. Dental treatment was considered timely and effective in responding to changes in dental and oral health status. In addition, the significant problems found in the nursing documentation of assessments for individuals who experienced a change of status that warranted hospitalizations reflected the significant need for nursing to develop and implement Facility protocols and procedures to guide nursing practices regarding conducting adequate and regular clinical assessments, and to clearly outline the criteria for nursing documentation, and physician notification regarding status changes. This is discussed in further detail with regard to Section M.1. As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to	

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		development or changes in an individual's status. Some examples of this included nursing assessments, particularly with regard to individuals who experienced acute illness; individuals who might benefit from communication systems; and individuals being considered for enteral nutrition.	
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.	The DADS Draft Policy #005 also set forth expectations for Facility clinical staff, specifically stating "Diagnoses must clinically fit the corresponding assessments or evaluations and 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." As part of the process in ensuring prescribed medications had an appropriate diagnosis, a corrective action plan became effective 4/8/11, with initiation of a procedure to ensure the 180-day medication order form had an indication for each medication. This also represented an accountability system to ensure no medication was ordered without a diagnosis consistent with pharmaceutical guidelines. This information was then to be entered into the WORx pharmacy database. As part of the DG1 process (a State form), physicians had been able to expand the diagnoses that could be entered into the system. The physicians used diagnoses with International Statistical Classification of Diseases and Related Health Problems (ICD) codes, and the removal of the limitation on permitted diagnoses provided for a more comprehensive record. From medical record reviews, the diagnoses that were listed based on laboratory and clinical assessments were consistent with current clinical standards and nomenclature (ICD codes). At times, the concern was the lack of aggressive work-up and assessment to determine all the significant diagnoses affecting the health of the individual (as is discussed in further detail in Section L), especially in cases in which there were repeat hospitalizations for the same condition. At that point in the clinical treatment, the next step in assessment and treatment options would potentially be lacking. Part of the resolution of this was the development of the collaborative at-risk process that the PSTs conducted, as well as the development of the PNMT. As is illustrated with regard to Section J of the Settlement Agreement, the assessment processes used to determine diagnoses were not always consistent with Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria or generally accepted standards of practice. The psychiatric diagnoses utilized at AUSSLC were consistent with the nomenclature in the DSM-IV-TR. The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which set forth the specific symptoms that the individual presented with in a manner that would support the	Noncompliance

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		validity of the psychiatric 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.	Timely treatment and intervention remained problematic for those with chronic recurring illness requiring repeat hospitalizations. Once notified of concerns, the PCPs provided acute care which was timely and of good quality, but there was little evidence of aggressive evaluation and treatment to prevent readmissions to the hospital for similar problems. For instance, constipation appeared to be treated once it occurred, with use of frequent pro re nata (prn, or "as needed") medications, rather than preventing constipation. Those with episodes of acute respiratory distress and wheezing were not worked up for Gastroesophageal Reflux Disease (GERD), or if the work-up was completed and indicated GERD, treatment was not aggressive or recommendations not followed. Much of this section should improve once a number of clinical guidelines are finalized, and implemented. Guidelines should include expectations of tests and consultations to be completed as part of the assessment and diagnostic process. As part of the guidelines, treatments and interventions should be listed as options, followed by an expected timeframe of implementation and review to determine effectiveness.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	In DADS Draft Policy #005, the expectation/requirement was set forth that: "clinical indicators of the efficacy of treatments and interventions are determined in a clinically justified manner." The State Office then provided guidance for several areas of healthcare by referring the clinical departments to specific guidelines, which national organizations with expertise in specific areas of healthcare had developed and continued to update. The scope of practice covered by these guidelines was wide ranging, including preventive care, immunizations, cardiac care, diabetic care, breast cancer, cervical cancer, pneumonia, depression, and other guidelines available through the US Agency for Healthcare Quality and Research. The State Office clearly had identified a framework and level of expectation with regard to the quality of care. Based on these guidelines, the policy further stated "the facility must develop a system to identify which guidelines to follow …" The aspiration pneumonia prevention algorithm had been acted upon through the at-risk process and PST discussions of risk assessment. There were several other clinical guidelines or pathways that were nearing finalization. At the time of the Monitoring Team's visit, they had not been adopted and implemented across the system. The final documents should reflect current standards of care, and provide a timeframe and critical clinical steps in the diagnosis and treatment of common diagnoses and illnesses. The guidelines should provide appropriate choices to meet the needs of the individual at each step. In creating these guidelines, clinical indicators should be built into the pathway as a measurement tool, which could be readily used for quality care measurement. As the	Noncompliance

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		pathway proceeds, certain expectations would be required (timeline to next decision step, expected baseline work-up, choice of medications, determination of need for consultation, etc.), and some of these choices also could be the clinical indicators used in assessing quality medical care. Additionally, AUSSLC, under the direction of the Medical Department, had created a draft policy entitled "Preventive HealthCare Guidelines for Medical Care for the Developmentally Disabled Client." This document provided detailed guidance on numerous aspects of preventive care, and clinical indicators could be extracted from this and readily used as measurement tools for quality care. To be compliant with the Settlement Agreement, valid and reliable clinical indicators must be developed and tracked for a range of common illnesses or health parameters (for prevention and wellness), which can be measured across time for trend analysis and interpretation. As is illustrated in various sections of this report, clinical indicators often were not identified. For example, when psychiatric medications were prescribed, the target symptoms were generally not tracked. Tracking these symptoms would assist in determining the efficacy of the treatment. Likewise, nursing plans did not identify what clinical indicators would be tracked, by whom, or when. Many PNMPs also did not identify the functional outcomes to be measured. The at-risk plans that had been developed also did not include measurable clinical indicators to determine improvement, or lack thereof, in individuals' at-risk status.	
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.	DADS Draft Policy #005 also set the standards and expectations the Medical Director needed to use in creating a health status monitoring system. The expectation appropriately, but ambitiously set the standard as monthly monitoring on a wide variety of domains of health care, including staffing, timeliness, equipment and resources, quality of care, morbidity, clinical indicators, etc. At the time of the Monitoring Team's onsite review, many of these expected monthly monitoring systems were not in place. Quality improvement (QI) review and initiatives in medical care had not occurred at the time of the Monitoring Team's visit. There were many challenges ahead. The information technology infrastructure was not in place. As pointed out with regard to Section L.3, there were several databases, and the data was not the same in each of these databases. The reason for the different results was not known, but the first step should include a review of the capacity of the databases, and software systems. Database entry completeness and quality would also need to be reviewed. In order for adequate trend analysis, data entry needs to be accurate and based on current information. For many of the Monitoring Team's requests related to healthcare, the extraction of data was manually done, which indicated the lack of infrastructure. Medical QI cannot proceed without quality database management.	Noncompliance

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		Additionally, the creation of the clinical guidelines will prompt clinical indicators, and the finalization of these clinical guidelines is essential to allow the Medical Department to proceed to the next step. At this point in time, there was no clerical support dedicated to medical QI management, and there were no personnel with dedicated time to begin the process of record review and extraction of data, report writing, and summarization of information, etc. The Medical Department had significant challenges in this area. The other two clinical areas, dental and pharmacy, likewise had no staff with dedicated time for quality review. Monitoring of health status will require these challenges to be resolved. The Medical Department should prioritize quality improvement endeavors using the quality of various databases as one parameter in deciding which database to use (i.e., which database is most reliable). Development of a clinical indicator would not be helpful, if there was no ability to measure it with meaningful and reproducible data. As the Medical Department meets with the information technology staff, the Medical Department will have to determine ahead of time what it wants to measure (i.e., clinically meaningful data), and how it could be measured and quantified in a database. All these areas will need continual collaboration to develop a successful medical QI system that will eventually demonstrate improvement of care through clinical evidence.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The Medical Department is encouraged to develop clinical indicators based on the "Preventive care guidelines" draft, as well as from the "Health Care Guidelines," and begin to pilot clinical indicators in order to understand their application/ implementation. The topics and areas of need for review could be discussed at the morning medical meeting. For instance, as noted with regard to Section L, a review of ER visits and hospitalizations would assist in determining where considerable energy and time should be directed. It would assist the Medical Department in providing quality care in many aspects of acute care, for example, by examining transportation options, timely transfer, appropriate early assessment of health status change, etc. The data related to ER visits and the reasons for the visit were available and appeared reliable and complete. This section is dependent on valid clinical indicators to reflect improvement in health, and each area of health risk. Once established, this becomes the barometer by which all treatments should be measured. As noted above, clinical indicators should be part of the clinical guidelines. If the PCP followed the clinical guideline and the chosen treatment or intervention did not change the health of the individual (i.e., the clinical indicator was not met), then the PCP would again review the clinical guideline for alternative choices of treatments, or consider the need for further testing to refine treatment options. Because the clinical guidelines were not in place, and initial treatment might require days to	Noncompliance

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		months to result in a measurable effect, this component of the Settlement Agreement is a future goal. As a follow-up to creation of the clinical indicators, the appropriate department will need to collect accurate and complete data relevant to that clinical indicator being discussed. This information, once shared at the PST meeting, will drive the next step, as to whether the intervention resolved or reduced the risk, or whether additional steps need to be taken. However, at this point, such a system-wide approach was not in place.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Medical Department had implemented the DADS SSLC policy entitled "Medical Care," dated 2/16/11. This provided the framework for policies and guidelines with clinical focus on one or more aspects of health care. However, at the time of the review, the Facility did not have a comprehensive set of integrated services policies, procedures, and guidelines. The draft clinical pathways included an integrated approach inclusive of the medical staff, nursing staff, and direct support professionals in such areas as seizure management and aspiration pneumonia prevention. More specific guidelines awaited development by the appropriate clinical departments. However, these draft clinical pathways/flow charts provided the integrated approach necessary for a successful quality program in health care.	Noncompliance

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

1. Change in health status should be a priority subject of in-service training for nurses, direct support professionals, and other residential management and support staff. (Section H.1)
2. Weights should be tracked on all individuals, with parameters set when to notify the PCP for significant weight loss or gain. (Section H.1)
3. For individuals readmitted to hospitals for the same signs and symptoms, at the time of discharge back to AUSSLC, critical assessment should occur to determine the cause of repeated decline (i.e., a determination of what tests have not been completed, but should be to provide additional information, or a new diagnosis that is treatable), as well as a review of all possible treatment options, surgical and medical. (Section H.1)
4. Clinical guidelines/pathways should be finalized and implemented. They should provide a timeframe and critical clinical steps in the work-up and treatment of common diagnoses and illnesses. Clinical indicators should be built into the pathway as a measurement tool, which can then be readily used for quality care measurement. (Sections H.1, H.3, and H.5)
5. The healthcare departments should review the capacity of the databases, and the capabilities of the software systems, and make changes, as appropriate. Quality and completeness of database entries also should be reviewed. Timeliness of data entry should be tracked to ensure the database is up-to-date. Identification of the reason(s) for the continued use of multiple conflicting databases and resolution into one quality database would be an important step. (Sections H.5 and H.6)
6. Quality review will require staff with time dedicated to record review, database management, and review of data. (Sections H.5 and H.6)
7. Based on the current policies and drafts available, the Medical Department is encouraged to develop clinical indicators as pilot initiatives. (Section H.5)
8. The Medical Department should focus on quality improvement initiatives using data that is known to be complete and accurate, while waiting

for the clinical guidelines/pathways to be finalized. (Section H.5)

9. The Medical Department might have to prioritize quality improvement endeavors using the quality of various databases as one parameter. However, as the Medical Department meets with the information technology staff, the Medical Department will have to determine ahead of time what it wants to measure (i.e., clinically meaningful data), and how it could be measured and quantified in a database. (Section H.5)
10. Once clinical guidelines are developed, the Medical Director should develop clinical measures (clinical indicators) that reflect success in treating the illness. It is recommended that for each clinical guideline, two or more clinical indicators be defined that can measure success of treatment (improved laboratory test results, functional improvement, reduction in medication, improvement in chest x-ray, improved findings on physical examination, etc.). (Section H.6)

SECTION I: At-Risk Individuals	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section I; o Presentation for Settlement Agreement Monitoring Team Visit for Section I, not dated; o DADS SSLC Policy #006: At Risk Individuals, dated 10/28/10; o SSLC Risk Guidelines-laminated copy; o AUSSLC At Risk Lists of Individuals (initial and final lists); o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) Evaluations, Aspiration Pneumonia/Enteral Nutrition (APEN) Evaluation, Nutrition Evaluation; OT/PT/SLP consultations for the last year, Personal Support Plan and PSP Addendums for the last year, including PSPA for PSP Risk Assessment, OT/PT/SLP Consultations for past year; Physical and Nutritional Management Plan (PNMP) with pictures, PST Integrated Risk Rating Form, PST Action Plan for Risk Assessment, person-specific monitoring, PNMP Clinic Notes for the past year, competency-based training for staff, supporting documentation for PST Risk Assessment and Action Plan and PNMT Action Plan implementation, Health Management Plans (HMP) (Nursing), and current Medication Administration Record (MAR) documentation for the following four individuals: Individual #286, Individual #452, Individual #6, and Individual #413; o The following documents: APEN Evaluation, Head of Bed Elevation (HOBE) Evaluation, PNMT Assessment and Updates, PNMT Action Plan, PSP and PSPAs for PNMT Action Plan, PNMP with pictures, Integrated Risk Rating Form, competency-based staff training by PNMT, individual-specific monitoring by PNMT and supporting documentation for implementation of PNMT Action Plan for the following two individuals: Individual #396 and Individual #199; o The following documents: OT/PT Evaluations, OT/PT Consultations for the past year, supporting documentation for individuals receiving direct OT/PT services, PST Integrated Risk Rating Form, PST Action Plan for Risk, PSP and PSPAs for the past year, PNMP with pictures, PNMP Clinic Notes for the past year, person-specific monitoring, competency-based training for staff, dining card/diet card, for the following three individuals: Individual #336, Individual #423, and Individual #194; o The following documents: Integrated Risk Tracking Form and Action Plan for Risk Assessment for the following Individual #72, and Individual #74; o The following documents: Integrated Risk Tracking Forms, Action Plans for Risk Assessments, PSPs and PSP Addendums, Nursing Assessments, and Health Management Plans for the following 23 individuals: Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, and Individual #424;

	○ At-risk individuals, 69-page report from new database using new at-risk process; ○ List of individuals who are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia with their corresponding risk severity; ○ Email dated 1/5/11, with Personal Support Plan Meeting Agenda; ○ Medical sections of the active record, Integrated Risk Rating Form, and Action Plans for the following individuals: Individual #396, Individual #339, Individual #5, Individual #81, and Individual #124; ○ Integrated risk rating form and action plans for the following individuals: Individual #72, and Individual #74; and ○ Three documents used in training the QMRPs who facilitate and document the PSP process, including: "Quick start for risk process," Frequently asked question regarding the aspiration pneumonia initiative, and "AUSSLC Action Plan shell." ▪ **Interviews with**: ○ Informational meeting reviewing the integrated risk rating form, and risk action plan with the Monitoring Team and PSTs of the following individuals: Individual #72 on 5/10/11 and Individual #74 on 5/11/11; ○ Connie Horton, APRN, State Office Consultant; and ○ Priscilla R. Hackett, MSN, MPH, RN, CCM, Chief Nurse Executive. ▪ **Observations of**: ○ PSP Meeting for Individual #107 on 5/9/11; ○ PSP Meeting for Individual #102 on 5/11/11; ○ PSP Meeting for Individual #82 on 5/12/11; and ○ Infirmary.
	Facility Self-Assessment: The Facility provided a very brief summary of steps taken to implement the At-Risk process. This included: ▪ With the implementation of the At-Risk Policy, there was initial training of professional staff on 12/21/10. ▪ The State Policy for At-Risk individuals was updated on 1/1/11 (#006), and later on 2/18/11 (#006.2). ▪ On 1/11/11, the QMRPs were trained on the new at-risk process. ▪ The projection was for all individuals to have been assessed for risk using the new policy guidelines (#006) by 3/31/11. The Facility determined it was progressing, but remained noncompliant in all areas of Section I. It will be essential as the Facility's self-assessment processes evolve for data to be included in the POI to substantiate compliance or noncompliance with the Settlement Agreement. Such data could come from a variety of sources, including audits, as well as other data sources, such as databases or outcome indicators.
	Summary of Monitor's Assessment: Using the at-risk process defined in DADS Policy #006, the Facility had completed risk ratings on each individual residing at AUSSLC. It was clear there was a learning curve

	for the different PSTs, and continual improvement was needed in this area. Some risk ratings were consistent with the State Office risk guidelines, and others were not. Teams were providing rationales for their decisions, although sufficient detail was not always recorded. For the teams to make quality decisions concerning risk ratings, and to develop action plans, the various team members will need to complete considerable preparatory work, and provide quality information to the teams. Teams can only discuss and make decisions based on the information presented to them. Additionally, teams need to think critically concerning preventing risk and reducing risk for those categories for which individuals are identified as being at highest risk. Each high-risk category should lead to a discussion of what other assessments and treatment options are available to reduce the risk. Currently, there were action plans developed without the recognition of the need for further assessment. To ensure uniformity across the campus, it would be helpful to have a staff person trained in the at-risk process, who could mentor the various teams. At this time, the quality of the outcome of the at-risk process varied greatly across the teams.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	In January 2011, AUSSLC had implemented the new risk system and State policy regarding At-Risk Individuals. The policy included Risk Guidelines, which were specific criteria to assist teams during individuals' PSP meetings to determine the appropriate risk levels for each risk indicator. The at-risk process was completed at annual PSP meetings for those who had an annual meeting scheduled between 1/1/11 and 3/31/11. An addendum meeting was scheduled for others. At the time of the review, the Facility reported that all the individuals had their risk levels reviewed and/or determined according to the new policy guidelines, and that a database for the at-risk ratings had been developed and was being updated. At the time of the review, the initial at-risk list that was provided to the Monitoring Team contained information about 178 individuals out of a total of 361 individuals. The final at-risk list that was provided, which was sent one week after the review, included information about 357 out of 361 individuals. Consequently, a comprehensive overview of the at-risk information was not available to the Monitoring Team while on site. Based on the Monitoring Team's observations of three PSPs and meetings with two additional individuals' teams, PSTs had made some minimal progress made regarding the at-risk process, as compared to the findings for this requirement from the previous review. Facility Administration provided guidance to all the teams through emails and attachments, including that the team should meet as changes in risk levels occurred. The instructions included that for "any individual with medium or high risks, an Action Plan must be created. You cannot simply state something like 'continue with the current plan.' You must describe exactly what safeguards are being put in place for the	Noncompliance

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		individual." There was also a blueprint of a "Personal Support Plan Meeting Agenda," which outlined and standardized the team approach to the discussion. The At-risk discussion was under agenda item #8, and was part of the integrated discussion that started with item #4. A series of bullets were provided to remind the PST the areas that needed to be covered during the at-risk discussion. Such instructions to the teams should assist in ensuring uniformity with regard to completeness and level of detail provided in the integrated risk rating form and action plan. However, administrative directives had added some concerns to the process. An email dated 1/5/11, discussed the at-risk discussions at the annual or addendum meetings. In the email it stated: "the physician should be present at the meeting, but the at-risk discussion can take place without the physician if necessary." Assuming the "meeting" this statement referenced was the annual or addendum meeting, it is concerning that the team could proceed with the at-risk discussion without the physician. Given the expertise of the physicians in medical areas, it would seem adequate discussions of risk could not occur without the physician present. From review of risk categorizations, physician input would be valuable to the team and the treatment of the individual. Further, the email stated that: "the physician is not the ultimate authority for the at-risk process; the whole PST shares authority." This would indicate the need for the physician to be present at the at-risk discussions, so that teams did not make decisions based on misinterpretation or misunderstanding of information. Further, with regard to complex medical conditions, the physician or PCP on the team brings education and expertise that other team members do not have. Although all members of the team should be involved in the decisions related to risk, for any risk ratings that diverge from the recommendations of the clinical discipline specifically assigned to that risk area as detailed in the State Office guidelines, the rationale should be well documented. There should be a system to resolve the conflict to ensure quality risk assessment and prevention. An additional step involving a brief meeting of the heads of the appropriately represented departments might resolve an issue. When the recommendation of a clinician is bypassed, factors that would need to be considered would be the concerns related to requiring tests which might not be needed, especially if they carry an additional risk, or the danger of minimizing a risk. To assess the Facility's risk screening process, members of the Monitoring Team observed three individuals' PSP or PSP addendum meetings (for Individual #107, Individual #102 and, Individual #82) while on site. Specifically, the observations of the PSPs indicated that: ▪ All appropriate disciplines were present at one (33%) of the PSPs. The individuals' PSPs/PSP addendum meetings that did not include all appropriate disciplines included: Individual #107 (Physician, Speech Therapist, Dentist, and	

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		Physical Therapist), and Individual #82 (Dietician, and Direct Support Professional). ▪ The staff present at the PSPs/PSP addendum meetings were the actual staff that worked with the individual and not substitute staff sitting in for other staff members for three (100%) of the PSPs. ▪ The individual was present at three (100%) PSPs/PSP addendum meetings. ▪ The PST used the Risk Level Guidelines when determining risk levels at one (33%) of the PSPs/PSP addendum meetings. The individuals' PSTs that did not use the Risk Level Guidelines when determining risk levels included: Individual #107, and Individual #82. ▪ The PST consistently used supporting clinical data when determining risks levels for one of the PSPs observed (33%). The individuals' PSTs that did not use supporting clinical data when determining risk levels included: o For Individual #107, the PST did not report the Dexa Scan results when assessing risk for osteoporosis. No clinical data was presented regarding seizures, such as the number of seizures that occurred in the past year, or the date of the most recent seizure supporting the assigned risk level. No Braden Score was presented to support risk for skin integrity. o For Individual #82, the PST assigned a medium risk level for gastrointestinal problems risk level, however, the PST did not know if there was a diagnosis of Gastroesophageal Reflux Disease. No supporting clinical data was presented regarding the risk for constipation. The PST did not report the number of seizures that occurred in the past year, or the date of the most recent seizure and could not find the Individual's Individual Notebook (I-book) to assess information regarding risks for seizures. The PST did not report the Dexa Scan results when assessing risk for osteoporosis, until a reviewer on the Monitoring Team asked. Specific clinical information including the Braden Score was not presented when assessing risk for skin integrity. In addition, specific clinical information was not presented when assessing risk for infections for an individual with chronic and recurrent infections. The Monitoring Team did note that there was some overall improvement for this indicator for one individual's PST (Individual #102). However, specific supporting clinical data should be used consistently when determining risks levels. Future compliance scores will reflect consistency for this indicator. ▪ The risk levels the PSTs designated were appropriate for each category for one individual (33%). The individuals' PSTs that did not appropriately designate risk levels included: Individual #107, and Individual #82. Due to the significant lack of clinical data the PSTs used to determine risk levels, and the lack of use of the Risk Guidelines, the Monitoring Team could not validate most of the risk levels the PSTs assigned.	

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		▪ There was clinical discussion among appropriate team members in decisions regarding risk levels in one (33%) PSPs/PSP addendum meetings observed. The individuals' PSPs where there was not adequate clinical discussions for making decisions regarding risk levels included Individual #107 and Individual #82, due to the significant lack of clinical data the PSTs presented when determining the risk levels for each of the clinical indicators. Although the Monitoring Team noted improvement for this indicator for one Individual's PST (Individual #102), the PSTs should continue to expand the depth and scope of the clinical discussions related to the risk indicators and levels. Future compliance scores will reflect the adequacy of these clinical discussions. ▪ Team disagreements regarding risk levels were noted in none of the PSPs. In the event this situation should occur, the Monitoring Team would evaluate the process of resolution based on the use of specific clinical data, the use of the Risk Guidelines, appropriate clinical judgment, and the use of a person-centered focus. ▪ The PSP facilitator kept the team focused for one (33%) of the PSPs/PSP addendum meetings observed. The individuals' PSPs/PSP addendum meetings where the facilitator did not keep the team focused included: Individual #107, and Individual #82. For these PSPs, the facilitator did not guide the teams to use specific clinical data and the Risk Guidelines to support the risk levels that the teams assigned to the individuals' health indicators. In addition, they did not keep the teams on track in addressing individual-specific issues succinctly, and ensuring that all team recommendations were adequately and clearly defined to facilitate follow-up. The facilitators for these PSPs did not appear to have a structured process for conducting the team meetings. Other positive observations from the Monitoring Team included: ▪ The PST for Individual #102 consistently used clinical data in conjunction with the Risk Guidelines when determining the risk levels. ▪ A number of the PST members for Individual #82 had a close relationship with the individual. ▪ Once the Dexa Scan score was reviewed for Individual #82, the PST appropriately rated the risk level based on the clinical data. Problematic areas that needing focus or improvement included: ▪ When determining risk levels, the PSTs should consistently use clinical data; ▪ Some team members were not aware of significant medical issues; ▪ PSTs were uncertain whether or not to rate risk levels based on if supports were in place, or to rate the risk as if the supports were not already implemented; ▪ Some rating of risks was based on "institutional" standards rather than how a community practitioner would rate the risk level (i.e., a lower standard was used, for example, with regard to dental health);	

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		▪ The facilitation of some of the PSPs lacked structure and focus; ▪ All appropriate disciplines were not present at the PSPs; ▪ A direct support professional familiar with the individual should be present at the PSP to provide the team their expertise regarding the individual's daily routines and status; and ▪ The Monitoring Team requested the Integrated Risk Assessment form and Action Plan for Individual #82. However, documentation received after the review from AUSSLC indicated "forms not ready." The Facility should complete the Integrated Risk Assessment forms and develop and implement Action Plans in alignment with the required timeframes. To further assess the risk rating and follow-up process, during the on-site visit, the Monitoring Team met with the PSTs for two individuals to review the completed integrated risk rating forms and the action plans. The following provides a summary of the review related to Individual #72. Further discussion about Individual #74 is located in the section of this report that addresses Section I.2 of the Settlement Agreement. ▪ Individual #72 recently had moved and had transitioned to a new PST. At the meeting with the Monitoring Team, both the old and new PSTs were in attendance. The new QMRP was the lead person for the teams. In reviewing Individual #72's risk ratings, she was determined to have no high-risk categories, and she was noted to be medium risk for aspiration based on two hospitalizations (from 11/2/10 to 11/16/10, and from 12/8/10 to 12/15/10). The hospitalization in 11/10 was defined as aspiration pneumonia, according to the aspiration pneumonia/enteral nutrition evaluation. She also had pneumonia in 12/10. Based on two recent hospitalizations for pneumonia, she would be considered high risk for aspiration. Although there might be differing opinions about etiologies of the pneumonia, given her history of dysphagia, and Gastroesophageal Reflux Disease (GERD), it would be difficult to separate the various etiologies of pneumonia in her case. It would be appropriate to take all steps to prevent both worsening dysphagia as well as reflux with dysphagia, and it would be meaningful to place her at high risk for aspiration. She also had a history of GERD, but there was no recent information that suggested a complete work-up of this potential cause of aspiration. She had periods of time with tachycardia and diaphoresis with or without fever. The team continued to search for an etiology, but it could represent worsening GERD with reflux aspiration. Under the risk category of gastrointestinal problems, GERD should have been listed as a known diagnosis, but the team needed to pursue evaluation to determine the current severity of this diagnosis. Finding significant GERD would change medical and surgical options for treatment. Considering she had a gastrostomy site and a PNMP positioning plan, she would be considered medium risk in this category, yet the PST determined she was low risk for	

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		gastrointestinal problems. Additionally, she was rated as low risk in the category of skin integrity, but her Braden scale score of 12, along with her use of adaptive equipment, such as a hospital bed, custom made contoured tilt-in-space wheelchair with Roho cushion, a Geo Mattress Pro, along with a history of wounds to her toe would suggest she was at high risk. (A Braden scale score of 13 to 14 suggested medium risk). She also was considered medium risk for osteoporosis. She was prescribed calcium and vitamin D. However, her last DEXA scan report, which was not listed as part of the rationale in the risk rating form, indicated a T-score of -2.4. A T-score of -2.5 indicates osteoporosis, and the T-score of -2.4 was reportedly several years old. It was not clear why the team had not reassessed her osteoporosis status by requesting an updated DEXA scan. The last category of "other" listed recurrent febrile episodes, and the team continued to track findings. It was recommended that the PCP review the record to ensure lab testing was current, and that the record reflected results of such tests as sedimentation rate, C-reactive protein, and testing for conditions that could present with her constellation of findings (lupus, etc.). The PNMT was represented at the meeting, but it became clear a recent evaluation and follow-up had not been shared adequately with the PST, and/or incorporated into the PSP. The PNMT should ensure their findings and action plans are incorporated into the PSP and PSP addendum, and their work should not be acted upon independently of the full PST. There was need for improved communication and coordination. This case suggested that the risk guidelines were not being followed, or when they were not followed, adequate justification provided to support the team's decision. An important aspect of this example was that the PST had not realized when more assessment was indicated to determine the actual risk level for a number of categories. Five records were reviewed to evaluate the risk process that had been implemented. The following summarizes these reviews: ▪ Individual #396 had a number of urinary tract infections (UTI) in the past. More recently she developed respiratory problems. She was hospitalized from 7/09 to 8/09, at which time a gastrostomy tube (G-tube) was placed. She was hospitalized for pneumonia, following emesis on 2/28/10, and for restrictive lung disease on 3/24/10 (she had an elevated left diaphragm). She was sent to the Emergency Room (ER) for respiratory distress on 4/3/10, and her G-tube feeding rate was lowered, because the increased rate caused transient aspiration. On 12/29/10, she was hospitalized for emesis, respiratory distress, and hypotension. On 1/21/11, she was hospitalized for asthma and bronchospasm, chronic dysphagia, and a urinary tract infection. She was admitted on 2/20/11 for reactive airway disease. According to the hospital record, she had chronic dysphagia with difficulty managing secretions. On	

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		4/15/11, she was admitted to the hospital for severe respiratory distress, severe bronchospasm, a urinary tract infection, and sepsis (pseudomonas). It was noted that many of these episodes of bronchospasm required prednisone administration and tapering. There was a note from 2/11/11 that the PNMT evaluation process had begun. On 4/4/11, her vitamin D level was reported as low. On 2/9/11, the integrated risk rating form for Individual #396 was completed, and there were no further addendums submitted, despite two additional hospitalizations. She was considered high risk for respiratory compromise due to her restrictive lung disease and bronchospasm. This was consistent with the SSLC Risk Guidelines. She was also considered high risk for weight, for an increase of 10 pounds in the month prior to the PST meeting for the integrated risk rating form. It was not noted if her weight continued to be problematic. She was 25 pounds above her desirable weight range. During the many hospitalizations, she required treatment with prednisone, which has the tendency to induce weight gain, but this was not mentioned in the rationale. She had many medium risk categories. There were two concerns noted. For aspiration, the team documented there was no previous documented history of aspiration pneumonia. However, there was some re-interpretation of the cause of pneumonia once the individual returned to the Facility, and the hospital information was reviewed. The hospital record mentioned several times the possibility of aspiration pneumonia. Of interest, she had on more than one occasion of emesis, followed by bronchospasm and respiratory distress, suggesting reflux and aspiration. However, from the information received, there was no information that a GERD work-up had been completed to ensure she was not refluxing. Given her high diaphragm, and based on her history of frequent bronchospasm, it was unclear why GERD testing had not been completed recently to rule this disorder in or out. If testing occurred for GERD, but it occurred greater than six months ago, it might need to be repeated. The increased hospitalization rate was concerning, and an aggressive approach would be important. Given the distorted anatomy of her upper abdomen, it was unclear why a surgical consultation had not been sought to assist in determining if she were a candidate for a fundoplication, a jejunostomy tube (J-tube) placement, or a tracheal esophageal separation. It also was not reported when her last swallow study was completed, and if it had been six months or more, or if there had been changes (and there had been several hospitalizations in the past few months), it was unclear why consideration had not been given to repeating this test. I t was also unclear, based on the number of hospitalizations in a short time, the reason for the PNMT to only become involved on 2/11/11.	

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		This occurred after the 2/9/11 integrated risk meeting, but no further meeting and risk rating was submitted. This suggested a need to prioritize the long list of individuals needing review by the PNMT. She also developed a number of urinary tract infections, and in 4/11, developed sepsis with pseudomonas growing from both urine and blood. Given sepsis has a high mortality rate, the team should have met after the 4/11 hospitalization to reassess her risk category for urinary tract infections. This might have occurred, but no information was submitted to indicate an addendum had been completed. There was also the high-risk category of fractures due to the history of prednisone use and history of osteoporosis. No T-score from the latest DEXA was recorded, and this would be helpful as part of the rationale in this section. However, the level of risk appeared appropriate. ▪ A number of documents were submitted for Individual #339. From review of the IPNs, there was discussion about reducing his phenobarbital, as he had been seizure free since the year 2000. However, review of information indicated whenever he was tapered from phenobarbital, the seizures would eventually recur. The neurologist suggested that if hyperactivity was a concern, the psychiatrist should provide an opinion and alternative antiepileptic medication could be chosen. The other note of interest was an incidence of pica that occurred 12/19/10. There was no note in the IPN about the pica event on 12/19/10, and there were brief follow-up nursing notes on 12/20/10 focusing on nursing assessment. There was no mention of the item ingested, although the BSP, revised 4/20/11, indicated there was a history of ingesting dangerous items. On 2/10/11, the integrated risk rating form for Individual #339 was completed. The only high-risk rating was under dental, due to a poor oral hygiene score, and the need for IV sedation for evaluation and treatment. Seizures was considered medium risk, although according to the risk guidelines he would have been considered low risk, because he had no seizures in 11 years. Of concern was the pica incident on 12/19/10. Unfortunately, information was not submitted describing the inedible item or liquid ingested, or the circumstances. This lack of documentation in the IPN was concerning, and each department involved (psychology, nursing, medical) should review the reason for lack of entries related to this serious behavior into the IPN, more so as the BSP confirmed the seriousness of his ingestions. Given the serious nature of pica, the only category applicable under the risk guidelines would be challenging behavior, although the descriptions of medium and high risk appeared not to readily apply to the pica behavior. He would appear to be higher than medium and lower than high. Further fine-tuning of the risk guidelines might produce subcategories of the	

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		diverse topic of challenging behavior. ▪ Individual #5 had a history of pica, and insertion of foreign objects to her nose (bean, fibrous material, wooden toothpick, gum wrapper, plastic, foam rubber). These were documented up through 2008. More recently, she was reported to have swallowed something (a piece of paper was considered, and cardboard was found in her mouth which was removed), but there was no further information submitted about this event that occurred on 2/6/11. There was also the notation from 11/4/10, which the mother/guardian limited testing and evaluations, and the identified tests would need her agreement. Her integrated risk rating form was completed on 4/8/11. She was considered low and medium risk for the areas the team discussed. However, several areas remained blank, including challenging behavior, which was of concern considering her pica behavior. The choking risk was left blank, although the action plan included the goal to not have any choking episodes. She did have a diagnosis of dysphagia, requiring thickened liquids, and was an unsafe eater due to rapid eating and stuffing her mouth. The integrated risk rating form was incomplete. ▪ Documents were submitted for review for Individual #81. In the past, he was diagnosed with dysphagia and GERD, and underwent a gastrostomy tube placement in 12/09, and a fundoplication. On 10/26/10, he was admitted to the hospital for fever, hypoxia, and cough. He had been admitted to the hospital three times in the prior year with similar symptoms. The 10/26/10 admission occurred after dental treatment requiring sedation, after which he was transferred to the Infirmary, at which time he developed the symptoms leading to a hospital admission. He developed a left lower lobe lung infiltrate and was treated for pneumonia. On 11/2/10, he was discharged with a diagnosis of aspiration pneumonia. On 2/20/11, he was seen in the ER for percutaneous endoscopic gastrostomy (PEG) tube replacement. On 2/21/11, he returned with fever, hypoxemia, and rigid abdomen. The tube was found to be outside of the stomach. He underwent surgery for repositioning of the PEG tube, as well as washing out of the feeding formula from the peritoneal cavity. On 3/2/11, he was discharged with resolving chemical peritonitis. On 3/4/11, his abdominal wound reopened, and he returned to the ER for evaluation. On 3/9/11, he was sent to the ER because the tube had clogged. On 3/30/11, he was discharged home. The PCP wrote a thorough note, also mentioning his history of multiple fractures and the increased risk of osteoporosis. At that time, a DEXA scan was scheduled with sedation. On 4/14/11, he returned to the ER, because the tube had clogged and this was replaced. On 4/19/11, he developed fever and cellulitis of his buttocks, and was transferred to the Infirmary. He was discharged back home the following day, on 4/20/11. His buttocks lesion grew	

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		Methicillin-resistant Staphylococcus aureus (MRSA). On 4/24/11, he was admitted to the Infirmary for observation and oxygen (O2) administration because of low oxygen saturation on the home. On 12/13/10, the PT noted that he was sitting halfway out of his wheelchair when he self-propelled. He was unable to hold a correct position, and was scheduled to see the wheelchair clinic. On 3/30/11, the integrated risk rating form for Individual #81 was completed. He was considered high risk for dental health, as well as urinary tract infections. Despite three to four hospitalizations in 2010 for fever, hypoxia, and cough, he was considered only medium risk for aspiration and respiratory compromise. It would appear that he met the criteria for high risk for respiratory compromise, based on the risk guidelines. He also would have been high risk for infection, because he had an open surgical wound. Further with the tube clogging at least twice in a short period of time along with the tube being placed outside the stomach, he would appear to be at high risk for gastrointestinal problems. ▪ Individual #124 had a fracture of his foot (1994), finger (2000), forearm (1997), and toe (2009). His vitamin D level was low in 2008. Medications included Divalproex ER and Sertraline for mood disorder. He had a history of constipation, and had been ordered Miralax and Lactulose, but refused medications, and refused to be checked for impaction when indicated. His orders were changed to Dulcolax suppository, which he tolerated on 3/7/11. On 1/13/11, he had signs and symptoms of a UTI, and was prescribed an antibiotic. He was uncooperative with a post void residual evaluation. He did not require any hospitalizations in the past six months. For Individual #124, the Integrated Risk Rating Form was completed on "4/11/10 (sic)." He was considered moderate risk for choking due to a textured diet, moderate risk for constipation due to need for routine medication to treat this diagnosis, moderate risk for fractures due to the fracture in 2009, and moderate risk for challenging behaviors due to the need for a BSP. These were appropriately rated risks. The following were noted from the record review of these five individuals: ▪ It was not possible to determine if appropriate disciplines were present at the PSP. Actual copies of attendance sheets were not provided when the PSP was copied. ▪ The actual attendance sheets were not included, so could not be determined if the individual present at the meeting. ▪ In five out of five reviews, the PST used the Risk Level Guidelines when determining risk levels. ▪ Although all five teams used clinical data to determine risk levels, as is described	

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		in detail above, only Individual #124's team had considered all of the relevant data (20%). ▪ As described in detail above, in one out of five (20%) (Individual #124), designated risk levels were appropriate for each category (i.e., the team provided adequate justification). From the Monitoring Team's observations, the Facility should consider additional training for PSTs regarding the at-risk process. This is necessary to ensure that the PSTs adequately identify critical and significant clinical issues, so that appropriate and clinically sound action plans can be developed to address the risks identified.	
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.	Based on a review of records for 25 individuals determined to be at risk (Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, Individual #424, Individual #413, and Individual #286), there was documentation that the PST started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals. Examples of records that did not contain documentation of this requirement included: ▪ Individual #413 died on 1/10/11. He was on the Pneumonia Target List for aspiration pneumonia on 6/1/10 and 10/1/10. The PST had not completed an Integrated Risk Rating Form, nor had he been referred and/or assessed by the PNMT. ▪ Individual #286's Integrated Risk Rating Form, dated 2/9/11, documented high risk for aspiration and respiratory compromise. Individual #286 had been admitted to the hospital on 5/6/11 with a diagnosis of rule out aspiration pneumonitis and urinary tract infection. His Action Plan service objectives were "[Individual #286] will display the best possible health as evidenced by no episodes of aspiration pneumonia in the next 12 months." His action plan was not reviewed and/or updated to address his change in status related to his hospitalization. ▪ Individual #426 was rated as at high risk for aspiration on the Integrated Risk Rating Form, dated 2/10/11, due to being hospitalized five times in the past year related to respiratory/aspiration issues. An Aspiration Pneumonia/Enteral Nutrition Evaluation was not completed until 3/27/11. In addition, the recommendations found on the assessment regarding positioning for meals and bathing were not integrated into the individual's PSP or nursing's Health Management Plan. In spite of the frequent hospitalizations for Individual #426 for respiratory/aspiration issues, assessments were not initiated within five	Noncompliance

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		working days of the individual being identified at high risk as required. ▪ For the following records, there was either inadequate documentation, missing documents such as PSPs and/or Action Plans, and/or missing dates found on documents. As a result, it could not be determined exactly when the individuals were identified as being at risk, what assessments were actually conducted, and if or when Action Plans were developed, and if these Action Plans were integrated in the PSPs: Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, and Individual #424. <u>Nursing Assessments</u> Based on a review of 23 individuals' records for which assessments were to be completed to address the individuals' at risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, and Individual #424. From discussion with the CNE, Nursing was using the last quarterly or annual Nursing Assessment to meet this requirement, even if it had been completed up to three months prior to the meeting held to determine risk levels. A review of the Nursing Assessments for the above 23 individuals found that they were not adequate assessments, in that they did not specifically address the high risk indicators, and were not updated regarding health issues related to the high risk health indicators. The following provides examples of assessments that did not adequately address the health indicators designated as high risk: ▪ The Integrated Risk Rating form, dated 4/1/11, indicated that Individual #404 was designated as high risk for cardiac disease due to hypertension. The Comprehensive Nursing Assessment, dated 3/18/11, noted only that the individual "had had fairly stable BP [blood pressure]," and that she was being monitored three times a day for hypertension prior to receiving medications. ▪ The Integrated Risk Rating form, dated 3/17/11, indicated that Individual #111 was designated as at high risk for weight loss issues. The Comprehensive Nursing Assessment, dated 2/9/11, basically noted only the individual's weight for the previous months, although weekly weights had been ordered, with a note next to the weights listed for November 2010, January 2011, and February 2011 that there was "possible scale inconsistencies," without mention of follow-up to	

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		ensure that all weights obtained were accurate. ▪ The Integrated Risk Rating form (not dated) indicated that Individual #214 was designated as being at high risk for dental issues, with an associated Action Plan dated 3/ 28/11. The Comprehensive Nursing Assessment, dated 11/1/11, that was completed four months prior to the development of the Action Plan, did not address any issues or problems related to the individual's dental status. Based on an interview with the State Coordinator for Specialized Services, State Office Nurse Practitioner Consultant, and Nursing Discipline Coordinator, there was no indication that the current Comprehensive Nursing Assessment form had been reviewed to determine if it would appropriately meet the requirements of an adequate assessment tool for addressing risk areas. It also did not appear that the need for the information contained in the Comprehensive Nursing Assessments to be updated in response to the identification of health risks had been identified specifically as a necessary component of the process. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. <u>Physical and Nutritional Management, and/or OT/PT/SLP Assessment</u> Based on a review of two individual's records for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate physical and nutritional management, and/or OT/PT/SLP assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included Individual #199, and Individual #396. The following provides examples of assessments that were not comprehensive: ▪ Individual #199's Integrated Risk Rating Form, dated 3/4/11, assigned a risk rating of medium although the Pneumonia target group list documented he was hospitalized on 8/10/09 and 2/17/10 for aspiration. There was no signature page attached to determine if the PNMT had been involved in the completion of the risk ratings. The PNMT Evaluation, dated 4/15/11, stated: "His aspiration risk is rated medium because there are measures in place that limit aspiration risk." Individual #199's aspiration risk should have been rated as high per established risk clinical data guidelines. The inaccuracy in the determination of risk level identification resulted in the development of an inaccurate and inadequate action plan. ▪ Individual #396's Integrated Risk Rating Form, dated 2/10/11, documented her risk rating for aspiration as medium. The Pneumonia target list documented that Individual #396 had been diagnosed with aspiration on 7/4/09, 2/28/10, and 12/28/10. Her risk rating for aspiration should have been high. This error would impact the PNMT evaluation and action plan. The inaccuracy in the determination of risk level identification resulted in the development of an	

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		inaccurate and inadequate action plan <u>Medical Assessments</u> The Monitoring Team met with PST of Individual #74 to review the integrated risk ratings and the action plan. On 4/8/11, there had been a PSP addendum meeting held. She was considered high risk in the categories of respiratory compromise, weight, diabetes, and dental care. For someone who had a diagnosis of Prader Willi syndrome and obesity, the implementation guidelines under the weight category did not meet the individual's needs. The section appeared to have been cut and pasted from elsewhere, as the gender and comments appeared to belong to another individual. For instance, there was a focus on ensuring the individual consumed 75% of snacks, when the need for weight loss suggested snacks did not need to be encouraged. The plan included the specific trigger of lack of interest in food, when actually the individual was often focused on eating, suggesting a lack of understanding of her diagnosis of Prader Willi syndrome. The role of psychology and psychiatry in addressing her food seeking behavior and the Prader Willi syndrome were not referenced under the weight section of her PSP addendum. The role of a formal exercise program and dedicated staff to assist in completing a prescribed exercise program was also not mentioned in this section. The integrated risk rating form appeared to follow the risk guidelines, but did not appear to have an action plan that was helpful to the individual in reducing these risks. An additional five records were reviewed to determine if adequate medical evaluations and assessments had been completed, and the following summarizes these reviews: ▪ For Individual #396, as mentioned previously, there were three high-risk areas identified. On review of the action plans, there appeared to be little critical thinking concerning next steps in assessment/evaluation. As mentioned with regard to Section I.1, she may have had significant dysphagia, and serious GERD, but it was unclear if evaluations had been completed recently. The repeated events of emesis and respiratory distress suggested severe GERD as a cause for her reactive airway disease. It was unclear if further surgical procedures had been considered as potential options, if appropriate. Referrals to pulmonary medicine and ENT would assist the team in providing important aggressive next steps. Given her hospitalizations and recent sepsis, the PNMT should be following her closely, and assisting the team in completing evaluations and ensuring proper positioning. ▪ For Individual #339, action plans provided many training/service objectives, but there was no review of needed assessments or next steps to resolve issues. This might have been due to the categorizations of risks as medium to low in all but dental. However, there was no action plan to attempt to reduce the high-risk dental category. This would have been an excellent opportunity for team discussion to assist the Dental Department in reviewing the obstacles to	

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		compliance with dental visits and a dental evaluation. The plan should have included the current status of desensitization plan development and implementation, as well as tooth brushing mentoring in the residence. Pica was not addressed in an aggressive way in the plan, other than to refer to the BSP. The BSP had been revised since then, but there was no information as to whether it revised the section on pica prevention or monitoring. Also, as there was a consideration to change from phenobarbital to another antiepileptic medication, action steps should have reflected collaborative steps between neurology and psychiatry, and communication with family members as needed. ▪ For Individual #5, information was not submitted as to whether the BSP was updated to reflect the recent pica incident. Further evaluations were limited by the mother/guardian request to not complete further testing. To ensure understanding of the health and behavior concerns by the mother/guardian, it would be important to have the mother/guardian attend the PST in person or by conference call. This would allow the team to understand the rationale of the mother/guardian and to proceed in a unified manner. ▪ For Individual #81, his action plans did not appear to question the frequency of hospitalizations for fever, cough, and hypoxia. Further evaluation was indicated, as he has had several admissions with the same symptoms. He had had a fundoplication, but the Medical Department needed to ensure it remained tightly wrapped. If it were not functioning properly, GERD would recur. A further work-up for GERD was indicated, to ensure maximum treatment. He also had difficulty with clogged and displaced feeding tubes, and the plan should have addressed this with competency-based training of feeding tube care and complications. All of these areas needed to be included in the action plan. Given that several events occurred after the 3/30/11 integrated risk rating form was completed, an addendum would need to be considered. ▪ For Individual #124, the action plan did not indicate the need for further evaluation or review of interventions. This was problematic in two areas. He had several fractures in the past, was prescribed Divalproex, and had a low vitamin D level. These heighten concern for osteopenia/osteoporosis, but there was no information indicating he had completed a DEXA scan. If that had occurred, it should have been listed on the integrated risk rating form. If one had not been done, it should be considered to verify that he did not have osteopenia/osteoporosis. Further, he cut himself with glass on 2/25/11. From the IPN, it was documented that "resident cutting himself with a piece of glass that is part of his behavior support plan." Additionally, he refused medications and examinations at times, and there was no discussion in the action plan about how to improve cooperation and compliance. Both these areas would best be resolved through an updated BSP, and/or retraining of staff. However, the action plan focused on monitoring steps.	

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		In summary: ▪ Based on a review of five records for individuals determined to be at risk, there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individual being identified as at risk for two out of five records. A basic systemic issue was the lack of identification of need for assessment. ▪ Based on a review of one individual's record in response to change in an at risk individual's condition (Individual #396), there was no documentation that the IDT started the assessment process as soon as possible, but within five working days of that individual's change in the at risk condition. ▪ Based on a review of five individual records for whom assessments had been completed to address the individual's at risk conditions, one out of five (20%) included an adequate medical assessment to assist the team in developing an appropriate plan. This was for Individual #5. Records did not contain documentation of this requirement in the other records reviewed, as described earlier in this section.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	Based on a review of 30 records for individuals determined to be at risk (Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, Individual #424, Individual #423, Individual #194, Individual #124, Individual #5, Individual #339, Individual #81, and Individual #336), there was documentation that the Facility: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in two out of 30 of the (7%) cases (i.e., Individual #124 and Individual #5). ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the PSPs in one of the 30 cases (3%) (Individual #396). ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ For none of the plans (0%) were appropriate, functional, and measurable objectives incorporated into the PSP to allow the team to measure the efficacy of	Noncompliance

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		the plan. ▪ Plans included the clinical indicators to be monitored and the frequency of monitoring for none of the individuals (0%). The following are examples of plans that were inadequate to address the at-risk factors identified for the individuals: ▪ Individual #423 was hospitalized on 2/2/11 and discharged with a diagnosis of aspiration pneumonia. His Integrated Risk Rating Form, dated 3/24/11, placed him at low risk for aspiration, and the rationale presented was "does not meet criteria." Individual #423 had experienced aspiration within the past year and per established risk guidelines would be rated at high risk. He was rated at high risk for choking, weight, and dental. His Risk Action Plan was not sufficient. Recommendations were made in the rationale section of the Integrated Risk Rating Form that were not reflected in his PSP health objectives. ▪ Individual #194's Integrated Risk Rating Form, dated 4/8/11, documented her at medium risk for aspiration pneumonia, even though she was diagnosed with aspiration on 3/19/10. No risk action plan was developed. Her most current OT/PT Update was dated 7/19/10 for OT and 8/12/10 for PT. A Consultation Report was requested as "[Individual #194] has had reduced oral intake with weight loss from 120-122 pounds down to a February 2011 weight of 103 putting her below her EDWR [estimate desired weight range] of 112-128. It has been reported that she has been complaining of her throat hurting." The consultation stated: "The team needs to meet to assess the risk vs. benefit of [Individual #194] continuing to eat by mouth. Although she has a long history of pneumonias, it appears that pneumonias have become more frequent in the past three years. Silent trace aspiration on video has been infrequent. Her esophageal dysmotility poses the risk of food stacking up in the esophagus and possible (sic) backing up to the level of the pharynx. This would put her at greater risk of aspiration. Although esophageal clearing is show with liquid during a brief video, this may not be predictive of what happens during a meal." There was no PSPA to discuss the results of the consultation report, no APEN evaluation had been completed, and no referral to the PNMT due to possible placement of a feeding tube. Individual #194 was hospitalized on 5/6/11 with a diagnosis of aspiration pneumonia and UTI. ▪ Individual #336 was diagnosed with aspiration pneumonia on 6/22/10. His Integrated Risk Rating Form, dated 1/13/11, did not rate him at high risk for aspiration. He was rated at medium risk for aspiration and the rationale presented was "[Individuals #336] has the potential for aspiration based on his DX [diagnosis] of seizure disorder, moderate GI reflux, altered diet texture (finely chopped) and fluid consistency (honey)." A Physical Nutritional	

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		Management Plan Coordinator (PNMPC) had completed a Simple Thick Competency check sheet. No other competency check sheets had been completed. His PNMP, revised 4/8/11, provided staff strategies for mobility, transfer, hearing aid, positioning, bathing, compressive socks and dining plan with choking and aspiration triggers and staff instructions. ▪ Individual #360 was designated as being at high risk for challenging behaviors on the Facility's At Risk list. However, there was no section found on the Integrated Risk Rating form, dated 3/8/11, addressing behaviors. The Action Plan provided in the documentation request was not dated, but indicated that a Positive Behavior Support Plan and Safety Plan had been initiated on 2/2/11. There were no specific comments included in the plan indicating why the Behavior Plan initiated a month prior to the high risk rating for challenging behaviors was not modified, or if it was having a positive effect, and the data supporting either status. ▪ Individual #424 was designated as being at high risk for weight issues on the Integrated Risk Rating form, dated 2/8/11, only stating that the individual was 20% over the desired weight range. The Action Plan, dated 8/18/10, indicated that the individual would "maintain the best possible health as evidenced by a loss of at least 20 pounds within the next 12 months." However, there were no specific interventions listed as to how this was to be accomplished, with only a reference to the Health Management Plan, which also did not include any specific strategies to assist the individual with the needed weight loss. There was nothing contained in the Action Plan that adequately addressed the need for increased clinical intensity related to a high risk rating regarding weight issues. Thus, there were no aggressive or proactive interventions included in the action plan. Consequently, the action plan for this high-risk health indicator was inadequate. ▪ For Individual #396, the action plan appeared only to continue the current treatment, which appeared not to work well, as she required repeated hospitalizations. The next step would be to reconvene and review the need for further assessments. There should be clear evidence that she does not have aspiration and does not have GERD, or if these are diagnosed, aggressive treatment is recommended. ▪ For Individual #339, the high-risk category of dental hygiene did not have an action plan. As mentioned, this would have been an important time to review the status of desensitization plans for this individual, as well as tooth brushing mentoring and training in the residential environment. There was no action plan concerning his recent pica incident and continued risk of his ingesting potentially dangerous items. There was no further discussion about the consideration of changing antiepileptic drugs, and the need to coordinate this	

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		decision with the psychiatrist, PCP, and family members. ▪ For Individual #5, the action plans were brief. The plan concerning hypothyroidism appeared to be written without the input from the physician, as clinically it was not a helpful action step. The action step: "[Individual #5] will have zero episodes related to hypothyroidism," suggested the need to educate the team. Findings of hypothyroidism are subtle, and do not usually produce acute episodes. Monitoring of blood levels to ensure optimal replacement therapy might be a more practical action step. The action plan should have required review of the current plan for pica behavior surveillance reporting, and prevention. If pica is infrequent, staff might need refresher training on how to address the behavior. Based on the recent pica event, there should be an action step for pica prevention. ▪ For Individual #81, the action plans were brief. Although goals were clear, there appeared to be no new steps to be taken or tools utilized. He had several hospitalizations for respiratory compromise, but there was no action step to maximize therapy, or to investigate the frequency of pneumonia. Given the complications following dental anesthesia, the plan should include a desensitization plan that would be applicable in the Dental Department, as well as in the residential setting for a tooth-brushing program. ▪ For Individual #124, the action plans were brief, and the PST did not question the need for further assessments, despite the various concerns mentioned with regard to Section I.2. In reviewing the documentation provided, there were a number of barriers rendering it difficult, if not impossible, in some cases, for the Monitoring Team to assess the requirements reflected by the indicators listed in Sections I.2 and I.3, such as: ▪ The lack of dates on documents; ▪ The lack of documents provided such as PSPs, Action Plans, and Integrated Risk Assessment Rating forms, which were either not completed, or not included in the document requests; ▪ Lack of clarification regarding nursing assessments included in the At-Risk Individuals policy; ▪ Discrepancies between documents regarding risk ratings; and ▪ The lack of completeness of the Facility's At-Risk list. The at-risk process appeared to be an active component of healthcare and safety on campus. The various PSTs were learning the process, and were experiencing various levels of success in rating risk categories for individuals, identifying the need for assessments, developing action plans, and implementing plans that reduced the risks identified. From the meetings that the Monitoring Team had with PSTs for two	

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		individuals, it would seem important that one or more staff on campus be thoroughly trained on the at-risk process, and be assigned full-time as mentors for all the PSTs in ensuring a successful at-risk process for each individual residing at AUSSLC. As AUSSLC progresses in developing its at-risk system, monitoring and tracking systems should be developed addressing the Facility's compliance with the requirements of the Settlement Agreement for Section I, which include the specific indicators noted above. Due to the critical nature of the at-risk system to the health and wellbeing of the individuals at AUSSLC, continued development of this area should be considered a priority.	

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

1. In prioritizing involvement in the PSP/at-risk process, PCPs should be expected to attend the at-risk discussion to ensure teams arrive at clinically appropriate conclusions. (Section I.1)
2. The risk guidelines should be reviewed to determine if further subcategories are needed to address the diverse topic of challenging behavior. (Section I.1)
3. All risk categories on the integrated risk rating form should be discussed and completed. (Section I.1)
4. For any risk ratings that diverge from the recommendations of the physician or other clinical discipline specifically assigned to that risk area as detailed in the State Office guidelines, the rationale should be well documented. If a conflict cannot be resolved, there should be a system to resolve the conflict to ensure quality risk assessment and prevention. (Section I.1)
5. Additional training on the at-risk process should be provided to the PSTs. This is necessary to ensure that the at-risk process adequately identifies the critical issues, and that appropriate and clinically sound action plans are developed to address the risks identified. (Sections I.1, I.2, and I.3)
6. To standardize the team process, one nurse and one behavior analyst should be trained on implementation of the new risk rating process, risk action plan development, and plan implementation process. These staff could then act as mentors (not as members of the PSTs) for the risk process implementation, and attend as many of the PST meetings as possible to ensure basic aspects of the new policy and procedure are followed. (Sections I.1, I.2, and I.3)
7. When the team convenes about an individual, the departments responsible for background information concerning a risk category should be sufficiently knowledgeable about that category to explain the risk to the remainder of the team. (Section I.1)
8. Each PST member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating.
9. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
10. When there is a change in health status, the PST should reconvene to rate the categories of risk, and incorporate any changes in health into the risk categories and into a risk action plan. Particularly, when an individual is hospitalized and subsequently discharged home, the PST should meet promptly address any changes in health and functional status. (Sections I.1, I.2, and I.3)
11. The PCPs should ensure complete and timely assessments are ordered, and results incorporated into the individual's treatment and care. The risk action plan requires critical clinical thinking on how to prevent recurrences such as ER visits or hospitalizations to improve the quality of life by improving the health of the individual. (Sections I.2 and I.3)
12. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)

13. Given that PSTs, at times, do not realize when more assessment is indicated, and department heads should review PST findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
14. The PNMT should prioritize their reviews to address the needs of the most critically ill (i.e., those with frequent hospitalizations). (Section I.1, I.2, and I.3)
15. The PNMT should ensure their findings and action plans are incorporated into the PSP and/or PSP addendum, and that their work is not acted upon independently of the full PST. (Section I.1, I.2, and I.3)
16. If an action plan item is deferred to a member of the team, that team member should have a document trail for implementation of the plan, and should document closure of the issue. (Section I.3)
17. As individuals' risks are identified, and risk action plans are developed, teams need to review the steps taken to ensure they are completed in a timely manner they actively reduce risk. In order for this to occur, measurable objectives or indicators need to be established to allow the team to measure whether or not the individual is better or worse, and if his/her risk level is reduced. If a plan is not working, the team needs to reevaluate it, and potentially revise it. (Section I.3)
18. The Facility should monitor the PSPs to ensure the risk ratings and action plans are integrated into them. (Sections I.1, I.2, and I.3)
19. As the Facility progresses in developing the At-Risk System, monitoring and tracking systems should be developed addressing the Facility's compliance with the requirements of the Settlement Agreement for Section I. (All sections of I and Facility Self-Assessment)

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, dated 5/9/11; o Emergency chemical restraint procedures; 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 (20% of individuals) who were receiving psychotropic medication: ▪ Individuals who were selected because of the acuity of their psychiatric illness: Individual #139, Individual #360, Individual #74, Individual #406, Individual #341, Individual #83, Individual #175, Individual #77, Individual #283, Individual #19, Individual #421, and Individual #108; ▪ Individuals whose records were produced in the pre-onsite review document request: Individual #291, Individual #355, Individual #210, Individual #320, Individual #350, Individual #424, Individual #8, Individual #158, and Individual #109; and ▪ Individuals whose names were selected randomly from the list of individuals receiving psychotropic medication: Individual #82, Individual #338, Individual #270, Individual #238, Individual #301, Individual #208, Individual #369, Individual #271, Individual #80, Individual #289, Individual #126, Individual #152, and Individual #16; The following sections of their records: ▪ The annual medical history; ▪ Physical Exam; ▪ Active Problem List; ▪ The psychiatry section; ▪ The BSP/behavior services section; ▪ Side effect [Monitoring of Side Effects Scale (MOSES)/ Dyskinesia Identification System: Condensed User Scale (DISCUS)] screening section; ▪ Rights section, including "Human Rights section" and "consents;" ▪ The pharmacy section; ▪ The neurology section (from the consultation section); and ▪ Documentation concerning the use of "pretreatment sedation" medication for dental appointments. If the individual had a Rights restriction regarding pre-treatment sedation for dental appointments, documentation of the Desensitization Plan; o Blank chemical restraint consultation form; o Minutes of the pre-treatment sedation committee meetings held 9/16/10, 10/25/10, 3/10/11, and 4/28/11;

	○ Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS, with scores and completion dates for all individuals who are followed in Psychiatric Clinics, dated 4/15/11; ○ Evidence tab for presentation book for Section J of the Settlement Agreement; ○ Four examples of completed Comprehensive Psychiatric Evaluations (CPEs); ○ The minutes of the monthly poly-pharmacy committee meetings, dated 12/16/10, 1/13/11, 2/10/11, 3/10/11, and 4/14/11; ○ List of individuals who have been administered the Reiss screen instrument, dated 3/31/11; ○ A copy of the Reiss screening instrument for every fifth individual that appeared on the list; ○ List of individuals who, in the last six months, were referred for a psychiatric evaluation as a result of an elevated score on the Reis screen: None; ○ Any Quality Assurance internal audits that were related to psychiatric services: Response that 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; ○ Curricula Vitae (CVs) of all psychiatrists employed at AUSSLC; ○ Weekly schedules for psychiatrists; ○ List of meetings and rounds attended by psychiatrists; ○ Criteria for determining usage of oral sedation or 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 polypharmacy, including intra-class polypharmacy; ○ Dental Desensitization Policy, dated 4/1/11; ○ List of individuals prescribed psychotropic medication, including medication and psychiatric diagnosis; ○ Integrated Risk Rating Form and related clinical documentation for Individual #72; ○ List of individuals prescribed intra-class polypharmacy, dated 4/15/11; ○ 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; and ○ List of individuals receiving benzodiazepines (with names of medication(s) prescribed, start/stop dates, and duration(s) of use. ▪ **Interviews with:** ○ Jose Levy, Director of Behavioral Services; Christy Pierce, Assistant Director of Behavioral Services; and Bruce Weinheimer, Discipline Coordinator for Psychological Behavioral Services for the State Supported Living Centers, on 5/10/11;

	○ Judi Stonedale, M.D., Staff Psychiatrist, on 5/9/11; ○ Scott Murry, M.D., Lead Psychiatrist, on 5/9/11 and 5/11/11; ○ Kenda Pittman, Director of Pharmacy Services; and Zach Corbell, Pharm. D., on 5/10/11; ○ Rhonda Stokley, DDS, Director of Dental Services, on 5/10/11; ○ Nilima Mehta, M.D., Staff Psychiatrist, on 5/10/11; ○ Tushar Desai, M.D., Staff Psychiatrist, on 5/12/11; and ○ Mary Gallo, R.N., Psychiatric Specialty Nurse, on 5/9/11. ▪ **Observations of:** ○ Risk Assessment Clinical Review Meetings for Individual #72, on 5/10/11, and Individual #74, on 5/11/11; ○ Polypharmacy Committee Meeting, on 5/12/11; ○ Pharmacy and Therapeutics Committee Meeting, on 5/12/11; ○ Psychiatry Clinic provided by Judi Stonedale, M.D., on 5/9/11; ○ Psychiatry Clinic provided by Scott Murry, M.D., on 5/11/11; ○ Psychiatry Clinic provided by Nilima Mehta, M.D., on 5/10/11; ○ Psychiatry Clinic provided by Tushar Desai, M.D., Consulting Psychiatrist, on 5/12/11; ○ Observations of the following: Individual #175, Individual #416, Individual #357, Individual #180, Individual #306, Individual #82, Individual #270, Individual #95, Individual #445, Individual #432, Individual #315, Individual #56, Individual #41, Individual #36, Individual #105, Individual #112, Individual #359, Individual #17, Individual #183, Individual #56, Individual #235, Individual #185, Individual #406, Individual #421, Individual #341, Individual #151, Individual #200, Individual #155, Individual #202, Individual #325, Individual #375, Individual #297, Individual #31, Individual #63, Individual #152, Individual #328, Individual #178, Individual #223, Individual #34, Individual #280, Individual #408, Individual #353 Individual #8, Individual #403, Individual #289, Individual #374, Individual #432, Individual #177, Individual #244, Individual #320, Individual #109, Individual #6, Individual #165, Individual #272, Individual #19, Individual #355, Individual #302, Individual #273, Individual #397, Individual #296, Individual #49, Individual #288, Individual #332, Individual #369, Individual #158, Individual #303, Individual #393, Individual #139, Individual #336, Individual #442, Individual #436, Individual #119, Individual #138, Individual #327, Individual #294, Individual #83, Individual #74, Individual #316, Individual #261, Individual #220, Individual #304, Individual #77, and Individual #376.
	Facility Self-Assessment: The supporting documentation for the initial meeting on 5/9/11 between the Monitoring Team and AUSSLC Staff listed the following new initiatives for the Psychiatry Department: 1. *Our Pre-treatment sedation committee has developed a process for developing, implementing, and monitoring desensitization programs. To begin the implementation of this process, home 788 has been selected as a pilot home, and we have started using the assessment tool, which will later be used to develop the desensitization plans. (Section J.4)* 2. *Our Pre-treatment sedation committee has also developed a draft policy for the collaborative selection and documentation of medications which will be used as pre-treatment sedation for medical*

	and dental procedures. (Section J.4) 3. *To better document the collaboration between Neurology and Psychiatry, we have revised the Neurology clinic consultation form so that it now indicates that both the primary care doctors and, when appropriate, the psychiatrists have reviewed the neurologist's recommendations. (Section J.15, recommendation #12)* 4. *With regard to our monthly, facility-wide review of psychiatric polypharmacy, two changes have been made to our documentation. The first is that a column that has been added to the form which will allow for documentation of the evidence of efficacy for the individual medications used as polypharmacy (sic). The second is that minutes of the Polypharmacy Committee have been updated to include historical information concerning the rates of polypharmacy adjusted for the number of people receiving psychotropic medication. (Section J.11, recommendation #7).* 5. *We continue to use the psychiatry clinic forms that we used at the time of the last visit. However, significant revisions to these forms have recently been completed which will allow us to better address multiple provisions of the settlement agreement.* Further discussion of the current status of these initiatives is included below with regard to the various provisions of Section J. The Psychiatry section of AUSSLC Plan of Improvement, dated 4/27/11, listed the Facility as being compliant with the Settlement Agreement for only Provision J.1, which relates to the professional qualifications of the Psychiatrists. The other items in Section J were rated as "N" for noncompliant. The Facility's Presentation Book for the Psychiatry Department contained the AUSSLC's Self-Assessment, Plan of Improvement, and related documents. The second of the two interviews with the Lead Psychiatrist focused on a review of these documents. During this discussion, he indicated that the Facility's rationale for indicating noncompliance for Provision J.5, which addresses the requirement for an adequate number of Psychiatrists. Specifically, he noted that, although the caseloads of the individual Psychiatrists were within accepted clinical standards, there was concern that they might not have sufficient time to complete the detailed CPEs for each of the individuals they follow, while also providing adequate clinical care. This is a valid concern. However, after further review, the Monitoring Team found substantial compliance based on the caseload distribution, which is further discussed with regard to Section J.5. A request for reviews of the Psychiatry Department performed by the QA Department produced one document, dated 4/28/11. This appeared to be based on the review of the record of one individual who resided on Residence 787, but the individual's name was illegible. The review of the individual's record appears to have been based on whether or not specific information was present in the record, as opposed to also assessing the quality of that information. However, there was no narrative summary of the review that would provide additional information to support or refute this observation. The comments section of the Facility Self-Assessment did not report any data related to internal QA reviews of records. During the discussion with the Lead Psychiatrist, he indicated that a new monitoring tool was being developed, and the Facility was waiting for that to be finalized before proceeding with the

	internal QA reviews of individual records. The implementation of a process that would utilize the staffing resources of the Psychiatry Department to conduct internal QA record reviews, in conjunction with the QA Department, would enhance the Facility's efforts to comply with the provisions set forth in the Settlement Agreement.
	Summary of Monitor's Assessment: At the time of the last review, the Facility recently had added two full-time Staff Psychiatrists, which brought the number of full-time Psychiatrists to three, plus the continuation of a Child Psychiatrist's weekly three-hour consultation time. Those individuals now had been fully integrated into the Department. During the current onsite review, the Monitoring Team observed a Psychiatric Clinic of each of the four Psychiatrists. These observations indicated that there was ample time for discussion, which included a thorough review of behavioral, psychiatric, medical, and environmental considerations. The Facility recently had completed a new version of the form that is used at the Quarterly Psychiatric Reviews. In addition to basic medication and behavioral data, this revised format included space for information to document the symptoms that justify the psychiatric diagnosis, the status of side effect monitoring, evidence of the efficacy of the prescribed medications, and a section on risk-benefit analysis, which included actual, as well as potential side effects that could then be empirically weighed against the demonstrated efficacy of each medication. The information that will be included in this documentation should address many of the provisions of the Settlement Agreement that are related to the rational use of psychotropic medication for individuals with developmental disabilities. As this new documentation had just been developed, its implementation could not be assessed during this review. At the time of the last review, a significant advance in the evolution of the format for the CPEs was noted. During the last review, four of these newly formatted documents were reviewed, and were found to be comprehensive and thorough. An additional ten CPEs were analyzed during the current review and were found to comply with the format and content specified in the Settlement Agreement. Unfortunately, the Facility only had been able to complete 21 of these CPEs, and there were 170 individuals receiving psychotropic medication. Thus, a major challenge confronting the Facility was the development of a mechanism to complete these documents in a more efficient manner, without compromising their quality. Psychiatry was the lead discipline for the initiative to implement Pre-treatment Sedation Desensitization Plans. The final format for the basic assessment form upon which these Plans would be developed had just been finalized and, thus, documentation related to that process would not be available for analysis until the next review cycle. The Settlement Agreement also required collaboration between Psychiatry and Neurology. The current plan was to have the Psychiatrist actually attend the Neurology Clinic, which was the best way to ensure clinical dialogue between the two specialties. A system also was being developed to document this communication between Psychiatry and Neurology.

	Thus, the general theme that ran throughout the current review was that there had been a number of positive changes that were in the beginning phases of implementation, but the execution of these changes could only be assessed during future reviews.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	As recently as four years ago, AUSSLC relied on as little as seven hours of Psychiatry Consultation time per week. Dr. Scott Murry joined the Department on a full-time basis approximately three years ago. Prior to the last review, the Facility had added two additional full-time Psychiatrists: Dr. Judi Stonedale and Dr. Nilima Mehta. Dr. Tushar Desai also had continued to provide three 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, and Dr. Desai was Board Certified in Child Psychiatry as well as Adult Psychiatry. All of the Psychiatrists had had extensive experience working with individuals with intellectual and developmental disabilities (ID/DD), through their previous employment. Four Psychiatric Nurses and two Psychiatric Assistants supported the Psychiatrists. At the time of the review, there were 170 individuals receiving psychotropic medication 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. Dr. Desai also continued to be available to the Facility for three hours per week, and had an active caseload of individuals that included adolescents and adults who resided at the Facility. The Lead Psychiatrist also had administrative responsibilities, which limited the number of individuals that he was able to follow directly. Although the individual caseloads of each Psychiatrist had fluctuated, they had remained at or below 60.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or 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 ID/DD. 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 ID/DD. The records of 34 individuals, representing a 20 percent sample of those who were receiving psychotropic medication, were reviewed and revealed that six (18%) of the records contained a CPE compatible with the requirements set forth in the Settlement	Noncompliance

#	Provision	Assessment of Status	Compliance
		Agreement. The specific individuals whose records contained a CPE were Individual #369, Individual #291, Individual #109, Individual #210, Individual #77, and Individual #421. At the time of the prior review, the Facility recently had begun the initiative to complete a thorough CPE 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 only found in 18 percent of the sample of 34 individuals receiving psychotropic medication. During the onsite review, a sample of 10 newly completed CPEs was requested. In response to this request, the CPEs for the following individuals were produced: Individual #77, Individual #109, Individual #183, Individual #210, Individual #421, Individual #325, Individual #284, Individual #174, Individual #445, and Individual #394. These CPEs were found to be very detailed, ranging in length from 10 to 37 single-spaced pages, with an average of 18 pages. The review of these documents indicated that all of them complied with the specifications of the Settlement Agreement. The diagnostic sections of the records provided a thorough description of the symptoms that supported the psychiatric diagnosis. The current problem facing the Facility was that although the CPEs were of a high quality, only 21 had been completed to date, and there were 170 individuals receiving psychotropic medication.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	The individual interviews with the Psychiatrists, and the direct observations of the Psychiatry Clinics, as well as the review of the records of 34 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 records review did indicate that for a number of individuals, the behaviors that were identified as the "target behaviors" of the psychotropic medication also were identified in the functional analysis and related PBSP 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 Settlement Agreement. 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. In addition, they potentially were being used in the absence of adequate behavioral treatments or interventions. Inadequacies of behavioral treatment at AUSSLC are discussed in detail with regard to Section K of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The Psychiatry Department was coordinating the implementation of the Behavioral Desensitization Plans for dental and medical appointments. In order to facilitate this process, a Pre-Treatment Sedation Committee had been established. Review of the minutes of the Committee Meetings, which were held on 3/10/11, 4/14/11, and 4/28/11, indicated representatives were present from Psychiatry, Medicine, Pharmacy, Dental Services, and Psychology. The following excerpt from the 4/28/11 Meeting described the status of the initiative to implement the procedures to minimize or eliminate the need for pre-treatment sedation as of that date: *The process was started on 4-22-2011 when some men from home 788 began visiting the dental office. The dentist reported that the DCS who brought the gentlemen to the dental clinic had not filled out their portion of the assessment tool and were uncertain about the purpose of the visit to the dental clinic. She also felt that there were certain common steps in the process of her part of the assessment. She would like these steps added to the part of the assessment tool that she completes. She would also like additional space so that she could, as necessary, give a more detailed explanation of how the individual responded to specific steps in the process. The QMRP coordinator agreed that it would be helpful to have that additional space for comments.* *The committee agreed that the assessment tool required further revision. The QMRP coordinator said that he would revise the tool and send it to the other members of the committee for review. The DCS on home 788 will then be retrained on the revised form. The committee continues to be aware of the need for the development of competency-based training for the DCS as well as the need for the development of a monitoring plan. The committee will address these issues after a final version of the assessment is agreed upon.* The Lead Psychiatrist indicated that the team recently had completed a new format for the individual assessments upon which the individual Desensitization Plans would be developed. This was the "assessment tool" that was referred above in the minutes of the 4/18/11 Meeting. The Plans that had previously been developed had been abandoned, because it was felt that they were too formulaic in nature and lacking in strategies that were specific to the individual. The Dental Services Department had been gathering data on the frequency with which intravenous (IV) sedation and pre-treatment oral sedation was required to accomplish successful dental appointments. This data for the previous six months was as follows: DATES (Number of Dental — NO SEDATION — ORAL PRE-TREATMENT SEDATION — IV ANESTHESIA	Noncompliance

#	Provision	Assessment of Status	Compliance
		Appointments) REQUIRED REQUIRED UTILIZED October (10) 59.3% 21% 19.7% November (10) 65% 17% 18% December (10) 71% 20% 9% January (11) 72.6% 13.7% 13.7% February (11) 65.5% 16.7% 17.8% March (11) 77% 10.6% 12.4% The Dental Services staff indicated that it is important to note that this data was reported on a per-appointment basis. For example, in March of 2011, 77 percent of dental appointments were accomplished without any pre-treatment sedation; 10.6% required pre-treatment sedation; and 12.4% utilized IV anesthesia. The observation that the data is reported on a per-appointment basis is significant, as an individual who did not require any sedation for a routine cleaning might require pre-treatment sedation, or even IV anesthesia for a complicated extraction. Thus, the data was specific to the appointments, and not the individual. The interview with the Facility Dentist and the review of the Facility orders for pre-treatment sedation from 10/10 through 4/7/11 confirmed that the vast majority of pre-treatment sedation orders were for Lorazepam (Ativan) in a range from 0.5 milligrams (mg) to 1 mg. There were occasional orders for Chloral Hydrate 500 mg, and Triazolam (Halcion) 0.125 mg. These were conservative dosages, and during the 5/10/11 interview, the Director of Dental Services indicated that if standard conservative dosages of sedative medications were not effective, she would seek consultation with the Psychiatry staff and/or the Pharmacy.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	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 Child and Adolescent Psychiatrist, who had a time commitment of three hours per week. There were 170 individuals receiving psychotropic medication. Thus, if the caseloads were divided equally, each of the full-time Psychiatrists would be responsible for less than 60 individuals (without taking into account the three-hour time commitment of the one part-time Psychiatrist). The actual caseload distribution of the individual Psychiatrists was requested and provided. This indicated that the two full-time Staff Psychiatrists had caseloads of 61 and 58. The Lead Psychiatrist followed 27 individuals, and the Consulting Child Psychiatrist had a caseload of 24 individuals. The full-time Psychiatrists provided coverage for those individuals followed by the Consulting Psychiatrist during the remainder of the week, when he was not present. In	Substantial Compliance

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<tr><td></td><td></td><td>addition to the Staff Psychiatrists, the Facility also employed four full-time Psychiatric Nurses and two full-time Psychiatric Assistants to help coordinate the psychiatric care of the 170 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.</td><td></td></tr>
<tr><td>J6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.</td><td>As indicated above, the Facility had developed an initiative to complete a thorough CPE for each individual receiving psychotropic medication, which they believed would meet the standards set forth in the Settlement Agreement. The review of the records of 34 individuals receiving psychotropic medication identified a complete CPA for six of the individuals in the sample (18%). As is discussed above with regard to Section J.2 of the Settlement Agreement, at the time of the onsite review, examples of ten recently completed CPEs also were requested.

The review of these documents indicated that they did contain the information identified in the Settlement Agreement as being necessary for a satisfactory assessment. However, a current challenge for the Facility was to complete these CPEs in a timely manner. To date, they only had been able to complete these documents for 21 (12%) of the 170 individuals who were prescribed psychotropic medication. The progress of AUSSLC's Psychiatry Department in completing these CPEs for the entire population of individuals receiving psychotropic medication will be monitored in future reviews.</td><td>Noncompliance</td></tr>
<tr><td>J7</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a</td><td>The spreadsheet produced on 3/31/11 listed the individuals who had been administered the Reiss Screen for Maladaptive Behavior from 11/30/09 (earliest date) to 3/25/11 (most recent date). This document indicated that the Reiss screen had been completed for a total of 175 individuals. The total census of the AUSSLC on 5/10/11 was 361, of which 170 individuals were receiving psychotropic medication. Thus, this information indicated that 175 (92%) of the 191 individuals who were candidates for screening with the Reiss instrument had, in fact, undergone that screening process.

A copy of the actual Reiss screening instrument was requested for a random sample of 20 percent 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. The dates on which they occurred, and the results were as follows:

<table>
<tr><th>INDIVIDUAL NUMBER</th><th>DATE REISS COMPLETED</th><th>26 ITEM TOTAL SCORE</th></tr>
<tr><td>Individual #50</td><td>10/6/10</td><td>0</td></tr>
<tr><td>Individual #414</td><td>12/11/09</td><td>1.0</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

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	comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.		

Individual #78	12/28/09	8.5
Individual #453	8/25/10	4.0
Individual #193	7/12/10	0.5
Individual #389	3/9/10	6
Individual #433	6/2/10	4.5
Individual #15	6/28/10	2.6
Individual #328	4/30/10	3.5
Individual #190	4/5/10	5.0
Individual #366	10/15/10	1.0
Individual #381	6/16/10	0
Individual #121	5/10/10	1.5
Individual #51	3/11/10	0.5
Individual #347	5/21/10	0.5
Individual #22	11/30/10	0
Individual #117	4/5/10	2.5
Individual #316	6/30/10	0
Individual #348	11/10/10	7.5
Individual #399	3/25/11	0
Individual #322	12/10/09	0
Individual #163	9/7/10	1
Individual #378	7/15/10	3
Individual #290	6/29/10	1.5
Individual #157	1/24/11	2.5
Individual #149	5/7/10	1
Individual #315	12/1109	9.0
Individual #148	1/21/10	2
Individual #458	9/22/10	0
Individual #379	3/29/10	5.0
Individual #137	10/4/10	2
Individual #173	3/30/10	2.5
Individual #128	6/29/10	1

The documents that were produced for these individuals were not the actual Reiss Screening Forms, but consisted of the four-page scoring sheets that listed the scores on the individual items, as well as the composite scores.

The Reiss screens for the individuals in the random sample were all below the designated Reiss cut-off score (of 9) that would prompt a formal CPE, with the exception of Individual #315, whose score on 12/11/09 was 9.0. The published guidelines for the

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		Reiss Screening instrument indicated that: *POSITIVE AND NEGATIVE TEST RESULTS. A person with scores above one or more of the cutoff points is said to test "positive" for dual diagnosis on the Reiss Screen. A positive test outcome can result from a total score of 9 or more, a score above any of the scale cutoff scores listed in Table 2, or a score of 1.5 or higher on one or more of the six special maladaptive behavior items. A person with all scores below the cutoff points is said to test negative for dual diagnosis.* Thus, the score of 9 should have prompted a CPE and, as discussed in further detail below, a CPE was subsequently carried out. Individual #78 obtained a composite score of 8.5 on 12/18/09. Although this individual's composite score of 8.5 was slightly below 9, there were notable elevations on some of the subscales, including the one for aggression. This profile might have been expected to prompt a review by a Psychiatrist, if not a complete CPE, because the score was so close to the cut off score and there were subscale elevations. The Psychiatry Department might want to consider implementing an additional review process for those profiles that are very near the cutoff score on the Reiss Screening Instrument. The 5/12/11 request for documentation related to individuals who had received a CPE as a result of an elevated Reiss Score indicated that this process had occurred for three individuals. This information prompted a further request for both the Reiss scoring documentation and the related CPEs. Her hand mouthing behavior precipitated the CPE for Individual #299. The following excerpt provides the rationale for the Reiss Screen, which was performed on 1/25/10, as well as the recommendations of the CPE. *On January 25, 2010, the Reiss Screen for Maladaptive Behavior (Second Edition) was administered. The evaluation was completed in preparation for a psychiatric evaluation to determine if [Individual #299's] hand mouthing behavior may be related to an undiagnosed psychiatric disorder. The conclusion from the screen was as follows: "The results of the Reiss screen does (sic) not suggest that psychotropic medication is indicated at this time. [Individual #299's] scores fell below the cutoff in all maladaptive behavior categories as well as the 26-item total score. The results of the evaluation will be shared with the psychiatrist as well as the personal support team at the scheduled psychiatric clinic. Her personal support team will continue to meet regularly to determine if these interventions are warranted in the future."* Documentation also was submitted for Individual #315. This was the same individual that was identified in the random sample of Reiss Screens identified above. The relevant	

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		information from the 3/25/10 CPE was as follows: *On January 14, 2010, a Reiss Screen was performed on [Individual #315]. The results showed that [she] scored 9.0 on the 26-Item Total Score. This is the total cutoff score on the Reiss screen that indicates that a person may have a mental illness in addition to their mental retardation. [Individual #315] also met the subscale cutoff score to suggest that she may have a problem with aggression. [She] typically displays aggressive and disruptive behaviors when her radio is lost or misplaced. She tends to have angry outbursts when she is frustrated, agitated, or without her radio. This persistent need to have her radio is often an antecedent to her engaging in target behaviors; including, self-injurious behavior, aggression, and disruptive behavior. [Individual #315] scored just below the cutoff to suggest that she might have symptoms of autism. In addition to her attachment to her radio, she may exhibit self-stimulatory behavior such as body rocking and rubbing her hands together. It is also reported that [she] often withdraws herself from tasks/activities which can easily escalate into a "problem" behavior. The results from her Reiss Screen are listed below…* (The Reiss Screening results were then illustrated in the report.) The recommendations of the Psychiatry Department were as follows: *<u>Pharmacological interventions</u>: There is no current recommendation for psychotropic medication use.* *<u>Non-pharmacological interventions</u>: [Individual #315's] present behavior support plan (BSP) addresses her target behaviors of self-injurious behavior, aggression, and tantrums. Her behavior support plan states that her replacement behavior will be to request her radio instead of engaging in SIB, aggression, and tantrum behavior. Antecedents to her target behaviors are generally related to escaping/avoiding situations, to seeking attention, and to communicate pain or physical distress. Typically, the target behaviors of aggression and SIB follow tantrum behavior and occur in conjunction with each other. [She] particularly enjoys having her radio as a sensory item and most of her tantrum behaviors begin when she cannot have access to her radio. They may also occur when she is on her way to scheduled work related activities, when she is hungry, and/or when she is redirected to an appropriate activity.* *[Individual 315's] BSP also states that restraint should not be used on [her]. It also states that she has visual impairment and that she requires assistance with activities of daily living. Therefore, having familiar staff is especially important to [her]. It is also noted that she is accustomed to a particular schedule which should be maintained on a daily basis. Reinforcers for [Individual #315] include: listening to the radio, food (cookies, chips, and other snacks) and drinks, going outside,*	

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		being left alone, being touched (i.e.: hugs, pats on back), interacting with preferred staff, and having her hair done. *[Individual #315] will not be followed in psychiatry clinic at this time. She may be referred back to psychiatry on an as needed basis.* The third individual, Individual #11, was screened with the Reiss Screening instrument on 12/16/09, and the CPE was carried out on 2/8/10. The CPE provided a detailed review of the Reiss Screening results, including many of the responses of the direct support professionals, who were interviewed as part of the Reiss Screening process. These results were summarized in the following paragraph: *In summary, results show that [Individual #11] scored 9.5 on the 26-Item Total Score. The cutoff score for the 26-Item Total Score is 9.0, thus placing [her] in the positive category for someone with a possible dual diagnosis, i.e., a mental illness as well as mental retardation. However, when 1 point is deducted due to enuresis, [Individual #11] scored 8.5 on the Total Score, thus placing [her] in the negative category for someone with possible dual diagnosis.* The final conclusion of the CPE indicated that no psychiatric diagnosis or pharmacological treatment was indicated at this time. The Facility clearly had made a great deal of progress in implementing the Reiss Screening instrument for individuals who are not receiving psychotropic medication. However, slightly less than 10% of the population still had not been screened. Subsequent monitoring reviews will continue to assess the Facilities' progress in administering the Reiss Screen to those individuals at the AUSSLC who have not had a psychiatric evaluation, and confirm 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 Assistant Director of Psychology Services. The integration was also visible in the observation of the Psychiatry Clinics of each of the four Psychiatrists, where it was apparent that the Staff Psychologist had a central role in both the conduct of the meeting, and the generation and sharing of the behavioral data upon which key decisions related to changes in the psychotropic medications was based. The observations of the Psychiatry Clinics and the related documents that were produced illustrated the active collaboration between the two disciplines. A current	Noncompliance

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		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 as also being present on a learned or behavioral basis in the Functional Analysis and the PBSP. It is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be 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 Settlement Agreement, where it is discussed in more detail.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of psychiatric and 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 sample of 34 records of individuals receiving psychotropic medication. The Psychiatrist relied heavily upon the data related to the frequency of those behaviors that had been 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 PBSP as being present on a learned/behavioral basis, and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and 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 sample of the records of 34 individuals receiving psychotropic medication identified 24 individuals (71%) for whom the dual classification of behaviors described above was present. The individuals' records that were identified as containing this dual reference to maladaptive behaviors were those of: Individual #152, Individual #139, Individual #301, Individual #424, Individual #270, Individual #82, Individual #208, Individual #175, Individual #341, Individual #80, Individual #16, Individual #8, Individual #406, Individual #355, Individual #421, Individual #210, Individual #350, Individual #83, Individual #74, Individual #271, Individual #360, Individual #238, Individual #283, and Individual #108.	Noncompliance

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		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 2/16/10 Behavior Support Plan for Individual #406: *[Individual #406's] primary behavioral problems are aggression (mainly choking others), and inappropriate urination. Food stealing (primarily steals it from locations rather than people) and self-stimulatory behavior (pacing, hand-flapping, making mouth movements, and yelling) have been a problem in the past. Hunger and delayed meals appear to be setting events for aggression. Many episodes are related to wanting more food or being unable to have food immediately. [Individual #406] also appears to be bothered by noisy and/or crowded areas and his peers displaying disruptive behavior.* And, later: *<u>Previous Interventions</u>: Previous interventions used with [Individual #406] include positive reinforcement of appropriate behaviors through immediate primary reinforcers (edibles) and secondary reinforcers, removal of precipitating stimuli, various communication techniques (i.e., books, picture boards, sign language), behavior plans, social skills training, hospitalization, crisis intervention, community services (foster care setting, CLASS program, ATCMHMR for autism services), structured and rigid programming, and several medications used for behavior management including Risperdal, Ambien, Ritalin, Pondinum, Tofranil, Zyprexa, Geodon, Klonopin, and Zonegran. [Individual #406's] medication history states that he has been tried on "about every class of drug for behavior." He experienced extreme weight gain with Zyprexa and Risperdal (felt to possibly increase his food-seeking behavior), and "screamed all night" while taking Zonegran.* The 5/12/11 Quarterly Psychiatric Clinic Note indicated that the target behaviors that were utilized to monitor the efficacy of his psychotropic medications (Lithium and Abilify) also were aggression and inappropriate urination. The documentation referenced above provided a clear description of these behaviors, which were not linked to a specific psychiatric diagnosis. The observation that these behaviors had failed to respond positively to prior trials of "about every class of drug for behavior" also tended to support the hypothesis that they were determined and maintained primarily by environmental and behavioral factors. A similar example appeared in the documentation for Individual #424, as illustrated by the following excerpt from the PBSP, dated 1/5/11: *<u>Setting Events/Antecedents</u>: Common situations that increase the likelihood a problem behavior will occur includes (sic) repeated denial or delays to requests,*	

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		belief that a peer is receiving special treatment, and peers being disruptive or aggressive towards staff. Problem behavior may also occur without any observable antecedent. Problem behaviors are also reported to occur prior to and following scheduled visits with family members. *When [Individual #424] becomes upset, she exhibits precursors including being overly excited and starting to laugh, giggle, and shake her hands in front of her face; excessive complaining in an irritated voice; reporting boredom, nervousness or anger; staring at someone angrily; disruptive behavior (threatening or cursing at another person); aggression (hitting another person); or self-injurious behavior (superficially scratching her wrist, or hitting her head). Physical cues of precursor behavior include flushed, rosy facial color; vacant "spaced out" look; and excessive drooling while awake.* *<u>Possible function</u>: It appears [Individual #424] engages in aggression, disruptive behavior, and swallowing inedible items to escape internal emotional states (anxiety, depression, guilt, shame, etc.) with a secondary function of gaining attention from staff (distraction from negative emotional states). Occasionally she may also engage in aggression and disruptive behavior to retaliate against another person who she feels has acted inappropriately.* *Interview with [Individual #424] and DCS [Direct Care Staff] indicate [she] denies wanting to hurt herself and expresses she feels nervous and sometimes angry prior to exhibiting a problematic behavior. She frequently will state she swallowed an object to "get attention". She usually can verbalize and identify her feelings but is unable to explain why she engages in a problematic behavior.* The Quarterly Psychiatry Review Note, dated 2/28/11, indicated that the monitored target behaviors of her psychotropic medication (Clozapine, Topamax, and Zoloft) were aggression, disruptive behavior, and swallowing inedible objects. The psychology documentation, which is cited above, clearly described the behavioral determinants of these behaviors without a reference to the contribution from a psychiatric illness. The records of the following 10 individuals (29%) contained an adequate differentiation of the behaviors that were present due to biological factors, as opposed to behavioral determinants: Individual #338, Individual #126, Individual #289, Individual #19, Individual #369, Individual #77, Individual #291, Individual #109, Individual #320, and Individual #158. The following excerpts from the PBSP of Individual #158, dated 3/16/10, illustrated an example of the differentiation of maladaptive behaviors that were related to a psychiatric	

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		disorder: *<u>Antecedents</u>: [Individual #158] has stated that he becomes upset, which may lead to aggression, when he feels that other people are talking about him, when others are displaying challenging behaviors, when others encroach on his personal space and when his environment is noisy or chaotic (crowds). [Individual #158] becomes upset, and has engaged in aggression, when he feels that others are not taking him seriously and when he feels his wants are being ignored. [He] has reported hearing auditory hallucinations that are female and his records also indicate that in the past he has cut himself when upset. Precursor behaviors to inappropriate sexual behavior include him requesting additional time to spend with a specific female staff, stalking behavior in which [he] may follow and/or seek out a specific female staff, giving a specific female staff gifts, and repeated attempts to be alone with a specific female staff.* *It should be noted that the diagnosis of Schizoaffective Disorder is the primary setting event for the targeted behaviors of aggression and inappropriate sexual behavior. The targeted behaviors typically manifest as a result of his psychiatric diagnosis. Preventative measures are critical for maintaining the low frequency and severity of both targeted behaviors.* *<u>Consequences</u>: Staff members use verbal prompts, verbal redirection and/or physical redirection when [Individual #158] exhibits aggression. When exhibiting aggression towards others, staff members intervene by using blocking and body-positioning, as well as verbal and/or physical redirection to prevent any injuries. Staff members use verbal prompts, verbal redirection and/or possible physical prompts when [he] displays inappropriate sexual behavior. If the inappropriate sexual behavior is severe, then the AuSSLC policy regarding a sexual incident shall be followed.* *<u>Hypothesized Function of Maladaptive Behaviors</u>: Aggression appears to function as a means to escape or avoid undesirable situations or individuals, and to a lesser degree, to escape/avoid tasks or requests. Inappropriate sexual behaviors are likely automatically reinforcing, wherein each successful act is in itself reinforcing and increases the likelihood that additional acts will be displayed in the future should the situation arise.* This documentation provided the linkage between the psychiatric diagnosis and the monitored maladaptive behaviors. It also indicated that the recommended behavioral strategies to address these behaviors were primarily designed to minimize the expression of these behaviors.	

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		Another example of a plan that provided differentiation of the behaviors that were related to an underlying psychiatric disorder appeared in the Human Rights Committee (HRC) Review of the PBSP, dated 2/24/11, for Individual #338, as indicated by the following excerpt: *<u>Setting events</u>: [Individual #338] has been diagnosed with Bipolar Disorder, mixed with psychotic features. When she enters a manic phase, she tends to exhibit a decreased need for sleep, increased psychomotor agitation, goal directed behaviors (e.g., removing clothing from hangers, repeatedly folding clothes, stealing items or food, etc.) and she can become increasingly agitated. Also, targeted maladaptive behaviors tend to increase, with and without environmental antecedents. When in a depressive phase, [Individual #338] tends to isolate herself, refuses to participate with any tasks (preferred or otherwise), and displays of target behaviors tend to be elicited by environmental antecedents (e.g., people asking how she feels). Note that she may be more "sensitive" to these antecedents. Currently, it is unclear how psychotic features present.* *[Individual #338] in (sic) to become constipated. Although it is not clear if there is a direct correlation between this and aggression, it is possible that some of her irritability and aggression is related to discomfort.* *<u>Antecedents</u> Reported predictive behaviors include striking objects, increased mumbling and/or cursing, attempting to walk away, or bouncing her leg rapidly. Reported antecedents include DCS using physical prompts, failing to offer choices, denied or delayed preferred tasks, and repeated demands from caregivers to complete tasks.* The section of this document entitled "Mental Illness Symptoms/Behaviors Medication" indicated that: "[Depakote ER] is prescribed to treat," and provided further delineation of the specific maladaptive behaviors that were attributed to her psychiatric diagnosis of Bipolar Disorder. Specifically: *Manic phase: decreased need for sleep, increased psychomotor agitation, goal directed behaviors (e.g., removing clothing from hangers, repeatedly folding clothes, stealing items or food, etc.), and she can become increasingly agitated; targeted maladaptive behaviors tend to increase, with and without environmental antecedents; Depressive phase: isolate herself, refuses to participate with any tasks.* The documentation for individual #338, as described above, provided an explicit detailed description of both the symptoms of her psychiatric illness, as well as the linkage between these symptoms and her related overt maladaptive behaviors. The Lead Psychiatrist had modified the format for the Quarterly Psychiatric Reviews so	

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		that it would contain more explicit information concerning the linkage between the symptoms of the individual's psychiatric disorder and his/her other monitored maladaptive behaviors. This information should be available for analysis during future reviews. The newly developed CPEs also provided additional documentation related to these issues. The consistent incorporation of this information into the individual PBSPs should decrease the current deficits in terms of the dual classification of maladaptive behaviors as being present both on a behavior basis, and as targets of prescribed psychotropic medication.	
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 record, as well as the PBSP. The review of these sections of the records in the sample of 34 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. The terminology that was commonly used in these sections of the records implied that the medication would produce the desired results, and did not contain a specific 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. No indication was provided 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 record was not sufficient to make a reasonable decision regarding whether the benefits outweighed the risks for any of the 34 individuals reviewed in this sample. The process described above was illustrated in the following excerpt from the Human Rights Committee review of the PBSP for Individual #83, dated 12/16/10: *[Individual #83] is currently diagnosed with Impulse Control Disorder, Oppositional Defiant Disorder, and Mild Mental Retardation. Symptoms related to these diagnoses require treatment with Seroquel, Abilify, Clonidine, and Depakote on a regularly prescribed basis as well as the emergency use of Zyprexa if [he] became severely agitated (as evidenced by protracted and dangerous aggressive or self-injurious acts) and could not calm down on his own. Geodon has been recommended to replace Abilify for [Individual #83]. His attending psychiatrist is*	Noncompliance

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		of the opinion that Geodon may have a greater impact in reducing [his] symptoms than Abilify at this time. *Medication* / *Potential Adverse Side Effects* / *Rationale* *9/23/10* — *Geodon 40mg dd [daily dose]* — *Mood Stabilization* *10/14/10* — *Depakote 2000mg dd reduced 750mg BID* — *High Liver Profiles, titration of medication* *Justification: The therapeutic intent of the interventions is to assist [Individual #83's] to function adaptively in the greatest number of environments and situations. Although the focus of [his] BSP will be on teaching alternative and more socially appropriate behaviors, in order to provide [him] with the most effective treatment, the PST determined that [he] requires a combination of procedures which include: psychoactive medications (scheduled and emergency), programmatic restraint (personal and mechanical), and increased supervision. The PST agreed that the possible risks of not participating in the interventions outweigh the risks of participating in the interventions. It was determined that the effects of [Individual #83's] maladaptive behaviors (to herself and others) (sic) were more harmful than the possible negative side effects of medications, restraint, and increased supervision. The use of psychoactive medications are (sic) closely monitored by [Individual #83's] PST; any potential side effects will be immediately reported to medical personnel for follow-up. Medication reductions will be considered should behavior improve or side effects become evident and at least annually.* *Less intrusive approaches previously attempted: Previous interventions include the use [of] hospitalization, DRO/DRA procedures designed to reinforce [Individual #83's] appropriate behavior and improve his overall functioning. Extinction, redirection, loss of priviledges (sic), changes in levels of supervision, providing access to preferred activities, elevating boredom, and integration into milieu activities were of limited success.* *Risks of participating in BSP and Psychoactive Medications: [Individual #83] may not like the use of the interventions in his BSP (such as restraint, environmental restrictions, etc.). Use of such interventions may temporarily upset [him] and*	

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		evoke more targeted behaviors. *<u>Risks of not participating in BSP and Psychoactive Medications</u>: The potential harmful effects of [Individual #83's] behaviors include: serious injury to self/others; injury to self if recipient of [his] aggression or instigation retaliate; fewer residential and educational options in less restrictive environments; fewer opportunities to engage in training activities designed to increase his functional adaptive behaviors, fewer opportunities to engage in social interactions with individuals with whom he lives, and have interfered with his educational pursuits. [Individual #83's] maladaptive behaviors have proved to endanger self/others and impede his personal growth. He has caused injuries to others as a result of his behavior, and lost his community placement with his family due to aggression and challenging behaviors. His leaving designated area puts him at risk in the community (running into traffic; potential victimization). [Individual #83] does not foresee the consequences of his actions and does not fully understand the consequences of his actions.* The side effects of the prescribed medications were described as follows: *Side effects of the prescribed psychoactive medications may include: Seroquel – dizziness, headache, somnolence, weight gain, leucopenia; Depakote – sedation, nausea, vomiting, indigestion, elevated liver enzymes, pancreatitis, thrombocytopenia, toxic hepatitis; Clonidine – dry mouth, drowsiness, dizziness, constipation, fatigue and headache; Abilify – headache, insomnia, dizziness, sleepiness, agitation, weight gain, constipation, nausea; and Zyprexa (emergency medication) – sleepiness, dizziness, constipation, postural hypotension, fever, neuroleptic malignant syndrome.* The key paragraph with regard to the risk versus benefit analysis was as follows: *<u>Risks of not participating in BSP and Psychoactive Medications</u>: The risks of not participating in the BSP and taking psychoactive medications include increased psychiatric symptoms (i.e., command hallucinations that tell [Individual #83] to hurt himself or others, volatile and unstable mood, etc.) causing serious injury to others. If [his] targeted behaviors are not addressed, it will decrease his ability to learn functional behaviors that would allow him to develop relationships with others, live in a less restrictive setting (such as with his family or a group/foster home), and increase his financial compensation through vocational placements as well as his overall quality of life. If [he] continues to refuse to attend school, he will not receive education that will aid him in reaching his personal goals. He will also lose opportunities for socialization with his peers and opportunities to develop relationships with other students. Additionally, [Individual #83's] targeted behaviors could lead to serious injury, arrest, and possible incarceration. [His]*	

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		maladaptive behaviors have proven dangerous and impede his personal growth. There were positive elements to this risk versus benefit analysis that represented an improvement over the documentation seen in the records reviewed during prior onsite reviews. The primary improvement was represented by a more detailed description of the specific physical risks that the individual presented. There was also one reference that linked this risk to the underlying psychiatric illness "command hallucinations that tell (Individual #83) to hurt himself or others," as well as reference to "volatile and unstable mood, etc., causing serious injury to others." Significant deficiencies that persisted related to the global statement that "it was determined that the effects of [Individual #83's] maladaptive behaviors (to herself and others) (sic) were more harmful than the possible negative side effects of medications, restraint and increased supervision," without any specific discussion of, or reference to, the factors that went into this determination. There was a subsequent hypothesis that "psychiatric symptoms (related to Bipolar Disorder) may be intensified if medications are not prescribed," followed by a general description of these symptoms. This individual had now been receiving psychotropic medications for a sufficient amount of time that it should have been possible to introduce actual empirical data that would have demonstrated the efficacy, or lack thereof, of the prescribed medications. The potential and realized side effects of the prescribed psychotropic medications essentially represented the expression of risk in the risk versus benefit equation. The listing of the side effects contained in the excerpt above was relatively brief and did not address side effects that may or may not have actually been experienced by the individual. The general reference to "other adverse effects not listed here for each medication (Abilify and Depakote) may also occur," did not adequately address this issue. There are references available, such as Facts and Comparisons, which list the percentage of side effects that have been documented in large populations for each psychotropic medication. A relatively simple approach to the problem of ensuring an adequate discussion of medication side effects would be to list the most common, the most serious life-threatening side effects, and those that have been experienced by the individual in those cases where the medication had already been prescribed for several months. 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 #338, dated 2/24/11: *Risks of not participating in interventions: The risk of failing to address targeted problem behaviors may lead to [Individual #338] injuring her house mates or staff*	

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		members, particularly should she become aggressive. Taking items from the trash could cause illness, particularly with regard to eating discarded food items of injuring her self (sic) when digging through the trash. [Individual #338] is noted to have difficulty swallowing and has a modified food texture plan to prevent choking. Failure to maintain the appropriate texture could place her in harm of choking. Further, taking items (food or otherwise) from or hitting her house mates strains social relationships, which could result in social isolation. [Individual #338's] house mates, in turn, may become aggressive toward her when she strikes out at them or takes their property. *Finally, psychiatric symptoms (related to Bipolar Disorder) may be intensified if medications are not prescribed. These symptoms include: developing a depressed mood (increased somnolence, lack of interest in preferred activities, socially withdrawn, increased irritability, etc.), developing mania (elevated mood, increased motor agitation, hyperactivity, decreased sleep, or fixation on engaging various activities). Historical reports indicate that she also has been noted to experience delusions and/or hallucinations when psychiatric symptoms are present. When these symptoms are present, it is likely that targeted maladaptive behaviors would increase.* *<u>Risks of participating in Interventions</u>: [Individual #338] may not like the use of behavioral strategies outlined in her Behavior Support Plan (BSP), particularly when they interfere with her attempts to strike others or steal items. Teaching protocols and intervention protocols may increase displays of targeted behaviors. For example, if a staff member uses body positioning to block [her] from taking another house mate's food, [she] may strike the staff member, the house mate, or both.* *Additionally, there are several adverse effects that may develop with the use of psychotropic medications. Abilify (Aripiprazole) is an atypical antipsychotic to be used due to the discontinuation of Risperdal to treat Bipolar Disorder. Frequently reported adverse effects when Abilify is used to treat Bipolar Disorder include headache, insomnia, lightheadedness, nervousness, confusion, nausea, constipation, and blurred vision. Depakote has a "Black Box Warning" cautioning toxicity if regular blood levels are not taken. Additional frequently reported adverse effects when Depakote is used to treat mania include sedation, abdominal problems (bloating/gaseous, feeling full, pain), nausea, vomiting, diarrhea, and dizziness. Other adverse effects not listed here for each medication (Abilify and Depakote) may also occur. The use of the medications will be frequently monitored to assure that adverse effects will be detected as quickly as possible, if any appear. Presently, [Individual #338] does not appear to have any of these effects.*	

#	Provision	Assessment of Status	Compliance
		Risk vs. Risk: Given the risks to others and [Individual #338], and the potential for a decreased quality of life, the PST thinks that the risk of psychotropic medications and protocols outlined in the BSP are less likely to cause [Individual #338] less harm (sic), than if no interventions were utilized. Medications can be reduced or discontinued to address adverse medication effects (note that Lithium was discontinued in April 2008 following a reported increase in tremors), and behavioral procedures can be modified, added, or removed as necessary. The PST will monitor [her] response to psychotropic medications and behavioral procedures, and make recommendations to change protocols based on necessity. Psychotropic medications are reviewed regularly by her physicians and she will attend psychiatric clinic at least quarterly. The psychological staff will monitor her progress monthly and make quarterly reports to the PST. This example also illustrated progress in terms of commenting on the link between the symptoms of the underlying psychiatric disorder and the "targeted maladaptive behaviors." There was also a more specific discussion of the actual types of physical harm that had been observed. A deficiency in this risk versus benefit analysis related to the global statement that "the risk of psychotropic medications and protocols outlined in the BSP are less likely to cause [Individual #338] less harm than if no interventions were utilized" (sic). As with Individual #83, the prescribed medications had been utilized for a considerable length of time, and it should have been possible to incorporate empirical documentation related to efficacy into this discussion. The comments that applied to the description of the side effects of the medications prescribed for Individual #83 are also applicable to the discussion in this plan for Individual #338. The authors of this document did note that, to date, no medication side effects had been observed. 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 PBSP for Individual #158, dated 8/19/10: *Program Summary (to include restrictive/intrusive components): [Individual #158] has a Behavior Support Plan which targets inappropriate sexual behavior and aggression. The BSP seeks to teach [him] social skills that will aid in developing appropriate relationships with others. Reinforcement techniques include (but are not limited to) praise and behavior contracts. Preventive strategies include notifying PST members if [he] appears to be fixated on a particular female staff member and removing that staff member from the home for her safety, female staff members setting firm boundaries, redirecting [him] to a different area if others are displaying challenging behavior, and prompting him to*	

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		respect others' personal space by staying at arms' length. Reactive techniques for addressing targeted behavior include verbal prompts, blocking, body positioning, redirection to a quieter area, and problem-solving exercises. If inappropriate sexual behavior towards a peer occurs, [Individual #158] will be told to stop and immediately [be] separated from that individual. All [AUSSLC] polices (sic) regarding a sexual incident will be followed. If [Individual #158] displays inappropriate sexual behavior toward a staff member, that staff member should be assigned away from the home until it is determined that it is safe for her to return. *[Individual #158] is currently diagnosed with Mild Mental Retardation and Schizoaffective Disorder. Symptoms related to these diagnoses require treatment with Clozaril and Depakote on a regularly prescribed basis.* And, later: *<u>Risks of not participating in Interventions</u>: In the past, [Individual #158] has become fixated on particular female staff members and engaged in stalking behavior that eventually culminated in assaulting the targeted female. During an admission to ASH [Austin State Hospital] in 1992, he attempted to strangle an RN with whom he had become obsessed and subsequently served 6 months in the Travis County Jail for this assault. On 2/10/07, [Individual #158] stalked and assaulted a nurse. Records indicate he waited outside the group home, grabbed the nurse through an open window, and would not let go of her. Prior to the incident, he had reportedly made inappropriate sexual comments regarding masturbating to the nurse and he reported experiencing command hallucinations which ordered him to assault her and others. In April 2007, he attacked a female nurse he had stalked and lunged at her with his belt in an attempt to strangle her. In October 2007, he assaulted a female staff member. [Individual #158] reportedly waited until he was alone with the female staff, grabbed her genital area, and refused to let go even when other staff appeared to assist. The risks of not participating include physical and sexual aggression toward females with a potential for serious injury. The risks of not receiving psychoactive medication include increased psychiatric symptoms and subsequently, increased maladaptive behavior. If [Individual #158] continues to engage [in] maladaptive behaviors, it will decrease his ability to learn functional behaviors that would allow him to develop relationships with others, live in a less restrictive setting (such as a group/foster home), and increase his financial compensation through vocational placements.* *<u>Risks of participating in Interventions</u>: The possible side effects of the prescribed psychoactive medications may include: Clozaril – drowsiness, sedation, dizziness, tachycardia, hypotension, dry mouth, constipation, excessive salivation, seizures,*	

#	Provision	Assessment of Status	Compliance
		leucopenia, agranulocytosis; Depakote – sedation, nausea, vomiting, indigestion, elevated liver enzymes, pancreatitis, thrombocytopenia, toxic hepatitis. Although this discussion contained more detail describing the negative effects of the maladaptive behavior, it did not contain specific information related to the potential or realized 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 had different mechanisms of action and side effect profiles. This observation was consistent throughout the records reviewed. The Lead Psychiatrist had made extensive revisions to the form that was utilized to document the Quarterly Review of the individuals' clinical status. This revised format contained a section related to empirical individualized risk versus benefit analysis. The format for this documentation was finalized only recently and, thus, did not appear in the records reviewed for this monitoring review. However, they should appear in the records reviewed during future monitoring cycles. After the system is established to ensure that this information is routinely documented in the Quarterly Psychiatry Review, it will be important to ensure that it is referenced in the Human Rights Review of the PBSP and Psychotropic Medication Plan.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility-level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	AUSSLC had formed a Committee that met monthly to review and monitor the Facility's progress toward reducing polypharmacy with psychotropic medication. The documentation of these meetings, which were referred to as the "Monthly Psychiatry Poly-Pharmacy Reduction Meeting Notes," was generated for the following dates: 4/14/11, 3/10/11, 2/10/11, 1/13/11, and 12/16/10. The staff Psychiatrists, Director of Pharmacy Services, Clinical Pharm. D., Psychiatric Specialty Nurse, and the Medical Director attended the meetings, which the Psychiatric Assistants facilitated. The Meeting Notes indicated that there was a detailed case-by-case discussion of individuals whose medication regimens met the criteria for polypharmacy. A member of the Monitoring Team observed the meeting of this Committee, which occurred on 5/12/11. The meetings were routinely held on Thursdays, so that the Consulting Child Psychiatrist could attend. The meeting format included a brief review by the prescribing Psychiatrist of the status of each individual whose profile met the criteria for polypharmacy. This discussion focused on the feasibility and current status of the attempts to reduce polypharmacy for each individual. Documentation from the 4/14/11 meeting provided a summary of the Facility's progress toward minimizing polypharmacy as of 3/31/11. This data indicated that nine	Noncompliance

#	Provision	Assessment of Status	Compliance
		individuals were receiving two or more medications from the same class, and 40 individuals were receiving three or more medications, regardless of class. The total number of individuals who met the criteria for polypharmacy was 40, as the nine individuals who were receiving two or more medications from the same class also met the criteria for three or more medications regardless of class. The specific information regarding the number of individuals receiving multiple medications was as follows: ▪ Two medications = 0; ▪ Three medications = 28; ▪ Four medications = 11; ▪ Five medications = 1; and ▪ Six medications = 0. Historical data from several years ago was not available for comparison. However, monthly comparative data was available going back to July of 2010. Tabular representation of that data is as follows: **DEFINITIONS OF POLYPHARMACY** / **JULY 2010** / **MARCH 2011** Number of individuals receiving two or more meds from the same class: 13 / 9 Number of individuals receiving three or more meds regardless of class or indication: 49 / 40 Number of individuals receiving both I & II: 12 / 9 Total number of individuals on polypharmacy: 50 / 40 Total number of individuals receiving psychotropic medication: 184 / 169 % Patient Population (PP) / % PP 27% / 23% 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. AUSSLC	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>was not yet adequately clinically justifying the use of psychotropic medication. This subject is discussed in further detail below, with regard to Section J.13 of the Settlement Agreement. The ongoing progress of AUSSLC in minimizing the use of unnecessary psychotropic medications will be followed in future monitoring reviews.</td><td></td></tr>
<tr><td>J12</td><td>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.</td><td>This provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. This review also analyzed the latency between the time that the exam was completed by the nurse and subsequently reviewed by the prescribing physician. The review of the sample of the records of 34 individuals who were prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months), had been performed at least every six months, and had been reviewed by the prescribing physician within two weeks of completion was present for the following 11 (32%) individuals: Individual #80, Individual #175, Individual #270, Individual #338, Individual #126, Individual #289, Individual #238, Individual #424, Individual #77, Individual #109, and Individual #82.

The records of the following individuals contained documentation that the MOSES evaluation had been completed as specified, but there was a delay of greater than two weeks between the completion of the evaluation by the nurse, and the review by the prescribing physician. This information only pertains to those instances for which there were delays in the review by the prescribing physician. The actual MOSES evaluations for these individuals were completed as specified in the Settlement Agreement.

<table>
<tr><th>INDIVIDUAL NUMBER</th><th>DATE MOSES WAS COMPLETED</th><th>DATE OF SIGNATURE SIGNIFYING REVIEW BY PRESCRIBING PHYSICIAN</th></tr>
<tr><td>Individual #421</td><td>8/12/10</td><td>9/15/10</td></tr>
<tr><td></td><td>2/4/11</td><td>2/25/11</td></tr>
<tr><td>Individual #406</td><td>7/1/10</td><td>8/12/10</td></tr>
<tr><td>Individual #16</td><td>9/3/10</td><td>9/29/10</td></tr>
<tr><td></td><td>12/2/10</td><td>1/3/11</td></tr>
<tr><td>Individual #341</td><td>8/16/10</td><td>9/13/10</td></tr>
<tr><td></td><td>11/5/10</td><td>12/7/10</td></tr>
<tr><td>Individual #139</td><td>8/12/10</td><td>9/22/10</td></tr>
<tr><td></td><td>11/12/10</td><td>12/20/10</td></tr>
<tr><td>Individual #74</td><td>8/5/10</td><td>9/13/10</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

Individual #83	12/9/10	1/13/11
Individual #360	8/2/10	9/2/10
	11/12/10	12/2/10
Individual #19	7/15/10	8/12/10
Individual #350	7/8/10	8/12/10
	12/13/10	1/13/11
Individual #8	8/17/10	9/13/10
	11/5/10	12/7/10
Individual #355	8/2/10	9/24/10
Individual #210	7/1/10	8/12/10
Individual #320	8/10/10	9/13/10
	11/2/10	12/2/10
Individual #369	12/3/10	1/13/11
Individual #283	11/4/10	12/2/10
Individual #108	12/3/10	1/13/11
Individual #291	10/1/10	11/4/10
Individual #271	3/5/10	4/1/10

The individual records that did not contain documentation of completed MOSES evaluations that adhered to the time schedule specified in the Settlement Agreement were as follows:

INDIVIDUAL NUMBER	MISSING DOCUMENTATION
Individual #208	No 2nd page with signature for 6/29/10; only MOSES in record was dated 6/29/10
Individual #301	No 2nd page with signatures for all MOSES in file
Individual #152	No signature page for 5/16/10 MOSES; no signature documenting review by prescribing physician for 5/16/10
Individual #158	Gap from 2/9/10 to 11/8/10 (nine months)

The purpose of the DISCUS is to detect emergent motor side effects related to the use of antipsychotic medication. The review of records of the sample of 33 individuals (Individual #80 was not receiving antipsychotic agents and no DISCUS was necessary)

#	Provision	Assessment of Status	Compliance
		identified documentation that the DISCUS was current, had been performed quarterly for the past year, and had been reviewed by the prescribing physician within two weeks of completion of the evaluation by the nurse, in the records of eight of the 33 records (24%). This included the following individuals: Individual #109, Individual #175, Individual #208, Individual #301, Individual #126, Individual #77, Individual #289, and Individual #152. Those individuals whose records contained documentation of a current DISCUS (within the last three months), as well as quarterly over the past year, but for whom there was a delay of greater than two weeks between the date the evaluation was completed by the nurse and signed by the prescribing physician were as follows:	

INDIVIDUAL NUMBER	DATE DISCUS COMPLETED BY NURSE	DATE DISCUS REVIEWED AND SIGNED BY PRESCRIBING PHYSICIAN
Individual #210	7/1/10	8/12/10
Individual #355	8/2/10	9/2/10
Individual #8	8/17/10	9/13/10
	11/5/10	12/7/10
Individual #320	8/10/10	9/13/10
	11/12/10	12/2/10
Individual #421	6/1/10	7/1/10
	8/12/10	9/13/10
Individual #406	7/1/10	8/12/10
Individual #16	9/3/10	9/29/10
	12/3/10	1/3/11
Individual #270	5/31/10	6/29/10
Individual #338	12/21/10	1/25/11
Individual #139	6/16/10	7/1/10
	8/12/10	9/20/10
	11/12/10	12/22/10
Individual #74	8/5/10	9/13/10
Individual #83	12/9/10	1/13/11
Individual #108	12/3/10	No prescriber Signature or date
Individual #283	11/4/10	12/2/10
Individual #369	12/3/10	1/13/11
Individual #19	7/15/10	9/12/10
Individual #360	8/2/10	9/2/10

#	Provision	Assessment of Status	Compliance

Individual #350	7/8/10	8/12/10
	12/13/10	1/13/11
Individual #341	8/16/10	9/10/10
	11/5/10	12/7/10

The records of the following individuals did not contain documentation that the DISCUS had been completed quarterly, as specified in the Settlement Agreement:

INDIVIDUAL NUMBER	MISSING DOCUMENATION OF QUARTERY COMPLETION
Individual #291	Most recent DISCUS 1/25/11
Individual #158	Most recent DISCUS 11/8/10
Individual #424	Gap of four months between 11/10/10 and 3/24/11
Individual #82	Most recent DISCUS 12/29/10
Individual #271	Gap of six months between 6/18/10 and 12/9/10
Individual #238	Most recent DISCUS 1/21/11

The numbers and specific information 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 being 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.

The DISCUS and MOSES are also necessary to monitor for the side effects of Reglan, which although prescribed for GERD, has pharmacological properties that are similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS and MOSES for those individuals who were receiving psychotropic medication. Thus, a Psychiatric Nurse would monitor an individual for side effects who was receiving, Reglan as well as a psychotropic medication. A Nurse from their Residential Unit performed the monitoring for those individuals who were receiving Reglan, but were not also receiving psychotropic medication. Accordingly, a list was obtained from the Pharmacy of all individuals who were receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to create a list of individuals who were receiving Reglan, but who were not also prescribed psychotropic medication. The following random sample of five individuals (50 percent) of those who fit the above criteria was selected, including: Individual #454, Individual #426, Individual #452, Individual #65,

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and Individual #62.

The review of the records of these individuals for documentation related to the MOSES is presented below:

<table>
<tr><th>INDIVIDUAL NUMBER</th><th>DOCUMENTATION OF MOSES IN RECORD</th></tr>
<tr><td>Individual #454</td><td>None present</td></tr>
<tr><td>Individual #426</td><td>Current MOSES, dated 5/4/11, but no prescriber review signature or date; additional MOSES in record not signed by Nurse and not dated</td></tr>
<tr><td>Individual #452</td><td>None present</td></tr>
<tr><td>Individual #65</td><td>Two identical MOSES in record; neither signed or dated by Nurse who performed the evaluation</td></tr>
<tr><td>Individual #62</td><td>Current MOSES, dated 11/5/10, signed by prescribing physician on 11/5/10; prior MOSES dated 5/7/10 signed by prescriber 5/17/10; prior MOSES dated 2/24/10 signed by prescriber 2/24/10</td></tr>
</table>

Thus, only one individual (i.e., Individual #62) of these five records (20%) contained documentation of the MOSES being completed as specified in the Settlement Agreement.

The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review are contained in the following Table:

<table>
<tr><th>INDIVIDUAL NUMBER</th><th>DOCUMENTATION OF DISCUS IN THE RECORD</th></tr>
<tr><td>Individual #452</td><td>Current (4/7/11) and quarterly for the last year with all forms signed by prescriber within two weeks</td></tr>
<tr><td>Individual #454</td><td>Only DISCUS in record dated 2/8/11, and signed by Prescriber 2/8/11</td></tr>
<tr><td>Individual #65</td><td>None present</td></tr>
<tr><td>Individual #426</td><td>None present</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		<table><tr><td>Individual #62</td><td>Most recent 11/5/10 (signed by prescriber 11/5/10), with prior 5/7/10 (signed 5/17/10)</td></tr></table> Thus, only one individual (i.e., Individual #452) of these individuals (20%) was monitored with the DISCUS as specified in the Settlement Agreement. The subject of the latency between the completion of the MOSES and DISCUS, and the date they were reviewed and signed by the prescribing physician was discussed with the Psychiatric Specialty Nurse during the 5/9/11 interview. She indicated that any abnormal findings on these examinations were reported immediately to the prescribing physician. However, there did not appear to be any documentation of this process. In light of the number of Psychiatric Nurses and full-time Psychiatrists, it should be possible to develop a system that would ensure that these evaluations are reviewed by the prescribing physician within two weeks, if not sooner. To the extent that new abnormal findings on an evaluation are identified and reported immediately to the prescribing physician, it would be useful to devise a mechanism to document this process. The monitoring of individuals who are prescribed Reglan and who are not also receiving a psychotropic agent clearly needs to be improved, as this medication can cause significant side effects. These may include acute extrapyramidal motor side effects (EPS), which might require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed.	
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	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 records of a sample of 34 individuals (20%) receiving psychotropic medication indicated that a description of the specific symptoms that would support the psychiatric diagnosis of record could be identified for 19 individuals (56 percent). Those individuals for whom this documentation could be located included the following: Individual #16, Individual #175, Individual #208, Individual #338, Individual #126, Individual #152, Individual #289, Individual #19, Individual #369, Individual #77, Individual #291, Individual #320, Individual #8, Individual #424, Individual #210, Individual #158, Individual #109, Individual #421, and Individual #350. The individual records in which this documentation could not be identified were those of Individual #360, Individual #238, Individual #283, Individual #108, Individual #355, Individual	Noncompliance

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	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.	#406, Individual #80, Individual #341, Individual #82, Individual #270, Individual #301, Individual #139, Individual #74, Individual #83, and Individual #271. However, it should be noted that even in those records where documentation of the symptoms that supported the psychiatric diagnosis were 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 10 examples of the new CPEs that were being developed (more detailed discussion can be found with regard to Section J.2 of the Settlement Agreement) indicated that those documents provided 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. These findings were consistent with the review of the four newly formatted CPEs that were reviewed in conjunction with the prior review. Thus, the Facility had made progress in documenting this information in a cohesive manner. This provision also addresses the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were referred to in the AUSSLC documentation as the "target behaviors" of the psychotropic medication. As noted above with regard to Sections J.8 and J.9 of the Settlement Agreement, a pervasive problem with the documentation in the 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. The 10 records (29%) that contained a clear delineation between these two categories of behavior were those of the following individuals: Individual #338, Individual #126, Individual #289, Individual #19, Individual #369, Individual #77, Individual #291, Individual #109, Individual #320, and Individual #158. Examples of this documentation are contained above with regard to Section J.9 of the Settlement Agreement. The 24 records (71%) in which there was a dual classification of behaviors as both a target behavior of the psychotropic medication and as being present on a behavioral basis, were those of Individual #74, Individual #83, Individual #350, Individual #271, Individual #360, Individual #238, Individual #283, Individual #108, Individual #210, Individual #421, Individual #355, Individual #406, Individual #8, Individual #16, Individual #80, Individual #341, Individual #175, Individual #208, Individual #82, Individual #270, Individual #424, Individual #301, Individual #139, and Individual #152.	

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		This provision also addresses the question of efficacy of the prescribed psychotropic medication. The review of the 34 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 three of the records reviewed (nine percent). These records were those of: Individual #126, Individual #289, and Individual #291. 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 did not include a discussion of the actual objective, empirical evidence that would support these conclusions. AUSSLC Psychiatry and Psychology Progress Notes routinely 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 was 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 these medication changes. This data also would provide additional historical data points with which to make comparisons of current frequencies that would enable the Personal Support 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 PST. This review of a sample of the records of 34 individuals indicated that Quarterly Reviews were performed as specified in this provision on a uniform basis 100 percent 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	The review of the Rights/Consents sections of the records for the sample of 34 individuals who were receiving psychotropic medication indicated that 19 individuals (56%) 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	Noncompliance

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	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.	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 both the realized and potential side effects of the medication. As indicated with regard to Section J.10 of the Settlement Agreement, 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 these beneficial effects actually would be realized, or had been realized for those individuals who already had been receiving the medication for a lengthy period of time. 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 occurred in the general population, as based on published data. 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 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 requirements set forth in this provision were being adhered to involved locating a recent (within the last year) Neurology Consultation Note in the Consultation section of the individual's record. 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. The Psychiatric team indicated that the note that was contained in the Psychiatry Section also was duplicated in the Integrated Progress notes. The rationale for the dual filing of the note in these two separate locations was to ensure that it could be readily seen and located by those clinicians who needed to be aware of this documentation. In addition, if it was difficult to locate in the Integrated Progress notes, it could be easily found in the Psychiatry Section of the individual's record. Neurology Consultation Notes were located in the Consultation section of the record for the following 10 individuals: Individual #421, Individual #406, Individual #80, Individual #341, Individual #175, Individual #208, Individual #82, Individual #301, Individual #74, and Individual #355. At the time of the prior review, the Lead Psychiatrist indicated that a plan had been	Noncompliance

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		developed to have the Psychiatrists attend the Neurology Consultations when the individuals they followed were being reviewed. The discussion between the Neurologist and the Psychiatrist would then be documented on both the Neurology Consultation Note and with a Progress Note in the Psychiatry section of the individual's record. A follow-up discussion on this topic with the Medical Director during the current onsite review indicated that this plan had been initiated, but had not yet been completely implemented. In order to assess for the documentation of the consultation between the Consulting Neurologist and Psychiatrist, the Neurology Notes were assessed for reference to the individual's psychotropic medication, as well as other aspects of the individuals' psychiatric status, and a corresponding reference to the Neurology Consultation in the Psychiatry section of the record. Both of these forms of documentation were identified in the records of Individual #80, Individual #341, Individual #175, Individual #208, Individual #82, Individual #301, Individual #74, and Individual #355. Thus, eight of the 10 individuals (80%) for whom a Neurological Consultation had been obtained within the last year, contained this documentation of collaboration between Psychiatry and Neurology.	

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

1. The Psychiatry Department should continue to complete thorough CPEs that are compatible with the criteria set forth in the Settlement Agreement for each individual who is receiving psychotropic medication. In this regard, the Department should explore mechanisms that would increase the completion rate of these documents, without compromising their quality. For example the Department might want to consider utilizing the Psychiatric Assistants and/or the Psychiatric Nurses to help with the compilation of the large amounts of historical information that were incorporated into these documents. (Section J.2)
2. Treatment Plans should be developed that integrate both the psychiatric and psychological perspectives on 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. (Sections J.3, J.8, J.9, and J.13)
3. Those individuals for whom the behaviors that are identified as the targets of psychotropic medication also are co-identified as being present on a behavioral basis should be reassessed, and justification provided for any which continue to be dually classified. (Sections J.3, J.8, J.9, and J.13)
4. A system should be established to clearly monitor and track the development and implementation of the behavioral Desensitization Plans for dental and medical appointments. (Section J.4)
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. (Sections J.10 and J.14)
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. (Sections J.10 and J.14)

7. Document the efficacy of the individual medications for those combinations of medication that meet the definitions of polypharmacy and are deemed to be essential for the individual's psychiatric stability. (Section J.11)
8. Implement the revision to the Quarterly Psychiatric Review Notes that will:
    a. Document the symptoms that support the psychiatric diagnosis;
    b. Provide empirical evidence that documents the efficacy of the prescribed medications;
    c. Identifies both the potential and realized side effects of the prescribed medication; and
    d. Utilizes the information described above to weigh both the risk of the prescribed medications and their benefits. (Sections J.9, J.10, and J.13)
9. After the system is established to ensure that information related to risk versus benefit is routinely documented in the Quarterly Psychiatry Review, it will be important to ensure that it is referenced in the Human Rights Review of the PBSP and Psychotropic Medication Plan. (Section J.10)
10. The system to ensure that the MOSES and DISCUS screening is completed for individuals who are receiving Reglan and are not receiving psychotropic medication needs to be significantly improved. (Section J.12)
11. A mechanism should be developed to ensure that the prescribing physician reviews the MOSES and DISCUS side effect evaluations in a timely manner. (Section J.12)
12. 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. (Section J.13)
13. For those individuals for whom such a review is clinically indicated, joint Neurology and Psychiatry Consultation reviews should be completed. (Section J.15)
14. The AUSSLC should expand its efforts to conduct internal QA reviews to assess the degree to which individual records, and the treatment reflected in those records, meets the standards set forth in Section J of the Settlement Agreement. The Psychiatry Department should participate in the conduct of such reviews. (Facility Self-Assessment, and all of Section J)

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 Section K Presentation Book, including: Monitoring Team report, dated 11/29/10; AUSSLC Plan of Improvement, dated 4/27/11; Settlement Agreement Cross Referenced with ICF-MR Standards; Psychology Staff Roster listing degrees and progress through certification process; Training Schedule for Behavioral Services Staff, for 3/11 and 4/11; Training materials for Task Analysis, Data Collection, Replacement Behaviors, Functional Behavior Assessment, and Training Cues; Guideline for Peer Review; Rubric for Scoring Positive Behavior Support Plans; Data Recording Work Group meeting minutes; Template for Psychological Evaluation and sample; Hierarchy for completing testing and FBAs; External Peer Review information; E-mail correspondence between J. Levy and J. Carr; E-mail correspondence between J. Levy and university personnel; Practicum/internship brochure; and article by J. Luiselli and D. Russo; o Staff Rosters for in-service training provided by psychologists regarding positive behavior support plans, completion of data collection sheets, and related Safety Plans in Residence 729, Residence 730, Residence 732-D, Residence 732-M, Residence 772, Residence 779, Residence 779-F, Residence 779-R, Residence 781, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 791, Residence 792, Residence 793, Residence 794, Residence 796, and Residence 797; o Quizzes used to assess understanding of positive behavior support plans for individuals living in Residence 729, Residence 730, Residence 732-D, Residence 732-M, Residence 772, Residence 779, Residence 779-F, Residence 779-R, Residence 781, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 791, Residence 792, Residence 793, Residence 794, and Residence 796; o Positive Behavior Support Plans for: Individual #332, Individual #210, Individual #342, Individual #108, Individual #445, Individual #168, Individual #424, Individual #406, Individual #428, Individual #179, Individual #261, Individual #84, Individual #421, Individual #30, Individual #181, Individual #293, Individual #283, Individual #185, Individual #10, Individual #140, Individual #395, Individual #103, Individual #77, Individual #299, Individual #167, Individual #158, Individual #186, Individual #320, Individual #11, Individual #26, Individual #202, Individual #74, Individual #142, Individual #360, Individual #177, Individual #425, Individual #219, Individual #56, Individual #139, Individual #98, Individual #382, and Individual #73; o Draft Positive Behavior Support Plans for: Individual #78, Individual #318, and Individual #80; o Positive Behavior Support Plan Summary I-Book for: Individual #78 and Individual #299; o Behavior Support Plan Summaries for: Individual #77 and Individual #167; o Structural and Functional Assessment Reports for: Individual #78, Individual #185, Individual #186, and Individual #2;

	○ Behavior Observation Notes for: Individual #251, Individual #168, and Individual #80; ○ Behavior Observation Notes and Data Sheets for: Individual #351, Individual #333, Individual #78, Individual #394, Individual #140, Individual #167, Individual #165, Individual #382, and Individual #73; ○ Monthly Psychology Progress Notes, from 11/10 to 4/11 for: Individual #332, Individual #210, Individual #168, Individual #78, Individual #165, Individual #158, Individual #202, Individual #140, Individual #382, and Individual #73; ○ Monthly Counseling Progress Note for 2/11 for: Individual #160, Individual #154, Individual #424, Individual #395, Individual #158, Individual #7, and Individual #360; ○ Psychological Assessment Documentation for: Individual #355, Individual #210, Individual #342, Individual #168, Individual #424, Individual #406, Individual #78, Individual #428, Individual #304, Individual #421, Individual #403, Individual #394, Individual #335, Individual #101, Individual #409, Individual #199, Individual #216, Individual #10, Individual #350, Individual #158, Individual #186, Individual #320, Individual #212, Individual #11, Individual #19, Individual #177, and Individual #161; ○ Completed Positive Behavior Support Observation forms for: Residence 501, Residence 727, Residence 732, Residence 772, Residence 779, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, and Residence 797; ○ Human Rights Committee Meeting minutes, from 9/2/10 through 2/24/11; ○ Tracking, by residence, of Peer Review Committee, Behavior Therapy Committee, and Human Rights Committee review of Positive Behavior Support Plans; ○ Psychology Department Meeting minutes, from 10/12/10 to 4/12/11; and ○ Behavior Therapy Committee Meeting minutes, from 10/26/10-3/28/11. ▪ **Interviews with**: ○ Jose Levy, Director of Behavioral Services; Cristy Pierce, Assistant Director of Behavioral Services; and Bruce Weinheimer, DADS Coordinator of Behavioral Services, on 5/11/11; and ○ Vira Benson, Facility Director, on 5/12/11. ▪ **Observations of**: ○ Residence 729, Residence 732, 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; ○ Workshop 527, Workshop 532, Workshop 544, and Workshop 775; ○ Day Program 510, Day Program 512, and Day Program 533; ○ Personal Focus Assessment Meeting for Individual #332, on 5/9/11; ○ Restraint Review Meeting, on 5/9/11; ○ Behavior Therapy Committee Meeting, on 5/9/11; ○ Timber Creek Unit Meeting, on 5/10/11; ○ Internal Peer Review Meeting, on 5/10/11; ○ Psychology Department Meeting, on 5/10/11; and

	o Human Rights Committee Meeting, on 5/12/11.
	Facility Self-Assessment: A review of the Facility's Plan of Improvement for Section K indicated that there was agreement between the Monitoring Team's findings and the Facility's self-assessment. In one of 13 areas, the Facility was in substantial compliance with the Settlement Agreement. The Director of Behavioral Services met the specified qualifications. Although the Facility acknowledged that it was not in compliance with all other areas, it had taken steps to correct this situation. As noted in the POI, four psychologists were Board Certified Behavior Analysts, and of the remaining staff, 69% were enrolled or had completed at least one course required for certification. The Facility also had taken steps to improve the peer review process. An internal peer review committee had been established, the function of which was to provide clinical oversight of Positive Behavior Support Plan development and the functional behavior assessment process. Additionally, contact had been initiated with staff from the Lubbock State Supported Living Center who were providing external peer review. This was in its earliest stages. A working group had been formed to develop a standardized data sheet. Staff in select areas had been trained, and implementation had begun in May. The Facility also reported that this group was continuing to meet to develop a system for collecting measures of inter-observer agreement. The Facility had also initiated plans to standardize psychological assessments. A template had been developed and a hierarchy of need had been identified. Positive Behavior Support Plans included a section entitled "Staff Directions." This provided a concise and clear description of the plan's components, including environmental supports to minimize problem behavior and specific strategies to employ when problem behavior did occur. The POI included a significant amount of valuable information. However, at times, the status provided did not have a direct correlation with the provision of the Settlement Agreement with which it was connected. For example, the status column for Section K.12, which addresses competency-based training for staff, discussed monthly reviews, with no reference to training. Similarly, with regard to Section K.9, which addresses the development and implementation of PBSPs, the status column discussed an assessment that had been completed for the one individual who was admitted to the Facility since the last review. However, no updates were provided with regard to efforts to develop and implement PBSPs that met applicable standards. In the future, each section of the POI should describe activities undertaken that are specifically related to the Settlement Agreement provision. In addition, the POI included minimal data to support findings of compliance or noncompliance. Examples of where data was used included data related to continuing education for psychologists, and some data related to eight record reviews that had been completed. As the Facility continues to expand its self-assessment processes, it will be important to increase the use of data to assist the Facility in identifying areas of strength and weakness to allow further analysis and corrective actions to be implemented, as

	appropriate.
	Summary of Monitor's Assessment: As noted in the Facility's Plan of Improvement, steps had been taken to meet the standards outlined in the Settlement Agreement. The Psychology Department had increased the number of Board Certified Behavior Analysts on staff, and the majority of those not yet certified were enrolled in graduate courses. The Director of Behavioral Services had pursued affiliations with local universities to recruit practicum students. This collaborative effort might help in the recruitment of future staff members, and should create expanded opportunities for professional growth and continuing education for current staff members. Changes had been made to the internal peer review process in response to feedback from staff. While still working out the format and addressing staff satisfaction with this activity, the process continued with peers providing clinical support regarding all aspects of behavioral programming. Efforts to develop an external peer review process with staff from the Lubbock State Supported Living Center (LBSSLC) had been successful. Plans had been shared between the Facilities with peers from each site providing support and feedback to each other. Efforts to address data collection problems were also addressed. This new system just recently had been introduced with selected staff trained on its use. Based on observation and document review, the accuracy and reliability of collected data remained problematic. Staff are encouraged to continue their focus on designing systems that are manageable and valid. Training staff to understand the importance of objective measures and to accurately record data as behavior occurs will be essential to improving the Facility's compliance with the standards set forth in the Settlement Agreement. Since the last visit, only five Structural and Functional Assessment Reports had been completed. As the information gleaned from these assessments is critical in developing appropriate and effective Positive Behavior Support Plans, this activity should be a priority. The Facility's efforts to develop standardized psychological assessments that will include functional behavior assessment are commended. The Positive Behavior Support Plans currently developed for the individuals at the Facility provided a range of very helpful and specific guidelines for staff. Future plans should include a greater emphasis on identifying appropriate replacement behaviors, with guidelines for teaching these behaviors throughout the day. Considerable changes to these plans also should be made to ensure that appropriate reinforcers are identified, differential reinforcement is applied, and schedules of reinforcement are dense enough to effect positive behavior change. Ensuring high levels of treatment integrity through effective, competency-based training is another task for the psychology staff to address.

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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 17 psychologists, all of whom had a graduate degree. Four of these 17 psychologists (24%), including the Director, were Board Certified Behavior Analysts. An additional associate psychologist had completed all necessary coursework, and had recently taken the exam. Eight other associate psychologists had completed at least one of the required courses. Of the remaining four associate psychologists, two were expected to begin classes in the fall of 2011, one planned to enroll in the spring of 2012, and the last had yet to make a commitment to the process. All coursework was being completed through the University of North Texas. As noted in the last report, the State is commended for the support offered to existing staff to complete the certification process and for its efforts to continue recruitment of psychologists who already are certified. AUSSLC and the psychology staff in particular are commended for their accomplishments in obtaining and pursuing certification. Since the last visit, the Director of Behavioral Services had made contact with at least two university programs, the University of Texas at Austin and Texas State University at San Marcos. Faculty from each university had expressed an interest in affiliating with AUSSLC as a practicum site for students. This was expected to begin in the fall. Members of the psychology staff did raise four areas of concern during this visit. First, the Monitoring Team was informed that a salary increase had been identified for psychology staff to be awarded upon certification. However, this increase had not been applied in a timely manner. Second, it was reported that the Facility lacked a well-stocked library for psychology staff. While the staff members acknowledged that other staff members will share whatever materials are in their personal libraries, it would be helpful if resources could be identified to allow for journal subscriptions and current texts related to Applied Behavior Analysis to be obtained. Until this can be addressed, staff are encouraged to access the following website, where all but the most current volumes of the *Journal of Applied Behavior Analysis* can be accessed: http://seab.envmed.rochester.edu/jaba/. The third area of concern related to support for continuing education as required by the Behavior Analyst Certification Board. If attendance at local, regional, and national conferences could be supported, or if access could be provided to locally sponsored workshops and seminars, this might be effective in maintaining a staff of certified individuals. Lastly, staff reported that psychology assistants were often required to fill portions of shifts in the residences. Further, staffing difficulties did not always permit direct support professionals to participate in meetings relevant to the individuals they serve. As noted in the last report, this provision item was rated as in noncompliance because the majority of the professionals in the Psychology Department were not yet	Noncompliance

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		demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification. Equally important, the quality of the behavioral programming offered at the Facility remained an area of concern. This is addressed in detail in Section K.9 of this report.	
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 was a Board Certified Behavior Analyst and a Licensed Psychological Associate. He had over five years experience working with individuals with developmental disabilities. Based on observation and discussion, it appeared that Mr. Levy maintained a very good rapport with his staff. Other directors at the Facility also described a good working relationship with Mr. Levy. During the onsite review, it was commendable to observe Mr. Levy offering support to one of his psychologists, who was trying to assist in one of the residences as an individual was experiencing a behavioral crisis.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Since the last review, the Facility had created a Peer Review Committee in addition to the Behavior Therapy Committee. This peer group was charged with providing review and feedback to psychology staff regarding Positive Behavior Support Plans, Safety Plans for Crisis Intervention, and Structural and Functional Assessment Reports prior to presentation at the Behavior Therapy Committee meeting. As explained by the Director of Behavioral Services, staff members had expressed discomfort with presenting plans at the Behavior Therapy Committee, because staff from other disciplines were present. While this attempt to alleviate any punishing attributes of program review is commendable, it was reported that staff were no more comfortable with the Peer Review Committee. The Facility should help to educate the psychology staff to understand the benefit of internal peer review, regardless of which committee completes this service. As noted by Luiselli and Russo (2005): "Peer review should be an educative, supportive, and positive experience" (p. 481). Perhaps senior staff members could present while soliciting feedback from more junior staff members. Emphasis should be placed on the benefit of collaboration to ensure that plans are developed that will support positive behavior change for the individuals served. This is a challenging task, made easier with the support of colleagues who can provide thoughtful and constructive feedback. The internal Peer Review was scheduled to meet weekly with presentation of the PBSP by the author. The Director of Behavioral Services and fellow Associate Psychologists served as the reviewers. The Peer Review meeting the Monitoring Team observed reflected active participation by members and supportive feedback. Data on the percentage of PBSPs that had been reviewed since this committee was formed was unavailable at the time of the visit. As timely review of all plans has proven to be a challenge, the Facility is encouraged to complete its goal of combining the Peer Review and Behavior Therapy Committees as soon as possible. Initial steps had been taken to develop an external peer review process. Contact had	Noncompliance

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		been made with the Director of Behavioral Services at LBSSLC, and the exchange of information had begun. From the documentation provided by the Facility, it appeared that a review of documents for three different individuals residing at AUSSLC had been completed over a three-month period (October to December). In exchange, staff from AUSSLC had provided feedback on documents related to two individuals residing at LBSSLC in March of this year. This supportive collaboration is commendable. Staff are encouraged to schedule regular opportunities for external peer review, with a focus on individuals who are presenting with significant challenges. The Guidelines for Peer Review offered a good overview of the process and its purpose. The rubrics that had been developed to guide the review were useful and provided an objective measure of the degree to which a plan addressed all identified components. Staff should focus on positive feedback related to the plan's strengths and specific, constructive criticism to provide clear recommendations that will help to expand the psychologist's skill set.	
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.	Efforts to address data collection problems were also addressed. A new data sheet had been developed, and had just recently been introduced with selected staff trained on its use. Staff were directed to record the date and start and end time of all targeted problem behaviors. Additionally, a record was to be made of the following: a) the number of times the behavior occurred; b) the location of the target behavior; c) the activity in which the individual was engaged just before the behavior occurred; d) the events that occurred about one minute before the behavior occurred; and e) the staff behavior following the behavioral incident. While the information provided in this type of data system could prove to be very helpful, it is unlikely that staff will be able to take the time necessary to accurately record the outlined sequence of events. This might be information that would be better collected by psychology and/or support staff, with direct support professionals required to simply record occurrences. Considering what has been observed and reviewed since the initial baseline tour, it is apparent that staff have struggled with even the most basic data collection requirements. Based on observation and document review, the accuracy and reliability of collected data remained problematic. Staff are encouraged to continue their focus on designing systems that are manageable and valid. Training staff to understand the importance of objective measures and to accurately record data as behavior occurs will be essential to improving the Facility's compliance with the standards set forth in the Settlement Agreement. During the onsite review, there were multiple occasions where individuals were observed engaging in problem behavior. Data sheets and behavior observation notes were requested to determine whether these incidents were documented. In total, the information for 12 individuals was reviewed. For four of the 12 individuals (33%), some data and/or notes were recorded related to the observation. These are described below:	Noncompliance

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		▪ During a brief visit to his residence, Individual #351 was observed to hit himself eight times in the throat. One occurrence was recorded on his data sheet. ▪ Similarly, during a visit to the residence of Individual #333, she was observed to engage in five incidents of self-injury. The same number was recorded, although it appeared the record referred to an event two hours earlier. ▪ Individual #165 displayed aggression during a visit to her home. This was recorded on the data sheet. Staff noted their concerns in the comments section of one data sheet: "[Individual #165] slaps and hits clients and we have no way (of) removing to her room until she is ready. This could be for one to three hours. We block and prompt her sometimes with no luck." Psychology staff should meet with the direct support professionals to help resolve this matter with appropriate changes to the individual's behavior support plan. ▪ Individual #382 displayed repeated swearing and property destruction (throwing material, overturning a table) as she waited for dinner one evening. Nothing had been recorded for that day on the data sheet, but there was documentation in the behavior observation notes that she "… had some behaviors, nothing too major, some verbal and hitting another client." For eight of the 12 individuals whose records were reviewed (67%), the observed problem behavior was not documented on either the data sheet or behavior observation notes. This included the following: ▪ Individual #251, Individual #168, Individual #78, and Individual #73 were observed engaged in repeated self-injury, yet this risky behavior was not documented. During two one-minute observations, Individual #73 slapped himself 12 and 24 times. At one point the staff member asked him why he was hitting himself. When staff on the residence were asked how they were supposed to respond to this behavior, a member of the Monitoring Team was told that they are to direct him to stop, "but this only makes the behavior worse." Psychology staff should follow up on this matter as soon as possible. ▪ Individual #394 was observed striking Individual #80. The aggression was not recorded, and the injury was not noted. ▪ Individual #140 was observed striking a staff member four times. He was told that he did not need to hit. This behavior was not documented. ▪ Individual #167 was observed outside yelling. Although there was a similar incident recorded in the behavior observation notes, it was at a different time of day. The data sheet did not reflect the observed incident. As has been noted previously, important clinical decisions are made based upon the data that is recorded. Unless this data is accurate, changes might be made that are not warranted, or ineffective treatment, behavioral and/or psychopharmacological, might continue. Psychology staff should work with the direct support professionals to identify	

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		data collection systems that are manageable and provide the information needed. Another concern raised during the review was the sleep data sheet that was in use for Individual #338. The directions indicated that an "S" should be recorded if the individual was sleeping, defined as "laying still with his/her eyes closed for at least 15 minutes of the 30 minute interval." It is unlikely that a staff member will observe an individual for 15 consecutive minutes, or longer, to determine whether his/her behavior corresponds to the definition. This also would suggest that enough light should be available to determine that the individual's eyes are closed. This would appear to be very intrusive and possibly disruptive to the individual's sleep cycle. There are often times when it is important to have an objective measure of an individual's sleep patterns. However, the definition and the corresponding data sheet should be altered to ensure a manageable and humane method for collecting this information. Monthly psychology progress notes were reviewed for 10 individuals. The following summarizes the findings from this review: ▪ In nine of the 10 notes (90%), the author/psychologist was identified. However, none of the notes were signed. ▪ All the monthly reports included a review of the individual's progress or lack thereof, and several provided a description of significant events that had occurred in the previous month. Examples of the latter were provided in the notes for Individual #332 (March and April specifically), Individual #210, and Individual #78. ▪ Progress notes for Individual #332, Individual #202, and Individual #73 provided examples where specific recommendations were made to address healthcare issues (i.e., glaucoma, and allergies), increased opportunities for exercise, or environmental factors (i.e., noise), respectively. ▪ All but one of the monthly progress notes (98%) included recommendations to continue to implement the current PBSP. When the individual's problem behavior is not improving, in addition to ensuring that the plan is being implemented consistently, revisions to the PBSP should be discussed and considered. ▪ The notes for Individual #332, Individual #210, and Individual #73 noted that staff would be trained on the new PBSP as soon as appropriate reviews had been completed. In the first two cases, this was noted across a minimum of two months, and then there was no further mention of a revised PBSP or the completion of staff training. For the third individual, a revised PBSP was noted in December, but still had not been approved for implementation by April. ▪ The graphs presented were very difficult to read as multiple medications and/or behaviors were documented simultaneously. Medications were presented in bar graph format, and behaviors were presented in line graph format. Individual	

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		#212 had two separate graphs, each depicting three medications and six behaviors. Individual #158 had one graph depicting three medications and five behaviors. Individual #382 had one graph depicting four medications and six behaviors. With so much information presented, it was increasingly difficult to discern improvement or worsening in the target behaviors. As noted previously, these monthly averages also prohibit an analysis of response to treatment. ▪ One last concern raised when reviewing these monthly progress notes was the inclusion of headers regarding emergency medication and/or programmed restraint in all but one plan (90%). Examples in which specific information was provided included the following: o Individual #210 had a specific medication identified under "Chemical Restraint." o Individual #78 had a protective mechanical bodysuit identified under "Programmed Restraint." o Individual #202 had a specific "Emergency Medication" identified. o Individual #382 had basket hold and horizontal identified as "Programmed Restraint." Although in later progress notes a line was drawn through the words describing the forms of restraint, along with a note that these had been deleted, in fact, they were still visible in the progress reports. As these were progress notes regarding the individual's Behavior Support Plan, the inclusion of information regarding restraint implied that this was one component of the plan. If chemical, mechanical, or personal restraints are employed with any frequency, these should be identified within a Safety Plan for Crisis Intervention and should be used only when a crisis presents itself. While a review of the use of restraint for crisis intervention is important and appropriate, to ensure clarity, this should be reviewed under a section of the report devoted to the individual's Safety Plan for Crisis Intervention.	
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.	A total of five Structural and Functional Assessment Reports had been completed since the last visit. The field of Applied Behavior Analysis has long recognized the importance of developing an understanding of the function served by identified problem behaviors to ensure that behavior support plans are thoughtfully developed to ensure maximum effectiveness (see Carr, Robinson, & Palumbo, 1990). It is strongly advised that completion of these assessments be identified as a priority for the psychology staff. The assessments reviewed consistently included the following required components: a) indirect assessment using a published and acceptable tool; b) differentiation between learned and biologically-based behaviors; c) identification of setting events and motivating operations relevant to the undesired behavior; d) identification of antecedents and consequences relevant to the undesired behavior; e) identification of	Noncompliance

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		the perceived function(s) of the undesired behavior; and f) a summary statement identifying the variable(s) maintaining the target behavior. Areas that needed to be strengthened included: a) a summary of direct observation that describes the events before and following unwanted behavior; b) identification of functionally equivalent replacement behavior; and c) careful and systematic assessment of the individual's preferences and potential reinforcers. A review of four of the assessments developed since 10/10 was completed. The results are provided below. ▪ Individual #78: This report began with a concise description of the individual's preferences and methods of communicating. What followed was an in-depth review of early development, most of which was not relevant to the purpose of the assessment. The reader could be directed to the clinical record for such historical information. The data analysis section offered a very complicated graph depicting five different behaviors. The ensuing discussion regarding data analysis suggested that the program was effective for the treatment of pica attempts, but this behavior occurred quite often. If the psychologist completed a review of behavior observation notes, a summary of the information should have been provided versus a repetition of the notes themselves. Similarly, the psychologist should summarize the information gleaned from interviews, rating scales, and direct observation to offer support to the assessment conclusions. Generalizations based upon an individual's diagnosis of autism should be avoided. Recommendations should have been included to address pain and hunger, as these were identified setting events. ▪ Individual #185: The assessment began with a succinct history and information related to the individual's preferences and communication abilities. As noted above, the psychologist should summarize the results of behavior rating scales, rather than providing a table reflecting the responses of individual staff members, and provide a review of pertinent information gained through interview. The findings were presented concisely with accompanying hypotheses outlined clearly. While some variables were addressed in the recommendations section, the psychologist also should have addressed hunger and thirst as potential setting events. Revisions to the PBSP should have been made accordingly. ▪ Individual #186: The introduction provided useful information regarding the individual's preferences, typical behavior patterns, and some areas of adaptive behavior. A suggestion would be to refer the reader to the individual's clinical file for early history including the age at which developmental milestones were met. Although the report indicated that visual impairment in one eye and limited mobility did not appear to greatly impact his target behaviors, one could argue quite the opposite. These two factors should be given consideration.	

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		Relevant information gained from a review of observation should be provided, rather than repeating the notes themselves. One potential intervention for short-term consequences was to provide praise for engaging in an alternative activity. As being left alone was identified as highly preferred, it is unlikely that praise will function as a reinforcer. Consideration should be given to using some of the tangible reinforcers identified (e.g., pudding) to help shape his tolerance for personal care routines, training programs, and other demands. Revisions to the PBSP should be made accordingly. ▪ Individual #2: A brief introduction to the individual was provided. Staff should remove tables outlining a history of psychotropic medication, because this was not relevant to the current assessment of problem behavior. A summary of the information gleaned from a review of observation notes, rating scales, staff interviews, and direct observation should have been provided. The assessment should have been proofed carefully to ensure that information was consistent throughout (e.g., the individual was described to be walking about the living room, but then was guided to move in a different direction by staff steering his wheelchair). The recommendations included a note to update the PBSP after disseminating the results of the assessment. The report format should be streamlined to include only information that is relevant to the purpose of the assessment. One suggested format would include the following: a) identifying information (e.g., name, date of birth, date of admission, diagnosis, date of assessment, date of report, and person completing the report); b) reason for referral; c) brief profile of the individual with particular attention placed on his/her communication abilities; d) identified target behaviors, operationally defined, with corresponding data collection methodology; e) assessment procedures; f) assessment results, including a narrative description of direct observation; g) identification of setting events, antecedents, and current consequences; h) hypothesized function(s) of the behavior(s); and i) recommendations for supporting behavior change. Watson and Steege (2003) provide a format and several examples.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The Facility is commended for the efforts made to develop and implement a data collection tool that is simple to use while offering valuable information regarding antecedent-behavior-consequence patterns. Staff are encouraged to ask direct support professionals for feedback regarding the ease of use of this data sheet, because it might prove to be time consuming and not sustainable. This same group is encouraged to continue its efforts to develop a system for assessing inter-observer agreement. Based upon observation and document review, it is clear that data collection continued to be a challenge. The accuracy and reliability of the data collected and used to guide treatment was considerably compromised. Staff did not record events as they occurred	Noncompliance

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		and appeared not to have a clear understanding of the importance and need for objective measures. Specific problems are identified and reviewed in detail in Section K.4 of this report. The issues related to data collection should become a focus of the Facility's Plan of Improvement.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	Only one individual had been admitted to AUSSLC since the last visit. A copy of the Psychological Evaluation for Individual #109 was provided. More specifically: ▪ The Psychological Evaluation provided a review of relevant background information, including medical and psychiatric related issues, a brief statement regarding her communication abilities, and a summary of the results of prior evaluations. However, assessment of this school-aged individual's cognitive and adaptive behavior abilities was due, because her last formal evaluation was completed three years previously. The next section of this report listed topics related to a functional behavior assessment. However, no information was provided. It would have been more appropriate and useful if information was provided regarding the individual's adjustment to her new living environment. Plans for completion of an SFAR could be noted in the recommendation section. As written, the report was incomplete, was not dated, and did not identify the author. The Monitoring Team requested copies of the most recent psychological evaluation for a sample of individuals residing at AUSSLC. The Facility provided documentation for 27 individuals. A variety of documents were provided with multiple documents provided for several individuals. The following is an analysis of the most recent documents provided for the sample: an annual staffing or behavior summary was provided for 12 individuals, the Structural and Functional Assessment Report was provided for five individuals, the Reiss Screen and Progress Note was provided for three individuals each, and a Psychological Evaluation or Psychological Evaluation Update was provided for only two individuals each. Twenty-six of the 27 individuals had a report completed within the last five years. The report for Individual #335 was written in 1997. The information provided in these documents varied considerably. The Facility has developed a template for psychological evaluations that was quite comprehensive in scope. It is anticipated that this new format will improve the Facility's compliance with this provision in the future.	Noncompliance
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.	The Facility employed one psychologist, a licensed professional counselor, to provide individual and group counseling services to identified individuals. As of 3/14/11, ten individuals were involved. Nine of the 10 (90%) were scheduled to attend individual counseling sessions once per week. The tenth individual was scheduled to attend individual sessions twice weekly. Three of the 10 also were scheduled to participate in	Noncompliance

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	Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	weekly group therapy sessions. The most recent progress note (2/11) for seven individuals was reviewed. Each note provided a summary of the previous month's attendance, a review of progress made on each identified objective, a process summary, homework assigned, and recommendations for future services. As noted in the previous report, the counseling plans did not allow for an objective measurement of treatment efficacy. Clearly written objectives should include the following information: a) the conditions under which the behavior will occur; b) a description of how the behavior will 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. Examples of concerns included: ▪ Individual #154 and Individual #158 were learning to describe family, sweetheart, friend, acquaintance, professional, and stranger, and then were to demonstrate/identify appropriate levels of touch and conversational topics related to these relationships. The conditions under which these behaviors were to occur were not specified, the observable behavior was not clear, and the number of times per session they were to demonstrate these skills was not noted. ▪ Other individuals (Individual #395, Individual #158, and Individual #7) were to complete daily diary cards recording emotions, self-care, urges, and behaviors. Again, the conditions under which the behavior was to occur were not specified, the number of times the behavior was to occur was not indicated, and criterion to determine acquisition was not identified. While the goals of counseling might be very appropriate for the individual served, these should be written in a manner that allows for an objective analysis of 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	Forty-two PBSPs and three draft PBSPs were reviewed, and the following summarizes this review: ▪ All of these plans (100%) included a rationale for the plan within the text of the document, an operational definition of the targeted problem behavior(s), a potential function(s) of the behavior(s), baseline or comparison data, and strategies to apply contingent upon the problem behavior(s). ▪ All of the plans (100%) included a section that outlined directions for staff to follow. These provided a summary of the more detailed information provided earlier in the plan, allowing for an easier reference or review of behavioral definitions, preventative strategies, and steps to take when the problem behavior was exhibited. These generally were written in clear terms. ▪ Twenty-five of the 45 plans (56%) identified appropriate replacement	Noncompliance

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	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.	behavior(s), with 12 (48%) of these plans providing appropriate guidelines and scheduling for teaching the replacement behavior(s). ▪ Forty-four of the 45 plans (98%) included strategies to address setting events and antecedent management. However, only two (4%) included clearly identified schedules or reinforcement that were sufficiently rich to effect behavior change. ▪ While the author was identified in 38 of the 45 plans (84%), only two of the plans (4%) were signed. ▪ All but three of the plans (93%) had been written within the 12-month period prior to the review. At a minimum, plans should be updated annually. Specific feedback related to these components of the PBSP is provided below. Historical information should be kept brief, with a focus on important health matters and environmental factors that are related to the individual's current placement and presentation. An example where this was done well was the plan for Individual #332. Several plans included a review of medication history. It is suggested that this information is irrelevant to the current behavior support plan, and is likely available in the individual's clinical record. As noted, all of the plans included operational definitions of the identified problem behavior. The plan for Individual #395 included a behavior to be monitored, self-injury, but this behavior was not described in observable terms. Several of the plans included problem behaviors that involved vocal or emotional responses. The plan for Individual #181 identified "disruptive outbursts" which included whimpering, whining, crying, and screaming. Individual #318 had problem behaviors of crying and loud, agitated vocalizing identified in her plan. For these individuals and others who have similar responses, it might be helpful to indicate the duration necessary to identify an episode. Individual #186 displayed self-injury. The definition indicated that: "several blows constitute one incident." As written, this required interpretation on the part of the staff member. Lastly, a rating scale was used to measure the compulsive behavior exhibited by Individual #142. A particular number was recorded based upon the individual displaying the behavior none, "some," "half the time," "more than half the time," or constantly. The time frame was not identified, and these categories were not clearly defined to ensure reliability or accuracy in recording. While all of the plans noted the potential function served by the identified problem behavior(s), some plans did this more clearly and succinctly than others. The plan for Individual #332 directed the reader to the functional behavior assessment for details, but then provided a helpful summary of the information gained from the assessment. Other examples where information was clearly identified and briefly summarized	

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		included the plans for Individual #30 and Individual #202. Information regarding conditions when the target problem behavior(s) was least likely to occur were provided in the plans for Individual #77 and Individual #167. This can be very useful in identifying preventative strategies, and when scheduling the individual's day. The plan for Individual #84 noted that self-injury functioned as a means of obtaining tangible items or activities, yet later the function was hypothesized to be escape. Staff should review all plans to ensure that the information provided is consistent throughout. With the exception of the plan for Individual #299, preventative strategies were proposed to minimize occurrences of targeted problem behaviors. Examples where these were clearly delineated and comprehensive in scope included: ▪ Individual #406: His plan included the use of noise-reducing headphones, and a picture schedule to communicate the day's events. ▪ Individual #181: Her plan included providing her choices, explaining events that required her to leave her home, and limiting her time in noisy and/or crowded environments. ▪ Individual #10: His plan included helping him to exit noisy and/or crowded places, encouraging him to remain in bed until the nurse arrived to distribute morning medications, recognizing his preference for worn and soft clothing, and obtaining medication, if allergy symptoms were observed. ▪ Individual #167: Her plan included guidelines to obtain pain medication, if she reported discomfort during her menses. Replacement behaviors are often developed through functional communication training. As noted by Carr et al. (1994), functional communication training consists of teaching a socially appropriate form of communication that produces the same effect as the problem behavior, but is more efficient. The key is that the replacement behavior should be functionally equivalent to the targeted problem behavior. Examples where appropriate replacement behaviors were identified include: ▪ Individual #332: He was learning to the sign for "hurt" to communicate that he was in pain, and he was learning to leave an environment that became uncomfortable for him. The one function that was not addressed was teaching him a way to ask for tangible items. ▪ Individual #342: She was learning to ask for a break, and to make a request of staff to spend time with her. ▪ Individual #140: His leaning away from someone or something would be reinforced as an appropriate communication to request space. Examples where the replacement behavior did not match the hypothesized function of the problem behavior included: ▪ Individual #168: Although her self-injury was identified as a means to access	

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		something tangible, her replacement behavior was to learn to sign "Stop." ▪ Individual #84: Her PBSP indicated that screaming was an attempt to gain access to a tangible item, although later in the plan, this behavior and self-injury were identified as a means of escape, with a secondary function of gaining attention. Her replacement behavior would be dependent upon staff, because she was expected to answer questions presented to her. ▪ Individual #30: Two of three problem behaviors identified for this individual were hypothesized to serve as a means of escape. Rather than teaching this individual to request a break spontaneously and independently, he was to be asked whether he wanted a break. ▪ Individual #10: This individual displayed three problem behaviors, all of which were identified as a means to escape. His replacement behavior was to get out of bed for one minute. While working to teach this individual to leave his bed to engage in other activities was an appropriate goal, this would not serve as a replacement behavior for his targeted problem behavior. ▪ Individual #103: Her problem behaviors were hypothesized to function as a means to communicate pain, boredom, or discomfort, yet her replacement behavior was to manipulate objects, specifically Connect Four materials and blocks. Replacement behaviors should be identified that are functionally equivalent to the identified target behaviors. Teaching instructions should be clear with sufficient learning opportunities provided throughout the day. Some examples of problems with teaching replacement behavior include: ▪ Individual #428: While his replacement behaviors of asking for water and requesting a break were appropriate based upon the perceived functions of thirst and escape from demands respectively, the guidelines for teaching will likely be unsuccessful. Staff were advised to give the individual water or a break, even if he does make the request, when prompted or when a break is scheduled. ▪ Individual #210: His using sign language to communicate his wants and needs, and specifically a break was scheduled to occur at least once per shift. This did not provide sufficient opportunities to develop this skill. ▪ Individual #140: While the identified replacement behavior was to push back or lean away, the guideline for teaching replacement behavior advised staff to teach him to choose a sensory item. As noted previously, PBSPs continue to lack a focus on effective use of reinforcement to change behavior. The two plans that included sufficient use of positive reinforcement were for Individual #421 and Individual #139. Both of these individuals were noted to enjoy attention from staff. The guidelines indicated that attention should be provided once every five minutes, as long as the person was behaving appropriately. Examples	

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		where reinforcement was not sufficient included: ▪ Individual #185: This individual was scheduled to receive social praise and physical stimulation once hourly, yet his plan clearly reflected that he did not like to be disturbed. ▪ Individual #318: This individual's plan included no schedule of reinforcement. ▪ Individual #77 and Individual #167: These individuals were to make a call once each week to schedule time talking with a preferred staff member. This reinforcing activity was identified to replace the problem behaviors that were hypothesized to serve an attention-seeking function. As both exhibited high rates of problem behaviors, as indicated by the data presented, it was unlikely that this very lean schedule would effectively result in positive behavior change. ▪ Individual #11: This individual would be able to access a preferred item or edible once each week, as long as she did not engage in any target behaviors. As the data reflected that she displayed multiple problem behaviors each month, it was unlikely that she would ever sample this reinforcement system. Lastly, strategies applied when targeted problem behavior occurred were very similar across all 45 plans. In 33 of the 45 plans (73%), the individual was told to stop engaging in the behavior. Additional steps often called for separating the individual from others, and then providing praise when the individual calmed. While there might be similarity across 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. As with all aspects of a PSBP, consequences should be individualized to ensure an outcome of positive behavior change. Additional comments related to specific PBSPs can be found with regard to Section C.7 of this report. The minutes from the Human Rights Committee (HRC) meetings held between 9/2/10 and 2/24/11 were reviewed. The minutes were comprehensive and provided a good overview of the discussion and outcome related to each agenda item. Affiliate members were present at every meeting. The HRC Officer is commended for the work that has been done to educate individuals in self-advocacy. One concern related to the timeline of HRC review of PBSPs. Tracking sheets were provided to the Monitoring Team that noted the date the Personal Support Team, the Peer Review Committee (identified as pre-Behavior Therapy Committee), the Behavior Therapy Committee, and the Human Rights Committee completed reviews. There was no information indicating the date that the guardian or individual had provided approval/consent. The data indicated that PSBPs for 51 individuals had been created or revised since 11/10 (excluding those identified as "in progress"). Of these 51 plans, HRC	

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		review was noted for only 15 (29%). Of these 15, only five (33%) had been reviewed within one month of development. The timeline for review of the other 10 plans ranged from just over one month to just over three months. Twelve additional plans of the total sample (24%) reflected HRC review prior to the date of the plan. Of the remaining 24 plans that had yet to be reviewed, eight were developed in March, six in February, five in January, three in April, and one each in November and December. This delay in obtaining appropriate reviews resulted in a delay in program implementation. Staff should develop a strategy to ensure timely review of all plans by all required committees and individuals/guardians. It might be helpful to note on the plan the date of each required review to highlight the timeline for final approval and implementation. The Monitoring Team observed the HRC meeting held the week of the onsite visit. Members in attendance included Facility personnel, community representatives, and an individual who resided at AUSSLC. As noted in previous reports, concerns were raised when psychology staff members addressed medication changes. Although a master's degreed psychologist attempted to answer questions posed by committee members, it was noteworthy that a doctoral level psychologist reported that medication was not her area of expertise, and, therefore, she could not respond to the question she was asked. It is recommended that psychiatry assistants present changes in medication when HRC approval is required. This also would help to focus the psychologist's efforts on the contents of the PBSP. Another concern was noted specifically related to Individual #210. The psychologist presented his plan, one component of which was a 24-hour restriction to the residence following an incident of aggression. This punishment would not be meted out on days the individual was scheduled to attend school or medical appointments, church-related activities, or emergency off-campus events. This plan was presented on 5/12/11, but it was written on 4/1/11. As it was not indicated to be a draft, there were concerns that this was implemented prior to HRC approval. If this plan was implemented as written, additional concerns were that it would likely result in restrictions occurring more often in the evening hours and on weekends when there were fewer support and professional staff present. Further, this individual might quickly learn that he would not be exposed to the punishment, if he displayed aggression the night before school. While the thoughtful use of punishment can be an important part of any PBSP, caution should be used in this specific case due to the concerns noted. An issue related to Individual #217 deserved attention, as well. Prior to significant events that occurred in December, a decision was made to remove many personal items that were clearly important to this individual and his well-established personal identity. Although his guardian had made this request, this considerable rights restriction should have been presented to the HRC for review. This rights restriction was implemented and	

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		very likely contributed to events that led to this individual's incarceration.	
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 two reports is repeated here. Considerable questions remained regarding the accuracy and reliability of the data that was used to determine treatment efficacy, or the lack thereof. Staff will need to develop systems to measure inter-observer agreement to ensure that the data used to guide treatment decisions is, in fact, representative of the individual's behavioral patterns. At the time of this visit, data was presented graphically using monthly averages. Graphs consisted of multiple measures, making for a very "noisy" presentation of data that was difficult to read. These graphs 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. As noted in Section K.4, the depiction of multiple measures on one graph further exacerbates the difficulty in analyzing the data presented. "If too many data paths are displayed on the same graph, the benefits of making additional comparisons may be outweighed by the distraction of too much visual 'noise'" (Cooper, Heron, & Heward, 2007, p. 132). Without ongoing review of daily changes in the target behavior, timely revisions to behavior support plans will not occur. Unless an individual's problem behavior has been eliminated or reduced to a very occasional occurrence, staff should consider graphing daily measures for each identified problem behavior following standard construction guidelines.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	One component of the PBSPs reviewed was a section entitled "Staff Directions" or "Directions for Staff." As noted previously, these were clearly written and included information pertinent to providing a supportive environment and response to problem behavior. Additionally, staff interviewed during the visit indicated that plans were easy to understand and psychology staff provided sufficient levels of support. While this section of the plan provided a shorter review of critical components of the plan, these were multiple pages in length. Staff should consider a brief version of the PBSP, perhaps with bulleted information, that can serve as a quick reference for staff. As noted in the	Noncompliance

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		last report, one helpful addition to both the PBSPs and the staff directions section 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, and way to indicate pain, etc.). While the staff report was positive, it is only when staff are observed implementing the specific elements of a plan that a high degree of treatment integrity can be assured (see Codding, Feinberg, Dunn, & Pace, 2005). AUSSLC did not yet have a process in place to ensure treatment integrity. In addition to the staff directions reviewed in the PBSP sample, two PBSP summaries for I-Books (Individual #78 and Individual #299) were provided, as were two BSP Summary pages (Individual #77 and Individual #167). The I-Book summaries provided a review of the information contained within the PBSP, however, as these were not dated is was unclear whether these were current. The two BSP summaries were concerning as both included programmatic restraint guidelines. Again, these were not dated. Programmatic restraint should not be a component of any individual's plan per Facility policy. Staff should ensure that all documentation available to direct support professionals is current, dated, and signed. Additionally psychology staff should regularly solicit feedback from direct support professionals to assess their ability to implement the plans and to gather input regarding necessary revisions to the plan.	
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.	While didactic instruction is essential in laying the foundation for an understanding of the guiding principles and applied strategies involved in producing positive behavior change, competency-based training is necessary to ensure that behavior support plans are followed by staff when they are on the job. The Facility is commended for the initial steps that had been taken to monitor the implementation of Positive Behavior Support Plans. However, the usefulness of any monitoring will only be assured when the feedback provided to the staff results in improved performance. Competency-based training involves the development of checklists that outline the essential steps a staff member should demonstrate when working with an individual. Once a staff member is familiar with these critical components of his/her job, supervisory or support personnel should schedule a time to observe the staff member as he/she performs the identified task. Components of the checklist on which the staff member displayed competence should be noted, areas of change should be addressed, and immediate feedback should be provided. As noted by Ricciardi (2000), "…the combination of specificity and timeliness enhances the effectiveness of feedback aimed at performance improvement" (p. 4). The observation form the Facility has developed was a good first step in developing a comprehensive competency-based training system.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted in the Settlement Agreement, staff training should include a combination of didactic, modeled, and in vivo training. A competency-based training system should be in place to ensure that all staff are adequately and effectively trained on the PBSP for each of the individuals they serve. Training should take place prior to the PBSP implementation, when changes are made to the plan, and at a minimum of annually thereafter. Pulled and relief staff should be provided this same level of competency-based training. The professional responsible for the PBSP should provide the training. It is important to note a concern regarding staff training that the Psychology Department staff expressed. Reportedly, even when staff are scheduled for training, conflicts or other needs often occur that require the staff member's presence in his/her work environment or elsewhere to provide supervision to the individuals served. Without adequate time set aside to train direct support professionals, the training requirements outlined in the Settlement Agreement will not be met.	
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.	Based on information provided in the staff roster, dated 3/24/11, and the Plan of Improvement, dated 4/27/11, there were a total of 17 psychologists on staff. The Director and Assistant Director of Behavioral Services provided supervision. A third psychologist provided counseling services to individuals who resided at AUSSLC. This resulted in a total of 14 Associate Psychologists providing direct and indirect services to the 361 individuals in residence. With a ratio of 1:26, there was a sufficient number of staff to meet the identified criterion. As noted in the Plan of Improvement, every two psychologists were supported by one assistant. However, as noted in Section K.1 of this report, the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as required by the Settlement Agreement, as evidenced by the absence of professional certification, as well as by the quality of programming provided at the Facility. However, as noted previously, staff are commended for their ongoing efforts to obtain certification.	Noncompliance

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

1. The Facility should obtain and maintain an adequate number of Board Certified Behavior Analysts, and provide staff the supports to maintain the requirements for this certification. (Section K.1)
2. Psychology staff should be assisted to gain an understanding of the benefit of peer review, and should be supported in their participation in the same. Regularly scheduled opportunities for both internal and external peer review should occur. (Section K.3)
3. It is essential that the Facility improve its data collection system to ensure that collected measures are reliable and valid. More specifically:
    a. Reliance on systems that encourage staff to enter information at the end of their shifts should be eliminated.
    b. Measures should reflect the rate, duration, and/or intensity of problem behavior, and its corresponding replacement behavior.
    c. 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/or severity of the problem.
    d. 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.
   e. Each data sheet should include clear guidelines regarding the manner in which data should be collected.
   f. Feedback from direct support professionals on the ease of use should be recruited. (Section K.4 and K.6)
4. 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. (Section K.4 and Section K.10)
5. If the individual has a Safety Plan for Crisis Intervention, it is important and appropriate that the Facility reviews the use of chemical, mechanical, or personal restraint as part of the progress report related to problem behavior. However, it is recommended that the format of these reports be revised to ensure that there is no suggestion that restraint is an approved component of the Positive Behavior Support Plan. All reference to restraint should be addressed within the review of the individual's Safety Plan for Crisis Intervention. (Section K.4)
6. 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. (Section K.4)
7. The completion of Structural and Functional Assessment Reports should be a priority, particularly for those individuals who are exposed to frequent restraint or whose problem behaviors have proved resistant to treatment. Revisions to the assessment process and report format should be considered. Greater emphasis should be placed on information gathered through direct observation, and when conducted, functional analysis. Consideration should be given to streamlining the report to only include information that is relevant to the purpose of the assessment. One suggested format would include the following: a) identifying information (e.g., name, date of birth, date of admission, diagnosis, date of assessment, date of report, and person completing the report); b) reason for referral; c) brief profile of the individual with particular attention placed on his/her communication abilities; d) identified target behaviors, operationally defined, with corresponding data collection methodology; e) assessment procedures; f) assessment results, including a narrative description of direct observation; g) identification of setting events, antecedents, and current consequences; h) hypothesized function(s) of the behavior(s); and i) recommendations for supporting behavior change. Watson and Steege (2003) provide a format and several examples. (Section K.5)
8. 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. (Section K.5)
9. Psychology staff are encouraged to begin implementing the revised psychological assessment format while ensuring that the information is timely and relevant to the assessment's intended purpose. (Section K.7)
10. With regard to individual and group counseling, clearly written objectives should include the following information: a) the conditions under which the behavior will occur; b) a description of how the behavior will 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. (Section K.8)
11. 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. (Section K.9)
12. Staff directions or PBSP summaries should offer essential information to direct support professionals. Operational definitions of both problem behavior(s) and replacement behavior(s) should be included, as well as 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. (Section K.9)

13. 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. Guardian and/or individual review dates should be included in this tracking document. (Section K.9)
14. When medication changes are presented for review at the Human Rights Committee, a member of the psychiatry staff, for example, a psychiatry assistant, should be present to ensure that questions related to these changes can be addressed appropriately and adequately. (Section K.9)
15. Inter-observer agreement should be assessed regularly, but no less than once each month. (Section K.10)
16. Staff should consider a brief version of the PBSP, perhaps with bulleted information, that can serve as a quick reference for staff. One helpful addition to both the PBSPs and the staff directions section 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, and way to indicate pain, etc.). (Section K.11)
17. Measures of treatment integrity should be collected on a regular basis with samples taken on a variety of plans across shifts. (Section K.11)
18. All documents should be dated and signed. (Section K.11)
19. I-Books should be checked regularly to ensure that necessary documents are included and current. (Section K.11)
20. 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. (Section K.12)

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. (Section K.1)
2. It would be helpful if resources could be identified to allow for journal subscriptions and current texts related to Applied Behavior Analysis to be obtained. Until this can be addressed, staff are encouraged to access the following website, where all but the most current volumes of the *Journal of Applied Behavior Analysis* can be accessed: http://seab.envmed.rochester.edu/jaba/. (Section K.1)
3. 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.
4. 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 Morning report handouts (Infirmary census, medical observation), for 5/10/11, and 5/11/11; o Twenty most recent annual medical assessments and physical examinations and prior annual assessments and examinations for the following: Individual #272, Individual #12, Individual #30, Individual #222, Individual #180, Individual #174, Individual #288, Individual #310, Individual #42, Individual #208, Individual #351, Individual #182, Individual #223, Individual #49, Individual #320, Individual #356, Individual #3, Individual #247, Individual #135, and Individual #118; o Avatar pneumonia tracking forms for six months; o Aspiration Pneumonia from 10/1/2010 to 3/30/2011, print date 3/30/11; o Report of individuals with diagnosis of Down Syndrome and copies last thyroid lab results, print date 4/6/11; o Notes and orders for any Do Not Resuscitate (DNRs) Orders and rescinding DNRs; o Resuscitative Status List update with reason; o Rate of autopsy completion (number of autopsies/number of deaths) for deaths in last one year, per quarter; o Number of individuals on each physician's caseload, dated 4/1/11; o Employees listed under Medical Department completing Cardiopulmonary Resuscitation (CPR) training certification, with dates of completion; o List of all staff who work in the Medical Department, including names and titles; o Name and CV of Medical Director; o Copy of Continuing Medical Education (CME) for each primary care provider, since last monitoring visit; o Infectious disease data/quarter by category of infection, last two quarters: monthly statistics September 2010 to February 2011; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Compilation of decubitus ulcers for prior year; o Summary Report/Trend analysis of infectious diseases/communicable diseases for last two quarters; o Email from AUSSLC administration, dated 1/5/11, and 3/10/11; o Email from Medical Department staff/QA Department, dated 4/12/11; o Current list of all those with osteopenia/osteoporosis with medications and dosage per person: drug order report from 4/1/10 through 4/4/11; o Dual-energy x-ray absorptiometry (DEXA) reports for anyone over 50, completed in last six months; o Specialty clinic schedule per month, for past six months;

	o List of all outside consultations for medical purposes for the past six months, categorized by specialty; o Policies or procedures for medical screening and routine evaluations; o Any clinical guidelines developed and implemented since last Monitoring Team visit; o For the 10 individuals who most recently went to the ER, copies of integrated progress notes from start of signs/symptoms to transfer to ER, and ER report, including for the following: Individual #359, Individual #327, Individual #260, Individual #224, Individual #347, Individual #1, Individual #246, Individual #291, Individual #175, and Individual #182; o For those going to ER and not hospitalized, copy of discharge orders from ER and copy of Facility record orders, integrated progress notes (IPNs)/Infirmary progress notes, follow-up to any recommendations, for 10 most recent ER visits at least 30 days prior to Monitoring Team visit, including for the following: Individual #327, Individual #347, Individual #246, Individual #291, and Individual #175; o For those admitted to hospital, copy of admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility record orders, integrated progress notes/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, for 10 most recent hospitalizations that have returned for at least 30 days, including the for following: Individual #359, Individual #260, Individual #224, Individual #1, and Individual #182; o Drug Order Report from 4/1/11 through 4/7/11: list of individuals who have diagnosis of constipation or are receiving anti-constipation medication at least weekly; o Length of stay for Infirmary admissions for past six months; o For the last year, lists of individuals who have been: seen in the emergency room, including the date seen at the ER, and reason for visit; admitted to the hospital, including date of admission, reason for admission and discharge diagnoses, and date of discharge from hospital; admitted/transferred to the Facility's Infirmary, including date of admission/transfer, reason for admission/transfer, and date transferred back to residence; o Morning medical meeting documents, for 3/14/11 to 4/13/11, including 24-hour nursing log for all shifts, Infirmary census printout, and Hospital Liaison Nurse update notes; o Infirmary census 3/14/11 to 4/13/11, hospital liaison reports by individual with notes, 24-hour log book for each shift; o For those women over 40, date of last mammogram and reason listed if not up-to-date; o For those over 50, date of last colonoscopy, and list reason for colonoscopy (preventive versus evaluation of active problem), with reason if not up-to-date; o Drug order report from 4/1/11 to 4/4/11 from pharmacy for all pain medications; o For the last year, lists of individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia; and/or have had swallowing incident (defined as an event during eating that required an emergency intervention), including the date of incident, item that caused the swallowing incident, and the interventions following the incident;

	○ Minutes of skin integrity committee meetings, during the prior six months; ○ During the past 12 months, lists of individuals who have had a choking incident, including date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust; ○ During the past 12 months, lists of individuals who have had an aspiration, and/or a pneumonia incident; ○ During the past 12 months, lists of individuals who have had skin breakdown, and have an active pressure ulcer; ○ During the past 12 months, list of individuals who have had a fall; ○ During the past 12 months, list of individuals who have experienced a fracture; ○ For 10 most recent hospitalizations that have been completed, copy of Hospital Liaison Nurse documentation of hospitalization, including for the following: Individual #182, Individual #72, Individual #426, Individual #260, Individual #224, Individual #359, Individual #1, Individual #32, Individual #309, and Individual #326; ○ For past six months, documentation of seizure management for following individuals: Individual #297, Individual #89, Individual #299, Individual #301, and Individual #28; ○ List of individuals seen by neurologist, with dates seen and reason, since last monitoring visit; ○ List of individuals with refractory seizure disorder who are being evaluated for Vagus Nerve Stimulators (VNS) placement, and the stage of evaluation; ○ Pharmacy report anti-convulsant medications by patient, with diagnosis from 3/1/11 to 4/4/11; ○ List of those going to ER for uncontrolled/prolonged/new onset seizure, since last monitoring visit; ○ List of seizure medications per individual with diagnosis of seizure disorder; ○ List of those with status epilepticus, since the last monitoring visit; ○ Percentage of persons on older anti-epileptic drugs (AEDs) (e.g., Phenobarbital, Dilantin, Mysoline); ○ Percentage of individuals on two, three, four, and five antiepileptic drugs; ○ PCP email to Dental Department, dated 12/28/10; ○ Presentation book for Section L: 180 day medication orders procedure corrective action plan, dated April 8, 2011; Procedure for Individual Notebook (I-Book), draft dated 3/22/11; ○ DADS Policy Number 009.1; AUSSLC policy: Medical Policy, approved 2/16/11; ○ AUSSLC: Preventive Health Care Guidelines for Medical Care for the Developmentally Disabled Client, draft dated February 2011; and ○ Medical Provider Quality Assurance Audit tool, undated. ▪ **Interviews with**: ○ Fred Bibus, Medical Doctor (MD), Medical Director; ○ Archie Dan Smith, MD; ○ Alfredo Cisneros, MD; ○ Jae Yang, MD; and

	○ Jodie Friedrich, Family Nurse Practitioner (FNP). ▪ **Observations of**: ○ Individual #72, Individual #366, Individual #450, Individual #102, Individual #191, Individual #381, Individual #100, Individual #299, Individual #239, Individual #405, Individual #50, Individual #18, Individual #54, Individual #62, Individual #263, Individual #356, Individual #3, Individual #65, Individual #268, Individual #404, Individual #334, Individual #398, Individual #423, and Individual #453.
	Facility Self-Assessment: The Facility provided minimal information in its POI regarding compliance activities related to Section L. The Facility determined it was not compliant with any of the subsections of Section L, which was consistent with the Monitoring Team's findings. However, the Facility did not provide any data to support its findings. As the Facility's self-assessment process evolves, this should be a focus. The Facility provided the following updates in its POI: ▪ The Facility created a policy on preventive medical care that was forwarded on 2/3/11 to the State Office for review. The State Office policy concerning medical care (#009.1) was updated on 2/16/11. ▪ Several clinical pathways were in draft form that should provide timely medical guidance in the future for many of the illnesses that are common in the IDD population. ▪ An external non-facility medical peer review was completed on 4/8/11, with initial concerns corrected by the Medical Department. These steps are essential to the building of a Medical Department. With regard to Sections L.3 and L.4, the Facility indicated: "No action steps or initiatives have been initiated during the last six months."
	Summary of Monitor's Assessment: The Medical Department had developed a morning medical meeting, at which significant medical concerns that had occurred during the prior 24 hours, as well as current hospitalizations were reviewed. It was well attended by PCPs, psychiatry staff, and nursing staff. Rounds in the Infirmary followed it. This was one of the essential building blocks of ensuring quality care. The medical meeting had the potential to be expanded to review new clinical guidelines as they are finalized, as well as review of quarterly drug regimen reviews (QDRRs). It should be the forum for critical thinking, especially concerning how to prevent recurrences of hospitalizations and emergency room visits. However, the next step is documentation of the morning meetings. Such documentation should identify clinical concerns requiring closure, for which follow-up information should be recorded. At the time of this review, there was no formal process for follow-up of clinical concerns needing closure. With regard to routine care at the Facility, annual medical assessments were uniformly excellent, and provided a rich compendium of information concisely organized. However, timeliness of these assessments was problematic. The Medical Department should focus on ensuring timely completion of annual medical assessments and physical exams within a 365-day time period from the last annual medical assessment and physical exam. Also, the Medical Department should focus on synchronizing completion of the annual medical assessment and annual physical exam. They should be completed within a few days of

	each other, or ideally on the same day. An adequate database for tracking preventative care was needed, and this was an area that continued to need improvement. Acute care had numerous challenges needing attention, not all of which the Medical Department could resolve without the assistance of other departments. Additionally, once the acute illness had resolved, in many cases, there was little documentation of additional assessments or treatments to attempt to prevent repeat visits to the ER or hospitalizations. Given the relatively large caseloads of PCPs and the need for them to attend other required meetings, the PCPs had only a minority of their day dedicated to actual medical care. The Medical Department was lacking an adequate information technology system. There were several databases, which did not agree in content, and many appeared to be incomplete. The Medical Department should maintain complete and accurate data from which to determine trends. This was a significant barrier to any medical quality improvement program. Additionally, there was not the infrastructure in the Department to implement medical quality review, including accurate database entry, and adequate review of medical records. The continued issues related to timely and accurate filing of important information in individuals' records, as well as the lack of access to medical records made this more difficult. There had been recent reorganization of staff to assist in improving filing, but at the time of the monitoring visit, the filing of medical information appeared to have worsened. Non-facility medical peer review had been started, with an initial visit in April 2011. The results appeared pragmatic and helpful. However, there was no documentation of the visit, and it will be important to provide written documentation, as well as a plan regarding the numbers/percentages of the sample size that are expected to be reviewed over each 12-month period.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with	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, PCP participation in team process, routine care and preventative care, medical management of acute and chronic conditions, Do Not Resuscitate Orders, and mock drills. <u>Staffing</u> The Medical Department had a Medical Director, three staff physicians, and one nurse practitioner. The Medical Director had a small caseload of 10 individuals, consisting of individuals with significant medical complexities. At the time of the Monitoring Team's visit, plans were being made to close this unit and transfer the individuals to the unit that the nurse practitioner covered. The nurse practitioner had a caseload of 73, and the Medical Director supervised the nurse practitioner. For the staff physicians, one had a	Noncompliance

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	regard to this provision in a separate monitoring plan.	caseload of 103, a second staff physician had a caseload of 88, and the third staff physician had a caseload of 87. In determining an appropriate caseload for the primary care practitioners, and the Medical Director, a number of factors need to be taken into consideration, including, but not limited to the individual practitioners' experience in working with the ID/DD population, the acuity of the individuals on their caseloads, the other duties assigned, and the administrative or other staffing supports available. AUSSLC is encouraged to conduct an objective review of the current caseloads of PCPs to determine if changes need to be made, and if so, to make necessary modifications. Given the time commitments needed to attend required meetings as well as fulfill other duties, the Medical Department and Facility Administration should ensure efficient systems are in place that allow PCPs to obtain needed clinical information. Unfortunately, with changes in information systems, problems had occurred in at least one clinical area. PCPs routinely review monthly (or more frequent) weights for acute and ongoing care of the individuals. In a former database system, weights were logged/recorded onto a spreadsheet, which was readily available. Rapid visual review was possible for all individuals in a residence. There was also the ability to track serial weights over time in a user-friendly manner. This system was removed and replaced with Avatar, which also provided a database for weights. However, the login process was inefficient, and separate steps might need to be taken to obtain serial values. Although Avatar had advantages related to lab data and other clinical information, the reason for removing a spreadsheet that appeared to be efficient and valuable or not making both available was not clear. This and other issues suggested the need for the Medical Department to meet with the Information Technology Department to create user-friendly information systems with input from those that use this information most. The filing of medical information into the records remained a concern. Reportedly, in gathering documents to respond to the Monitoring Team's requests for information, much of the information was not in the records, and there was reliance on saved computer copies. It appeared that the filing system remained broken, and the backlog of unfiled information might be worsening. With new administrative organization and more filing clerks, this should resolve. However, oversight should occur to ensure it does. This is discussed in further detail with regard to Section V of the Settlement Agreement. Staff also reported that there was greater difficulty in accessing the actual medical records than there had been previously. In the past, a campus driver would bring records from the buildings to the PCPs for review and documentation. In recent months, the driver was assigned other duties, and for a period of time, there was no one to bring the records to the medical offices. More recently, the administrative assistants were assigned the task of bringing over records. This process was just beginning at the time of	

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		the Monitoring Team's visit. Based on the findings from the last Monitoring Team visit, the I-Book had been identified as an area needing improvement. There was a lack of timely filing of data from the I-Book into the active record. On 3/22/11, a "Procedure for Individual Notebook (I-Book)" was drafted to ensure timely placement of information in the active record. This remained an ongoing project, but it appeared work was progressing toward resolution of areas of concern. As part of the procedural draft, a detailed "individual notebook-purging schedule" was created. It is recommended that finalization of the procedure for the I-Book occurs, as well as implementation of the process to ensure timely filing of I-Book data in the active record. A list of employees from the Medical Department who completed CPR training certification was submitted, with dates of completion. It was assumed that certification was for a two-year period, in which case, all staff were currently certified. This included the physicians, nurse practitioner, psychiatrists, and psychiatry assistants. In the future it would provide clarity to include the date of expiration in the database. A list of continuing medical education credits was submitted for each of the PCPs. During the past six months, the number of credits obtained per PCP ranged from 3.75 to 38. Topics included procedural sedation, Reclast, Vancomycin resistant enterococcus, obstructive lung disease, osteonecrosis of the jaw, cardiometabolic syndrome, postmenopausal osteoporosis, adult immunization schedule for 2010, enhancing protection against influenza, abdominal distention and pain in the elderly, Lamotrigine, novel anticonvulsants, allergies and asthma. Some of the CME series did not list the topics, but only listed the total number of credits received. The various certificates received suggested the need for a uniform database indicating when the actual date the CME was completed and the topics involved. This would allow the Medical Director to determine areas of strength among the Medical Department with regard to continuing education, as well as areas of need. It would assist in ensuring participation in CME activities that were of practical value in treating the individuals residing at AUSSLC. <u>PCP Participation in Team Process</u> As noted with regard to Section G.1, the Medical Department had a morning medical meeting each business day at the start of the day. The PCPs, the psychiatrists, as well as representatives from the Nursing Department attended, including the PNMT nurse, the Infirmary nurse, and the Hospital Liaison nurse. Entries for the prior 24 hours (or 72 hours when reviewing the weekend) in the Infirmary 24-hour logbook were read and reviewed in detail. There was a review of those individuals who had been hospitalized, including any up-to-date information. A copy of the Infirmary census was distributed to the PCPs. Infirmary rounds followed this meeting. A few observations and	

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		recommendation are as follows: ▪ It would be helpful to have a pharmacy representative available at the meeting. In addition to the valuable input they could provide, this also would provide a forum to distribute the QDRRs for review and signature. The PCPs would need to ensure the recommendations were addressed, as the records would not be available to write orders during the meetings. ▪ Of highest priority was the need for a system to document the meetings. Such minutes could be in a brief format, with focus on documenting those in attendance, a brief synopsis of the individuals discussed, as well as a column or area identifying medical issues and administrative issues needing closure. These items requiring closure then should remain open until there is a date of closure and a brief entry describing the closure. Currently, there was no documentation of attendance, important clinical discussions, assignment of follow-up activities, or closure of pending issues. It is recommended that a staff member with healthcare/medical background be assigned the role of ensuring such minutes are created and available as a working tool. ▪ Additionally, this meeting also should be used as the forum to discuss new policies, clinical guidelines, and the clinical tools that will be measured in a medical QI review. PCPs' involvement in the team process also is discussed with regard to Sections G, H, and I. PCPs play a key role in the new at-risk process, which individuals' PSTs were implementing, as well as with the PNMP, and a number of committees in which it was essential that interdisciplinary collaboration occur. <u>Routine and Preventative Care</u> Routine and preventive care can be measured in a number of ways. The following provides a description of the reviews conducted to determine if AUSSLC was providing individuals with adequate routine and preventative care. As part of the review of routine care, 20 annual medical assessments and prior assessments were submitted. The content of the annual medical assessments was uniformly excellent, and provided a rich compendium of information concisely organized. Timeliness of these assessments was reviewed. Out of the twenty individuals for whom annual medical assessments and annual physical examinations were submitted, there was lack of timely completion in seven cases. Compliance was found fro 13 out of 20 (65%). Those for which annual medical assessments were completed more than 365 days from the prior assessment included the following individuals, with the dates of assessments: Individual #12, dated 3/4/10, and 4/12/11; Individual #30, dated 3/22/10, and 4/11/11; Individual #310, dated 2/11/10, and 4/6/11; Individual #351, dated 2/16/10, and 4/4/11; Individual #208, dated 6/24/09, and 4/1/11 (additionally,	

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		the physical exam for Individual #208 was not timely: 8/27/09 and 4/1/11); Individual #223, dated 2/10/10, and 3/28/11 (additionally, the physical exam for Individual #223 was not completed in a timely manner: 4/2/10, and 4/15/11); and Individual #3, dated 2/5/10, and 3/17/11. However, there were other irregularities. For several individuals, the time period between the annual medical assessment and the annual physical assessment varied from weeks to months. The following examples highlight this finding: Individual #222's annual medical assessment was on 5/13/10, but annual physical exam was 10/26/09, and annual medical assessment was on 4/9/11, but annual physical exam was on 8/12/10; Individual #180's annual medical assessment was on 5/21/10, but annual physical exam was on 4/23/10; Individual #174's annual medical assessment was on 4/29/10, but annual physical exam was on 11/6/09; Individual #310's annual medical assessment was on 2/11/10, but annual physical exam was on 8/26/09, and annual medical assessment was on 4/6/11, but annual physical exam was on 10/13/10. Other individuals for whom this was as issue, included: Individual #42, Individual #351, Individual #208, Individual #223, and Individual #3. These represented nine out of 20 individuals for the annual medical assessments due in 2010, and five out of 20 for the annual medical assessments due in 2011 that were submitted. Compliance was 55% in 2010 and 75% in 2011. The Medical Department should focus on ensuring timely completion of annual medical assessments and physical exams within a 365-day time period from the last annual medical assessment and physical exam. Also, the Medical Department should focus on synchronizing completion of the annual medical assessment and annual physical exam. They should be completed within a few days of each other, or ideally on the same day. The Facility might need to create and implement a policy that defines the expectations of timely completion of these annual forms. A wide range of methods can be chosen to measure the quality of preventive care. One such parameter is thyroid testing in those with Down Syndrome. At AUSSLC, 22 individuals were identified as having Down Syndrome. A list was submitted of test dates for the most recent thyroid stimulating hormone (TSH) test for each of these individuals. All individuals had had these tests completed. However, the standard is a yearly TSH for those with a diagnosis of Down Syndrome. Based on this standard, there were two individuals that needed an updated test. For Individual #186, the most recent TSH was 5/30/08. For Individual #117, the most recent TSH was 5/6/10. For this latter individual, the might may have been completed, as the report submitted was generated on 4/6/11. Because of this, Individual #117 was not considered in this calculation. The compliance for this measurement (annual TSH in Down's syndrome) was 20 out of 21 (95%). The Facility followed the document "Health Care Guidelines" in which women had a	

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		baseline mammogram at age 40, then every two years through age 49, then yearly between the ages of 50 and 70, with discretion over age 70 as to frequency. A list of those over 40 was submitted. Four of these individuals had invalid birthdates (i.e., born in 2019 or later). A total of 132 names were submitted. Of these, nine did not have up-to-date mammograms due to body habitus, and five due to the guardian not providing consent. There was an "other" category suggesting a reason, but it was not defined (physician discontinued order, as an example). These three categories were considered valid reasons for lack of up-to-date mammogram and totaled 22 individuals. There were 18 others that were overdue that should have completed a mammogram test according to recommendations. Of the 132 names provided, compliance was 114 out of 132 (86%). The Facility followed the document "Health Care Guidelines" for colonoscopies. As a preventive screening tool, the recommendation was for a colonoscopy every 10 years, beginning at age 50, assuming no family history. Information was submitted for those over the age of 50, with the date of last colonoscopy, whether it was for preventive testing or an active problem, and the reason if it was not current. Family history was not submitted, and the screening colonoscopy every 10 years was considered the indicator to be measured. There were 234 individuals over the age of 50. One individual was noted for whom the family refused consent. This meant 233 individuals were eligible for screening. There were 97 that had completed colonoscopies in the last ten years. This was a compliance rate of 97out of 233 (42%). Osteoporosis and osteopenia prevention and treatment were important in treating many of the individuals residing at AUSSLC. Many of the individuals were prescribed medications for these conditions. Unfortunately, the Facility did not have a database that listed those with a diagnosis of osteopenia or osteoporosis. This was problematic, as the Medical Department has no baseline of the numbers and severity of osteoporosis/osteopenia in the population residing at AUSSLC. Additional medical quality improvement will be difficult without available information. The Pharmacy Department provided an extensive drug order report of all medications prescribed for osteoporosis and osteopenia. It did not include calcium and vitamin D. Fifty-eight individuals were prescribed Alendronate, five were prescribed Risedronate, two were prescribed Reclast, seven were prescribed Raloxifene, one was prescribed Teriparatide, and 51 were prescribed Calcitonin nasal spray. This was a total of 124 individuals. The list indicated only two individuals were prescribed Reclast, but an email from one of the PCPs indicated that, as of 12/29/10, 25 individuals all needed Reclast (and that was from only four of the residences). Although 25 orders might not have been placed at the time of the email, it would have been anticipated that orders would be written and the Reclast IV treatment would have been completed at least on a few of these individuals prior to the drug order report dated 4/4/11. It is recommended that the Medical Department work closely with the Information Technology Department to create a system of reliable	

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		and complete data. Separately, copies of DEXA reports for those over 50, which were completed in the prior six months, were submitted. There were only five DEXA scans submitted. If this is a complete list, that only five were completed in six months was problematic, given that 124 individuals were on treatment for osteoporosis/osteopenia treatment or prevention. DEXA scans are repeated at varying intervals, but many current recommendations suggest that they be done every two to three years to determine if treatment is beneficial, and to ensure osteoporosis/osteopenia is not worse. Extrapolating five DEXA scans in six months, in two years that would only total 20 scans, and in three years, the total would be 30 scans. It would appear there is inadequate monitoring of treatment for efficacy. Further, the five submitted DEXA scan reports were compared to the information provided for those currently on treatment. The following summarizes some issues identified: ▪ Individual #434 completed a DEXA scan on 3/2/11, and the results indicated osteoporosis. She was not listed on the pharmacy list of individuals on medication for osteoporosis. There was a PCP entry on the DEXA report indicating referral for Reclast dated on 3/8/11, but the pharmacy had no order as of 4/4/11. ▪ Individual #381 had a DEXA completed on 1/21/11, and the results indicated osteoporosis. The history recorded on the DEXA report suggested she was already taking Reclast, and this was a follow-up test to determine if her osteoporosis was improving or worsening on treatment. However, the pharmacy had no indication that she had been on Reclast, although start dates for medication were recorded as of 2008 on the submitted list. This suggested the data the pharmacy provided was incomplete, and the Facility had no accurate baseline reflecting either the diagnosis of osteoporosis/osteopenia, nor how many individuals were currently treated for this diagnosis. ▪ Individual #178 had a DEXA scan 11/30/10, and the results indicated osteoporosis. She was not listed on the pharmacy list as being on a medication for treatment of osteoporosis. The DEXA report history indicated she was on hormone replacement. According to the submitted document, the drug order report was to include "drug order reports from pharmacy for all drugs prescribed for those conditions." If the pharmacy list was to be used to track treatment of osteoporosis/osteopenia, then the Medical Department needed to review the types of medications entered onto the list. There was no hormone replacement therapy (except Raloxifene, which has an estrogen effect on bone physiology) listed in the document submitted.	

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		Of the five DEXA reports, all individuals had osteoporosis, but only two had documentation of osteoporosis according to the pharmacy report, which was the only report available to determine osteoporosis treatment. The submitted information suggested the Medical Department had no baseline information concerning the prevalence of osteoporosis/osteopenia, or whether the condition was being treated. The Medical Department also did not have an ability to monitor the completion of follow-up DEXA scans to confirm effective treatment. A list of individuals with decubitus ulcers was submitted. There had been 11 decubitus ulcers documented with dates of onset from October 2010 through March 2011, which developed in six individuals. Of these, four ulcers developed in one individual, and three developed in another individual. The ulcers ranged from Stage 1 to Stage 3, and two ulcers could not be staged. There appeared to be three ulcers that remained, and the others had healed. However, Individual #442 had a Stage 2 ulcer that progressed from Stage 1 on 1/6/11 to Stage 2 on 1/7/11, but was considered healed by 1/10/11. The documentation of rapid healing of an ulcer on the malleolus of the ankle suggested it was not a decubitus ulcer, or that there was variation in the criteria used to determine healing. A Stage 2 ulcer on a malleolus, especially when rapidly worsening, would not usually be expected to have resolved and completely healed in three days. In modifying the database, consideration should be given to diagnoses for which decubitus ulcers might be inevitable, such as spina bifida or imminently terminal cancer patients. The current database was difficult to interpret given this information was not present. Additional information that would be of value would be the residence, to determine whether or not there was any cluster effect, indicating a need for increased monitoring or training of staff. It was of interest that eight of the 11 ulcers occurred on the feet and ankles, suggesting a need for increased monitoring/positioning/protection of the feet. Routine foot inspection in those most at risk for decubiti might prevent a number of ulcers. Although there were calculations of monthly incidence rates, with low rates based on the entire population residing at AUSSLC, this information might deflect from the importance of any decubitus ulcer present in the population. That there were 11 ulcers recorded in the prior six months indicated a need for routine monitoring and evaluation by a clinical department or interdisciplinary committee with focus on skin integrity. Such a system did not appear to be in place. The Facility was asked to submit minutes of skin integrity committee meetings during the prior six months. There were no minutes submitted, suggesting the committee did not exist. The Medical Department should assist in creating such a monitoring system to ensure aggressive treatment of decubiti, and to prevent recurrence of decubiti in individuals that have had a history of decubiti.	

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		Medical Management of Acute and Chronic Conditions A number of specialty clinics occurred each month at AUSSLC. From November 2010 through April 2011, the following specialty clinics occurred: orthopedics - 12, physical medicine - one, general surgery - 11, gynecology - one, eye - five, neurology - 12, optometry - five, podiatry - six, gastroenterology - four, and ENT- 10. Additionally, a number of community consultants were utilized over the prior six months, including: cardiology (12 appointments for six individuals), cardiothoracic surgery (two appointments for two individuals), dermatology (24 appointments for 15 individuals), pulmonary surgery (one individual), pulmonology (one individual), gastroenterology (11 appointments for 11 individuals), gynecology (seven appointments for three individuals), nephrology (nine appointments for eight individuals), endocrinology (four appointments for two individuals), oncology/hematology (14 appointments for 11 individuals), ophthalmology (23 appointments for nine individuals), orthopedics (13 appointments for seven individuals), Otolaryngology (14 appointments for 10 individuals), plastic surgery (six appointments for two individuals), podiatry (five appointments for four individuals), surgery (three appointments for two individuals), urology (nine appointments for nine individuals), glaucoma specialist (nine appointments for two individuals), rheumatology (one individual), sleep study specialist (seven appointments for three individuals), internal medicine (four appointments for three individuals), vascular surgery (one individual), orthodontist (12 appointments for two individuals), periodontist (two individuals), and physiatry (three appointments for two individuals). Additionally, a number of individuals underwent outpatient procedures, such as EEGs, hand therapy, and dialysis. Information concerning treatment of seizure disorders was submitted. As of 4/4/11, there were 156 individuals prescribed AEDs. Of these, 26.28% were taking two AEDs, 19.87% were taking three AEDs, 5.76% were taking four AEDs, and 2.56% were taking five AEDs. The Facility submitted information concerning the percentage of individuals prescribed the older AEDs (i.e., Phenobarbital, Dilantin, and Mysoline). A total of 45 individuals (28.84%) were taking these older AEDs. Continued use of older AEDs should include periodic documentation in the medical chart (and in a consistent location such as the annual medical assessment, neurology clinic notes, etc.) that the benefits of continued use (i.e., good seizure control, poor seizure control during trials of alternative AEDs, etc.) outweigh the risks (i.e., of side effects, drug-drug interactions, etc.). Concerning the need for acute care, there were no documented reports of an episode of status epilepticus, since the last monitoring visit. Three individuals were listed as going to the ER for uncontrolled or prolonged seizure/new onset seizure, since last Monitoring Team visit. More specifically, Individual #260 went in for an unrelated gastrointestinal (GI) bleed, and the documentation indicated breakthrough seizures as an additional	

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		diagnosis, which might have occurred while hospitalized. Individual #39 had tonic posturing frequently, and Individual #426 had tonic posturing with respiratory distress. Given the large number of individuals with seizure disorders, it is important to note there was no status epilepticus, and two admissions due to seizures had significant other comorbid conditions. As of 4/13/11, there were 27 individuals with vagal nerve stimulators. From the data submitted, the majority had been implanted between 2000 and 2005. One was implanted in 2008, and one in 2009. One had no confirmed date recorded. For one individual, Individual #113, testing indicated a dead battery, and need for replacement on 3/8/11. There was no one currently being evaluated for a VNS. The neurology clinic usually occurred twice monthly. The Facility submitted a list of those individuals that attended the neurology clinic. This included 11 individuals in October 2010, 21 individuals in November 2010, 23 individuals in December 2010, 24 individuals in January 2011, 14 individuals in February 2011, and 21 individuals in March 2011. The documentation of seizure management was reviewed for five individuals. The following summarizes these reviews: ▪ The neurologist saw Individual #297 several times in recent months: 8/9/10, 10/22/10, 4/2/11, with VNS check by the PCP on 10/25/10, and 11/15/10. Each neurology consult included current medications, lab results and dates, and dates of seizures. There was a consultant note in the form of a Subjective, Objective, Assessment, and Plan (SOAP) note. Copies of the seizure record were provided to the neurologist, and documentation of the seizures on this form ranged from complete, to forms with incomplete sections. There was a nursing Health Management/Maintenance Plan/Acute Care Plan for her seizures. Nursing staff should review the seizure records to ensure the staff complete these forms in a timely and complete manner. ▪ Individual #89 was seen by neurology on 10/25/10 and 4/4/11. Information provided to the consultant included current medication regimen, and recent lab results. She also underwent a sleep study on 9/1/10. ▪ Individual #299 was seen by neurology on 4/4/11. Current medications, lab results and dates, and dates of seizures, along with neurology comments were documented. ▪ Individual #301 was seen by neurology on 7/12/10, 1/10/11, 2/7/11, and 4/4/11 for Parkinson's disease. His last seizure was in 1991. Current medications were listed, and lab tests and dates, as well as a lengthy consultant note recorded on each consult form. ▪ Individual #28 was seen by neurology on 4/19/10 and 4/4/11 for new onset	

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		seizure and dementia associated with Down syndrome. Current medications were listed, along with recent lab results and dates, with dates of last seizure, and consultant discussion. These five neurology record reviews indicated appropriate ongoing treatment of a variety of neurological conditions. Documentation was excellent, with current medications, pertinent lab data and seizure record, along with consultant comments all on one form. Integrated progress notes from the start of signs and symptoms to transfer to the ER were reviewed to determine the quality of acute care. The Facility submitted information for 10 individuals who had most recently been transferred to the ER as of 4/19/11. In summary, the acute care and documentation of acute care had a variety of concerns, which would benefit from further resolution in all 10 records reviewed. The following summarizes this review: ▪ Individual #359 was noted by nursing staff to not be acting normal as of 3/23/11 at 0945 hour. He developed a low-grade temperature of 100 degrees by 1100 hour. The PCP was notified, and gave orders to recheck the individual every four hours. The individual's temperature rose by 1930 hour to 101.4 rectally. The PCP was notified and Tylenol was given. By 0745 hour on 3/24/11, his vital signs had stabilized and his temperature was 98.9, with respirations at 24. There was an untimed entry by nursing in which observation was made of an unsteady gait, increased respirations at 32 per minute with abdominal breathing, and lethargy. The MD examined him at 1300 hour, and noted decreased responsiveness, fever of 101.3, and hypotension, at which time he was transferred to the ER. It appeared his early nonspecific findings were watched closely, and when signs of progression developed, he was transferred to the ER in a timely manner. He was found to have bilateral pneumonia and a left sided empyema. The Hospital Liaison Nurse provided detailed visit notes of the clinical course in the hospital. He returned to the Infirmary on 4/6/11. The PCP wrote a detailed IPN on 4/7/11, and ordered a nutritional consult for weight loss. The PCP wrote an Infirmary discharge note on 4/8/11, at which time the individual was discharged home. A dietary consult on 4/8/11 documented a 48-pound weight loss during the year, and 13-pound weight loss since 3/1/11. Dietary orders were changed, going from a weight maintenance diet to a regular calorie diet. Although complete records were not submitted, it appeared that the 48-pound weight loss was new information, and the team was not aware of this significant weight loss. That the significant weight loss over several months was only addressed after a serious illness was problematic. The Medical Department should develop and implement a system in which significant weight loss (such as	

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		five-pound weight loss in a month, and/or 7.5% weight loss in three months, 10% weight loss in 6 months, as examples), unless it is part of a planned weight loss program, triggers a medical review including dietary consultation. The Dietary Department provided a follow-up consultation on 4/12/11, and Prostat was ordered. ▪ Individual #327 was riding on a golf cart, became agitated, and hit his head on the dashboard and then fell to the pavement, hitting his right eyebrow area. He had taken his helmet off prior to the fall. He had not lost consciousness when he hit his head. The PCP examined him, and he was transferred to the ER by non-EMS transport. On return, he was administered Tylenol for comfort. He refused to stay at the Infirmary and was returned home. Further information was not submitted, but the concern was the ease of removal of his protective helmet, as well as the level of supervision when he was agitated. Given this event, the BSP should reflect an addendum to reduce the risk of a recurrence. ▪ Individual #260 had a fecal impaction on 2/9/11. A fleet's enema was given with good results. Again on 2/15/11, he was checked and had much stool in his rectal vault. A fleet's enema was given. Enemas were given on a prn basis on 2/18/11, 3/2/11, and 3/3/11. On 3/5/11, he had a bowel movement. On 3/6/11, he had an emesis. A notation on 3/17/11 indicated he had a bowel movement, but on 3/19/11, there was an entry that he had no bowel movement in three days, and a fleet's enema was given. On 3/22/11, he developed rectal bleeding, and abdominal distention, at which time he was transferred to the ER. He was admitted to the hospital. He was discharged on 4/3/11 with a diagnosis of rectal bleeding due to anorectal disease, likely hemorrhoids due to constipation. He also was found to have a new onset hypertension and was placed on a Catapres patch. He was found to have sleep apnea with hypoxia, and his continuous positive airway pressure (CPAP) was changed to bilevel positive airway pressure (BiPAP). Discharge recommendations were to change from Lactulose prn to Lactulose 40 milliliters (ml) four times daily. The Hospital Liaison Nurse recorded visit notes, which reviewed his progress during his hospital admission. His blood pressure was monitored due to the history of new onset hypertension. On 4/5/11, it was discovered that the Catapres patch that was placed on him at the hospital could not be found. Despite this, he was normotensive. A drug order report from 4/7/11 indicated his only routine bowel management medication was Polyethylene glycol 17 grams (gm) with fluid daily. When a series of prn medications are given for constipation (including prn enemas), PCPs should review the medication regimen, and consideration should be given to adding a routine medication early in the course of constipation. The goal should be to prevent ER visits, as well as prn enema use. Additionally, the ER	

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		recommended the addition of Lactulose, but according to the pharmacy report, this was not ordered. There should be justification in the record for alternative treatments, if the ER recommendation is not followed. ▪ On 3/9/11, Individual #224 had a rectal temperature of 100.7, at which time she was given Tylenol. She appeared to do well, but on 3/14/11 did not eat supper. She did drink a health shake. On 3/16/11, she attended a quarterly psychiatry clinic, at which time the team assessed the individual to be stable. On 3/21/11, a critical lithium level was reported, and she was sent to the Infirmary for evaluation. She was found to be sleepy, but responsive. The PCP note indicated that she received her noon dose, and based on the concern for lithium toxicity, was sent to the ER. The lab result was not available prior to the noon dose being given. There appeared to be timely evaluation and treatment. She was admitted to the hospital and hydrated. Her abdomen CT scan was completed, and suggested ischemic bowel, but the clinical exam was not consistent with this finding, and the surgeon followed her, and the abdominal distention resolved spontaneously. The Hospital Liaison Nurse provided detailed visit notes. She was discharged on 3/23/11 to the Infirmary. Her lithium was discontinued. She continued to be followed by the psychiatrist. For her bowel regimen, she was already taking Miralax and Lactulose twice daily, and Dulcolax was added. She was discharged to her residence on 3/24/11. There was no IPN reflecting a psychiatry review of the lithium toxicity. There was an order to discontinue lithium, and it was not clear if that was a permanent decision from the psychiatrist or a temporary measure. Given the hospitalization was for lithium toxicity, it would have been valuable to have an IPN reflecting the psychiatrist's evaluation and plans for psychiatric medication for this individual. ▪ Individual #347 was noted to have a firm abdomen on 3/18/11. He had a record of having had bowel movements on 3/16/11 and 3/17/11. On 3/18/11, a fleet's enema was ordered, and results were recorded. A fleet's enema also was given on 3/19/11. A thorough MD note included his history, and examination, and the reasoning to send him for an x-ray of his abdomen. The ER did a CT scan of his abdomen and blood work, and all results were unremarkable except constipation. There was a large amount of stool in the colon. The ER recommended continuing the usual bowel regimen or GoLytely per his percutaneous endoscopic gastrostomy (PEG) tube. On return from the ER on 3/21/11, he received a bottle of magnesium citrate (the order written was magnesium sulfate and was not clarified by the nurse or pharmacy). The next day he received one liter of GoLytely in a series of four boluses. On 3/22/11, he received a tap water enema. On 3/23/11, he received magnesium citrate, and later a tap water enema. On 3/24/11, his Lactulose was held. The reason was not directly stated, but might have been due to abdominal gaseous distention. On 3/25/11, his order for Lactulose was discontinued, as well as Enlive. He was	

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		started on polyethylene glycol. He was eventually discharged back to his residence from the Infirmary on 3/28/11. A review of the drug order report indicated he continued to be prescribed only polyethylene glycol 17 gm once daily with fluid. Other medications were prn only. The lactulose was stopped permanently, and it was not known the total dose that had been administered per day. For severe constipation, more than one medication at maximum dosage might be required to improve bowel movement frequency. The Pharmacy Department would be able to assist in determining options. There was no mention of a dietary consult to determine whether his supplements/feedings maximized daily fiber needs in his diet. ▪ Individual #1 was noted to be sluggish with ambulation on 3/15/11. He had pitting edema of his right foot with some purple discoloration. OT/PT were consulted for possible skin breakdown. On 3/16/11, a nurse documented his feet were swollen, but that he refused to elevate them on a pillow. On 3/20/11, a large dark purple bruise was noted on his left hip. His feet were swollen and his blood pressure was low, at which time his Lasix was held. He also was reported to have refused all his morning medications. The physician note indicated his legs were weeping, and that the bruise on his hip was of unknown origin. Neither the cause of the bruise nor the length of time it had been there was known. His gait was unchanged despite the bruise. He was noted to be weaker, and based on his decline, the physician believed timely assessment was needed, and he was referred to the ER. On reviewing this record, there was concern that this large bruise was not investigated, which would have been an important step to ensure the safety of the individual. The ER also commented that he had a bruise of his buttock near the left hip, but that the last fall was in 3/07. The Hospital Liaison Nurse provided detailed visit notes. He was discharged from the hospital on 3/30/11, with a final diagnosis of diastolic heart failure, cardiomyopathy, cachexia, and urinary outlet obstruction requiring a foley catheter. During the hospitalization, the foley was removed, but he again was unable to void, and a foley had to be replaced. The PCP dictated a lengthy note on 3/31/11, summarizing the hospitalization. The PCP made several adjustments to medications upon his return. Initial attempts at removing the foley catheter failed, and additional medication to treat his benign prostatic hypertrophy was prescribed. On 4/10/11, he was evaluated in the ER for hematuria. The hematuria persisted on 4/12/11. He also was treated for a urinary tract infection. Communication with the urologist occurred, and the bleeding was believed to be due to tears of the prostate veins. During this time, the team and guardian met to discuss DNR status. Due to age (85 years), and multiple health conditions including heart disease, and likely poor response to attempts at CPR, a DNR order was put into place. On 4/14/11, he was discharged home, at which time his foley catheter was discontinued. The	

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		hematuria resolved, and he voided spontaneously. ▪ Individual #246 had an emesis on 3/15/11, and later refused her evening medications. She was documented to be screaming and uncomfortable on 3/16/11. A stat team meeting was called for refusal of medication. Background information suggested the team had already determined that her emotional health was affected by her current residential arrangements. A transfer to another residence was suggested, which her mother also had requested, and the meeting was called, in part, to address this information. On 3/17/11, she was noted to have refused her medications for the prior 48 hours, and she was noted to be anxious and hyperactive. She then ate a dry leaf outside. She also refused medications on 3/18/11 and 3/19/11, and was also noted to be refusing meals on 3/19/11. Based on this information, she was sent to the ER. During this time (3/15/11 to 3/19/11), there was no indication that a PCP had examined her to rule out medical concerns. The IPN did not have either a PCP or psychiatry note. If there was a stat team meeting, this should have been reflected in the IPN, either as a note from the QMRP summarizing the meeting, or the PCP or psychiatrist including the PST results in a progress note. The IPN did not reflect a response from the Medical Department over the five days of worsening behavior. She returned to the Infirmary on 3/20/11, and a nurse's IPN reviewed the ER treatment of IV fluids and sedation. She took her seizure medications in the ER. A urinalysis and CT of the head were completed. She was found to have a low potassium level, and received some replacement by mouth. Also on 3/20/11, there was a physician's IPN reviewing her recent history and ER evaluation. There was the comment that cooperation with medication occurred if the nurse was a "male and Spanish." She was discharged to her residence on 3/21/11. There was no further IPN, which addressed the PST consideration of changing residences. ▪ On 3/18/11, Individual #291 developed chest pain. A nurse conducted an examination, followed by measurement of vital signs and pulse oximetry, followed by a transfer to the ER by EMS. This was a timely transfer. He returned to the Facility later that day, and was sent directly to his residence. However, he was admitted to the Infirmary on 3/19/11 for musculoskeletal chest pain and vertigo. A thorough PCP note on 3/19/11 reviewed the findings and critical thinking leading to the decision for transfer to the Infirmary. The PCP learned that he had vertigo in January 2011, and was referred to ENT, but the ENT consult could not be located. The primary PCP later noted that a referral to ENT had been made in September 2010, but ENT had not seen him as of March 2011. The primary PCP requested the referral be expedited. He also was found to have postural hypotension. He was prescribed Ibuprofen, his Pantoprazole was increased, and he was provided close supervision. On 3/20/11, he was started on Meclizine for dizziness, and psychiatry was consulted to review his	

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		psychiatric medication (Clozaril) as a potential cause of his hypotension. Psychiatry saw him on 3/21/11, and provided a thorough IPN. He was discharged to his residence on 3/23/11. His Clozaril was decreased on 3/31/11, as part of a planned reduction. ▪ Individual #175 developed a bruise to her hand on 3/17/11, due to SIB according to the direct support professional. A nurse assessment indicated redness of the thumb, and she was sent to the ER for evaluation. She returned to the Infirmary later that day, and was discharged to her residence on 3/18/11. A thorough nurse note reviewed the ER visit. There was no fracture, and she returned with a splint to her left lower arm and hand. Her supervision level was one-to-one. Her splint was to be removed while sleeping. The IPN did not reflect whether the PST met to review the events leading to the ER visit, or whether psychology made any changes to the BSP based on the SIB leading to the ER visit. If such actions had occurred, a brief entry in the IPN would have provided helpful information. ▪ Individual #182 suddenly developed cyanosis and diaphoresis, with change of mental status, on 3/15/11. His pulse oximetry was noted to be below 80% on room air. He was placed on 4 liters (L) of oxygen (O2). EMS arrived and transferred him to the ER. He was discharged on 3/17/11, with a diagnosis of non-Q-wave myocardial infarction, and aspiration pneumonitis. It was recommended he be started on aspirin and Lopressor. The Hospital Liaison Nurse provided detailed visit notes. He was discharged to the Infirmary, and these additional medications were prescribed. The PCP reviewed the hospital information, and documented that the increased troponin was due to transient hypotension. A 3/20/11 IPN by the PCP stressed the importance of positioning. He was subsequently discharged home on 3/22/11. Considering he had a sudden onset of respiratory distress compatible with acute aspiration, and he was diagnosed with aspiration pneumonia, there was little evidence of a work-up to rule out GERD as a cause of his sudden respiratory distress. The IPNs included nursing entries on 3/13/11 and 3/14/11 that he had a Jejunostomy Tube (J-tube). According to the Medical Director, no individual currently had a J-tube at AUSSLC. If the individual did not have a J-tube, it is recommended that in-service training be provided to nursing to review the difference between G-tubes and J-tubes to reduce errors in documentation. There were 22 visits to the ER for injury from one report, and 28 from a separate report. A reason for the difference was that they covered different time frames. However, these reports highlighted the frequency of ER visits for injuries over six months. The Infirmary was staffed to receive those individuals who needed closer observation	

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		and treatment than could be provided in the residences, and those returning from the hospital for immediate post hospital recovery. The length of stay varied from one to 74 days. In the prior six months, there were 310 admissions to the Infirmary. <u>Do Not Resuscitate Orders</u> A list of those with DNR orders was submitted. There were a total of 15 individuals listed. The time period of the DNRs varied from recent (2/8/11) to remote (5/6/99). Once the State Office issues additional guidance on DNRs, PSTs will need to review all current DNRs to ensure compliance. For those with DNR orders in place for more than one year (12 of the 15 DNR orders), the teams will need to determine if the DNRs reflect the intent of the State Office guidelines, or whether the DNR orders should be rescinded, and the decision for a DNR reconsidered at a future time when criteria are met according to the new State Office guideline. Reasons were listed for each DNR, and further review will be necessary to determine whether or not the condition was terminal. For instance: ▪ Individual #121 had a DNR placed on 7/21/06, for a diagnosis of colon cancer. Individual #262 had a DNR placed on 6/18/07 with a diagnosis of renal cell carcinoma and chronic medical problems. Individuals might survive many years with a diagnosis of cancer before entering the terminal stage in which all reasonable treatments have been offered and failed, at which time a DNR might be appropriate. ▪ Several individuals had vague reasons for a DNR. For Individual #286, Individual #43, Individual #340, and Individual #22, the reason for the DNR was stated as "multiple chronic medical problems." The teams need to determine more precisely what is the terminal diagnosis (what organ system and what diagnosis, and confirm that the individual is at the end stage of that illness). ▪ Individual #354 had a diagnosis of Eisenmenger's syndrome, but it was not clear the reason for the DNR, because he had that diagnosis since birth. ▪ Individual #111 had a DNR with the reason listed as "guardian request." There needs to be more documentation of the communication between the team and the guardian regarding to the actual rationale and terminal diagnosis that was used to make that decision. When family or guardians request such actions, the teams need to ensure the decision is compatible with the State Office guidelines, and that the family is made aware that DNRs can be rescinded if the individual is determined to no longer qualify in the future (the individual stabilizes over time, and remains alive many months later). In summary, for each of the names listed, the teams need to review the diagnosis to determine if the individual has entered a terminal phase of the condition. There were no names submitted in which a DNR was rescinded in the past six months. The Facility	

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		should ensure a process is in place for this to occur, and staff are comfortable and proficient with this process.	
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.	As of 1/31/11, the State Office implemented a medical review system in which two PCPs reviewed quality care using a medical quality improvement audit tool. The PCPs who visited a SSLC worked at other SSLCs, and spent approximately two days at a site. Each Facility contributed, when possible, to the PCP pool that visited other sites. AUSSLC had a medical peer review on April 6 through 8, 2011. Reportedly, findings included the need for improved documentation of smoking history in the annual medical assessments, ensuring active problem lists were current, ensuring the PCPs entered allergies on the medication orders, and providing indications/diagnoses for all medications listed on the 180-day order sheet. At the time of the Monitoring Team visit, there was no written summary report with recommendations listed, which made compliance for AUSSLC with this section of the Settlement Agreement problematic. Compliance requires evidence of completion. It also was not clear the number of records reviewed, or the goal for the percentage of the population residing at AUSSLC that would have medical peer review completed annually. As part of the response to ensuring all 180-day medication orders had diagnoses for them, a corrective action plan was created on 4/8/11 outlining a procedure to ensure this is accomplished by 11/2/11.	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.	The Medical Department had many opportunities to begin medical quality improvement reviews. However, according to the Facility's POI, no progress had been made in this area, and no initiatives had been begun in the time since the previous Monitoring Team visit. The Avatar system provided a pneumonia tracking system, which could be used to determine trends, and once identified, action steps could be taken to have a positive impact on these trends. On review of the Avatar system, a number of parameters could be entered into the database to allow further interpretation of the data. However, several areas were left blank or needed further exploration. For instance, several individuals were listed as having nasogastric (NG) tubes. Unless this was for an acute illness in which a temporary feeding route was required, the Medical Department needed to review the accuracy and appropriateness of the choice of tube that was checked on the Avatar Form (choices included nasogastric, nasojejunal, jejunostomy, nasoduodenal, gastrostomy). Other individuals were listed as being tube fed, but the type of tube was not defined. Further, there were many forms in which the method of tube feeding (bolus, continual, intermittent) was left blank. For those on oral feedings, the texture of the diet	Noncompliance

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		was at times left blank (chopped, ground, pureed, regular). There were some entries marked with a question mark. However, data should be clarified before being entered on to the form and into the system. Considering the information on the form was routine information that would the nurse case manager would regularly provide or could be discerned from a review of the record, it is not clear the reason for lack of completeness and areas with question marks. For instance, there was a question mark as to whether Individual #262 took food by mouth, which would have been readily resolved had there been communication with the residence. The Medical Department should ensure such valuable databases are complete and accurate. This would allow ready access to valuable information about pneumonias on the campus. The Avatar data provided was collected from 9/15/10 to 1/16/11. This suggested there has been no updating of information over recent months to make the database current. Additionally, occasional cases listed two pneumonias on one form (for example, Individual #396, Individual #121, and Individual #39), which raised questions as to how this information was added to the computerized database. Based on the Avatar information provided, limited by completeness and accuracy as mentioned above, 33 cases of pneumonia were identified. It was determined there were 17 cases of aspiration pneumonia. Twenty-one of the 33 cases of pneumonia were associated with and individual with a feeding tube. However, little information beyond these simple statistics could be determined from the data forms provided. As individuals with feeding tubes experienced 21 cases of the pneumonia, and only two of the 17 aspiration pneumonias were associated with oral intake, the data suggested that the Facility was aggressively treating dysphagia (with feeding tubes), but might not be aggressively treating for GERD. For those with aspiration pneumonia and feeding tubes (15/17 aspiration pneumonias according to the Avatar date), there needed to be review to determine any commonalities. The PNMT would be of additional value in assisting the Medical Department in reviewing these individuals. Positioning would be an important consideration, not just during feeding and one hour after feeding, but during bathing, changing clothes, sleeping, etc. It would be important to determine if GERD was significant in these individuals, and if testing indicated significant GERD, further medical treatment or surgical treatment (fundoplication, etc.) would be important considerations to reduce recurrent aspiration pneumonias. Separately, a different dataset was submitted for aspiration pneumonias entitled: Aspiration pneumonias from 10/1/10 to 3/30/11. Under the date of diagnosis, it more precisely listed individuals as having aspiration pneumonia during a time period from October 11. 2010 to January 16, 2011. The information was not always consistent with the Avatar database. For example, for Individual #72, the 11/2/10 aspiration pneumonia in the Avatar system was not listed. Additionally, the 12/8/10 pneumonia listed under	

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		the aspiration pneumonia list, was entered as a community acquired pneumonia in the Avatar system. Individual #426 had two aspiration pneumonias listed in the Avatar system, but the 10/1/10 aspiration pneumonia was not listed in the aspiration pneumonia dataset. For Individual #182, this second dataset listed 10/11/10 as an aspiration pneumonia, but this was listed as "other" pneumonia in the Avatar system. Additionally, Individual #121 had aspiration pneumonia on 11/20/10 in the Avatar system, but not listed in the aspiration pneumonia list. Similarly, Individual #68 had aspiration pneumonia listed as occurring on 11/5/10 in the Avatar system, which was not listed in the aspiration pneumonia list. These discrepancies suggested a need to review the accuracy and consistency of the data being collected, as well as the need to review the quality of database entry. The discrepancies in these small databases suggested the need to review all medical database management systems. The Medical Department cannot make decisions and develop programs when the information is incomplete and of questionable value. Further, once an action plan is implemented to address identified concerns, the follow-up data will need to be timely, accurate, and complete to determine impact plan's implementation. Separately, infectious disease data per month for the prior two quarters was submitted. Infections were listed per category, including pneumonia, UTIs, Methicillin-resistant Staphylococcus aureus (MRSA), etc. This data also did not match the Avatar database information. According to the infectious disease monthly statistics, in September 2010, there was one new pneumonia, while the Avatar system listed five pneumonias. For October 2010, the infectious disease monthly statistics listed no new pneumonias, and the Avatar system listed seven pneumonias. In November 2010, the infectious disease monthly statistics documented two new cases of pneumonia, while the Avatar system listed 11 pneumonias. In December 2010, the infectious disease monthly statistics documented no new pneumonias, while the Avatar system listed five pneumonias. In January 2011, the infectious disease monthly statistics documented no new pneumonias, while the Avatar system listed four pneumonias. In February 2011, the infectious disease monthly statistics documented no new pneumonias, while the Avatar system listed one pneumonia. The different data systems did not agree in any month in the prior two quarters. It would be difficult for the Infection Control Committee, the Nursing Department, and the Medical Department to draw any conclusions based on the information provided by the different databases. There was an additional database concerning pneumonias which was submitted "for those with a diagnosis of pneumonia in the last six months and taking food/liquid by mouth, the type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study." According to the document, several different departments, including the data analyst, the dietary department, and habilitation therapies compiled the list. The information also was not consistent with the Avatar	

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		system. The following provides examples of the discrepancies noted. The 10/11/10 pneumonia for Individual #182 was listed as aspiration, while the Avatar system listed the pneumonia as other. The 10/21/10 pneumonia for Individual #182 was not listed, which was considered aspiration pneumonia. Individual #316 had a bacterial pneumonia on 11/1/10, according to this database, but the type of pneumonia was not recorded in the Avatar database. Individual #54 had a bacterial pneumonia on 11/24/10, according to this database. In the Avatar system, Individual #54 had pneumonia on this date, but it was recorded as "other" rather than bacterial. There were four other pneumonias in individuals with by mouth (po) intake from 10/10 through 1/11 that were not listed in this additional database, but were listed in the Avatar database. These were Individual #322, with a pneumonia 10/24/10, the type of pneumonia was not recorded, and he was on a pureed diet. Individual #341 had pneumonia on 11/28/10, the type was considered "other " and he was on a ground diet. Individual #331 had pneumonia on 11/14/10, the type was considered "other," and she was on a pureed diet. Individual #81 had pneumonia on 10/26/10, the type of pneumonia was not recorded, and he was reported to have both a chopped diet and intermittent tube feedings. In summary, this additional database in which those with pneumonia were listed with the texture of diet was incomplete. The list included six incidents of pneumonia, while the Avatar system reflected 11 incidents of pneumonia for those fed orally. It is not known if the problem is data entry, timeliness of entry, or other reasons for the many discrepancies. The Medical Department should review these various databases to determine the completeness and quality of the information entered, and begin to understand how the data is accumulated. The Medical Department will not be able to provide quality medical improvement if the baseline data is questionable. The Medical Department should meet with the information technology personnel at AUSSLC to obtain guidance on this complex issue. It is recommended that one accurate and complete database be developed rather than many databases of questionable quality. The Facility submitted a list of all those who had gone to the ER or had been hospitalized in the prior year. Starting from 10/1/10 to the date of the report, 4/19/11, there were 154 ER visits and/or hospitalizations. When categorized by reason for being transferred to the hospital, the following information provided a source of information for which a number of medical QI programs and interventions could be implemented. By organ system, there were 25 referrals for gastrointestinal concerns, 28 referrals for trauma, 25 referrals for respiratory concerns, 24 referrals for fever and infectious etiologies, 13 referrals for cardiovascular disease, and 12 referrals for neurological concerns. Based on this broad overview, one of the top four areas (GI, trauma, infections, respiratory) could be chosen for further review, and implementation of a plan to potentially produce a positive impact.	

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		Mortality Reviews An important part of a medical quality improvement process is the completion of thorough mortality reviews, as well as follow-up with regard to the resulting recommendations. From November 2010 through April 2011, there were five deaths. There were no autopsies completed. On review of the annual data, no autopsies were completed in the prior year on a total of nine deaths. Although clinical information might indicate certainty as to cause of death, autopsies should be encouraged as a clinical tool to provide evidence of the many pathophysiologic conditions and their effect at the time of death, as a method to verify the cause of death, and to ensure quality healthcare was provided. The medical records and mortality committee meeting minutes were reviewed for five deaths. The following provides a summary of these reviews: ▪ Individual #39 had a history of dysphagia and aspiration, feeding tube placement, steroid dependent asthma, tracheostomy, recurrent urinary tract infections (UTIs), sialorrhea, osteoporosis, scoliosis, and seizures. She was hospitalized nine times in the year prior to death, including two for aspiration pneumonia, once for pneumonia, twice for bronchospasm, once for acute respiratory distress, once for a UTI, and twice for seizures. In the year prior to her death, she was found to have GERD on testing. However, the PNMT was not aware of this test result, and the physician recommendation to change the formula feeding rate to continuous feeding did not occur. She had frequent repositioning, suctioning, oxygen administration, and nebulizer treatments. She was placed on hospice due to her decline in health, and died of respiratory failure. The clinical death review committee met on 3/29/11, and focused recommendations on the need for a better system of communication between team members, especially involving the PCP, PST, and PNMT. The QI death review that nursing services completed occurred on 3/30/11. The administrative death review occurred 4/7/11. ▪ Individual #68 had chronic renal failure, quadriparesis, cortical blindness, esophageal dysmotility, and partial gastrectomy, GERD with esophagitis, jejunostomy tube placement, osteoporosis, chronic prostatitis, persistent pyuria, gout, and anemia. He had a relatively brief illness over approximately one week, associated with vomiting, cough with sputum production, hypotension, and hypothermia. He was transferred to the hospital, where he was found to have sepsis, renal failure, pneumonia, and pancreatitis leading to multi-organ failure. The QI death review of nursing services occurred on 2/27/11. The clinical death review committee met on 3/1/11, and recommended training of health care staff concerning management of the various types of feeding tubes. The administrative death review occurred on 4/11/11.	

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		▪ Individual #413 had a history of severe congestive heart failure, atrial fibrillation, old myocardial infarction, gastrostomy tube (G-tube) placement, osteoporosis, and chronic kidney disease. During his last year of life, he had a gradual decline. He had hospitalizations for congestive heart failure, and respiratory distress, and was transferred to a hospice facility for palliative and comfort care for his terminal congestive heart failure. The QI death review of nursing services was completed on 2/20/11, the clinical death review on 3/1/11, and the administrative death review on 4/11/11. Recommendations focused on equipment and transportation concerns. ▪ Individual #166 had a history of seizures, dementia, atrial fibrillation, congestive heart failure, pacemaker insertion in 1998, osteoporosis, and a history of renal cell carcinoma. In early 2010, she had a hospice designation, but then was removed from hospice, because she clinically improved. She then developed dysphagia and recurrent pneumonia, and did not want tube feedings. Bloody urine recurred, and an ultrasound indicated continued tumor, and she again was given a hospice designation shortly before her death. The QI death review of nursing services was completed on 1/1/11. The clinical death review was completed on 1/20/11, and the administrative death review was completed on 2/10/11. ▪ Individual #331 had a history of congestive heart failure, atrial fibrillation, valvular heart disease, spastic quadriparesis, dysphagia with gastrostomy tube placement, osteoporosis/osteopenia, and constipation. Over the months prior to death, she had failure of several organ systems, including cardiac, respiratory, and renal. The guardian placed her on comfort care. She died of end stage cardiomyopathy. The QI death review of nursing services occurred on 12/15/10, the clinical death review occurred on 1/20/11, and the administrative death review occurred on 2/10/11. Recommendations included providing guidance on whether to use Emergency Medical Services (EMS) or the Facility van to transport to the ER. It was noted in all five cases, that there was prompt review by the QA department, the clinical departments, and the administrative departments with finalization of recommendations in a timely manner. Medical care was appropriate for the many acute illnesses, and the choice of palliative care was offered during the terminal phase of life. Recommendations appeared appropriate and practical. There was no information submitted to determine which recommendations were completed, or if there was a system in place to track recommendations to closure.	
L4	Commencing within six months of the Effective Date hereof and with	AUSSLC adopted the DADS SSLC policy #009.1 on medical care, effective 2/16/11. The Facility also presented a draft "Preventive Health Care Guidelines for medical care for the	Noncompliance

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	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.	developmentally disabled client," dated February 2011. It is noted that the guidelines in #009.1 concerning mammogram frequency might not match the guidelines in the draft policy of February 2011. Additionally, there had been no clinical guidelines that had been finalized from the State Office since the last Monitoring Team visit.	

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

1. AUSSLC is encouraged to conduct an objective review of the current caseloads of the Medical Director and PCPs to determine if changes need to be made, and if so, to make necessary modifications. (Section L.1)
2. The Medical Department and Facility Administration should ensure efficient systems are in place, which allow PCPs to obtain needed clinical information. (Section L.1)
3. Medical Department should meet with the Information Technology Department to create user-friendly information systems with input from those that use this information most. (Section L.1)
4. As recommended with regard to Section V, the Facility should ensure that documents are timely filed in the active 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. (Section L.1)
5. The system for retrieval of the active records from the residences for use by the PCPs in their offices or clinics should be reviewed, and modified, as necessary, to ensure the availability of information for clinical decision-making and the timely entry of information into the records. (Section L.1)
6. The procedure for the I-Book should be finalized, and implementation of the process should occur to ensure timely filing of I-Book data in the active record. (Section L.1)
7. The date of expiration of CPR certification should be included in the database to allow easy tracking, and avoid lapses in certification. (Section L.1)
8. A database should be developed for PCP CMEs, to include actual date of the CME and the topic included for each CME. The Medical Director should review regularly the information in the database to ensure that the CME is relevant to the individuals AUSSLC serves, and take action, as appropriate. (Section L.1)
9. With regard to the morning medical meetings:
    a. Pharmacy should be represented at the meetings.
    b. A system to document the morning meetings should be developed and implemented, including the attendance that day, a brief synopsis of individuals discussed, as well as documentation of areas needing closure and the person responsible for that closure. When closure occurs, the date of closure, and a brief entry describing the closure would allow tracking of outstanding items until resolution. This should be a working tool immediately available the next day, created by personnel with a healthcare background.

c. The morning medical meeting should be used as a forum to discuss new policies, clinical guidelines, and clinical tools/indicators. (Section L.1)

10. 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. (Section L.1)
11. A database for osteopenia/osteoporosis should be developed that includes all individuals with these diagnoses, the date of the last DEXA scan, or reason for not ordering the DEXA scan, the date due of the next DEXA scan, and a list of all medications prescribed for this condition, including calcium, vitamin D supplements, and hormone replacement, including dosages. (Section L.1)
12. The Medical Department should monitor follow-up DEXA scan reports to ensure timely completion, to confirm effective treatment, and to determine if a change of treatment is needed, if a positive effective was not realized. (Section L.1)
13. Database management of decubitus ulcers should be reviewed and the database enhanced to include information such as whether the individual has a diagnosis in which decubitus ulcers might be inevitable, such as spina bifida or the terminal phase of cancer, as well as the residence of the individual. (Section L.1)
14. Given that most of the decubitus ulcers occurred on the feet and ankles suggests the need for increased monitoring/positioning/protection of individuals' feet. The Medical and other clinical departments should develop a system to inspect routinely the feet of those individuals most at risk for development of decubiti. (Section L.1)
15. The Medical Department should provide leadership to develop and implement an interdisciplinary monitoring group (such as a skin integrity committee) with responsibility to review decubiti each month to ensure timely evaluation and treatment, and documentation of care and progress in healing. (Section L.1)
16. Continued use of older AEDs should include periodic documentation in the medical chart (and in a consistent location such as the annual medical assessment, neurology clinic notes, etc.) that the benefits of continued use (i.e., good seizure control, poor seizure control during trials of alternative AEDs, etc.) outweigh the risks (i.e., of side effects, drug-drug interactions, etc.). (Section L.1)
17. Nursing staff should review the seizure records to ensure staff complete these forms in a timely and complete manner. (Section L.1)
18. The Medical Department should develop and implement a system in which significant unplanned weight loss (such as five-pound weight loss in a month, and/or 7.5% weight loss in three months, 10% weight loss in six months) triggers a medical review, including dietary consultation. (Section L.1)
19. For those individuals with severe constipation, it is recommended the PCP regularly review the medication regimen and consider additional medication (either increased dosage of previously prescribed medication or the addition of medication), and continue to follow the individual until there is reduction in prn medication use. (Section L.1)
20. For ER recommendations not followed, there should be justification in the record and rationale for using alternative treatments or making no change in treatment. (Section L.1)
21. For individuals admitted to the hospital for an adverse outcome from a psychotropic medication (such as toxicity), the psychiatrist should write entries in the IPN to verify the psychiatrist is following the clinical course, and providing a rationale for future changes in dosage or class of medication, as well as identifying additional monitoring steps to prevent a recurrence. (Section L.1)
22. For a decline in health status, the IPN should reflect the PCP was notified and completed a timely assessment. For instances in which a stat PST is called, a member of the team should write an entry in the IPN indicating the meeting occurred, and providing a brief summary of decisions made by the team. (Section L.1)
23. If the IPN reflects the consideration of a change of residence for behavioral or medical reasons, there should be a closure note in the IPN

indicating whether this occurred (with date of move), or documenting the reasoning the move was not made. (Section L.1)

24. The Medical/Nursing Departments should create and implement a tracking system to ensure all requests for lab and other tests, as well as all consults are tracked until completion, including tracking to ensure lab results and consultant reports are received. (Section L.1)
25. If the PST meets to review behavior that leads to an ER visit (for injury or other reason), then the results of that meeting should be reflected in the IPN. Additionally, as appropriate, the psychologist should make a brief entry in the IPN indicating a change in the BSP in response to SIB or an ER visit for behavioral reasons. It is important for the IPNs to document the integrated approach taking place, and when this does not occur, valuable information is not available to all those providing care and treatment to the individual. (Section L.1)
26. In writing IPN entries, nurses need to ensure they provide accurate information about the type of feeding tube present. Nursing staff might need to participate in in-service training in which the differences between J-tubes and G-tubes are reviewed. (Section L.1)
27. Once the State Office finalizes the policy on Do Not Resuscitate Orders, the PSTs should review all current DNRs to ensure they are in compliance with the new State Office guidelines. For reasons listed for a DNR, further probing will be needed to determine whether the condition is end stage or not, with documentation of findings. In addition, teams will need to determine precisely what the terminal diagnosis is (what organ system and what diagnosis, and confirm that the individual is at the end stage of that illness). (Section L.1)
28. The Facility should ensure a process is in place for rescinding a DNR, which ensures families have a clear understanding of the State policy. (Section L.1)
29. The Medical Department should document action steps in response to medical peer review findings, and should have a system of monitoring to ensure corrective actions are sustained, and data is available providing the evidence of sustained correction. (Section L.2)
30. Autopsies should be encouraged, as a method to verify the cause of death, to understand the other pathophysiologic processes at the time of death, and to ensure quality healthcare was provided. (Section L.3)
31. For those individuals with feeding tubes and aspiration pneumonia, the medical record should reflect a work-up for GERD, and aggressive treatment, if GERD was found. (Sections L.1 and L.3)
32. Discrepancies in the different medical databases should be resolved. As a first step, the Medical Department should understand how the data is accumulated and entered into the various databases. It is recommended that one accurate and complete database be developed rather than many databases of questionable quality. (Section L.3)
33. 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. (Section L.3)

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 Additional Nursing Positions; o Daily Sign-In Sheet/Daily Sign-Out Sheets, for April 2011; o Nursing minimum and preferred staffing ratios; o AUSSLC's Nursing Schedules; o AUSSLC's Nursing monitoring data, since September 2010; o AUSSLC's QE monitoring data, since September 2010; o Monitoring observation data from the Cardinal building, and corrective action plans; o State procedure Competency-Based Training Curriculum-Agency/Contract Nurses, dated February 2011; o QE spot checks for Medical Records; o Environmental/Infection Control Surveillance Reviews; o Infection Control Committee meeting minutes, dated 12/13/10, and 2/11 (no specific date included); o AUSSLC's Hand Washing spot check data; o AUSSLC's Medical Emergency Drills, from 10/10 through 3/11; o Competency Training and Development (CTD) Department's schedule for conducting Mock Drill Schedule; o CTD Department's tracking system for recommendations from conducted drills; o The medical portions of records for the following individuals: Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, Individual #424, Individual #62, Individual #356, Individual #332, Individual #202, Individual #393, Individual #358, Individual #430, Individual #61, Individual #310, Individual #268, Individual #84, Individual #356, Individual #81, Individual #199, and Individual #402; 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 At Risk lists for health indicators, initial and final;

	○ AUSSLC's database for scheduling Medication Administration Observations; ○ AUSSLC's Medication Pass Observations data reports and raw data; ○ Pharmacy and Therapeutics (P&T) Committee meeting minutes, dated 1/27/11; ○ Medication Error/Prevention Committee meeting minutes, dated 2/17/10, and 3/22/10; ○ Curriculum for AUSSLC's Medication Administration Practices training and training roster; ○ AUSSLC's medication variance data by nurse, building, severity index, agency and staff; ○ AUSSLC's Medication Error Trend reports by Nurse, Home, Agency/Facility staff, Severity Index, Contributing Factors, and type of error, for January through March 2011; ○ AUSSLC's training grid from Nursing Education; ○ Documentation Guidelines; ○ Tracheostomy Care training curriculum; ○ Nurse Case Manager meeting minutes, dated 1/26/11; and ○ Nursing Administrative Team Meeting minutes, dated 10/27/10, 11/18/10, 1/20/11, 2/28/11, and 4/14/11. ▪ **Interviews with**: ○ Priscilla R. Hackett, MSN, MPH, RN, CCM, Chief Nurse Executive (CNE); ○ Jolene Harvey, RN, Nurse Operations Officer; ○ Carla Jones, RN, Program Compliance Nurse; ○ Kay Cowan, RN, MSN, FNP, BC, Infection Control Nurse IV; ○ Jennifer Mears, CTD Director; ○ Soledad Reyes-Hernandez, CTD Training Specialist II; ○ Vanessa Haupt, RN, BSN, BA, Nurse Educator ○ Tammy Snyder, QE Director; ○ Kimberly Quarry, Unified Records Coordinator; ○ Sherry Weir, Unified Records Coordinator; ○ Gail Tigue, Client Records Coordinator; ○ Connie Horton, APRN, State Office Consultant; and ○ Valerie Kipfer, RN, MSN, State Office Nursing Discipline Coordinator. ▪ **Observations of**: ○ Medication Administration in the Infirmary; and ○ Demonstration of the emergency equipment in the Infirmary.
	Facility Self-Assessment: Based on a review of AUSSLC's POI, the Facility found that it remained out of compliance with all of the provisions in Section M of the Settlement Agreement, which was consistent with the Monitoring Team's findings. The Facility clearly indicated that very few Health Monitoring audits had been conducted, since the last review and consequently, little to no data had been generated. Since the last review, the Nursing Department had focused its efforts on restructuring the roles and responsibilities of the nurses and the Nursing Department. Although this diverted energies from making progress with specific the Settlement Agreement requirements, it was essential that the Nursing Department build a solid infrastructure for positive outcomes to be sustainable. Since January 2011, the Facility began using seven out of twelve of the newly modified nursing monitoring

	tools. Although the tools had associated guidelines, to encourage consistent scoring, they should be reviewed to determine if additional instructions are needed to ensure that the specific criteria that constitute compliance with each item are identified clearly. In addition, the Facility reported that inter-rater reliability had not been established for any of the nursing tools. This would be crucial, since the Facility had a number of different auditors generating monitoring data for the same areas. At the time of the review, the Facility did not have a written procedure outlining the inter-rater reliability process to ensure it was executed appropriately and consistently. Without accuracy and reliability of the data generated from the monitoring tools, the analysis and interpretation of the data could easily be skewed, and trends not accurately identified. Developing and implementing a consistent procedure for conducting inter-rater reliability would ensure consistency in executing the process. Once this is established, the range of percentages of inter-rater reliability should be reported for each tool to allow evaluation of the reliability of the data collected. In addition, the Facility should develop a unified system to present the data from the monitoring tools in a meaningful way, so that it can be easily analyzed and trends identified. A unified system also would allow data to be easily reviewed and interpreted between disciplines and departments. As noted in previous reports, the presentation of data should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured. Once this data presentation system is developed, the Facility will then need to use these data to justify their compliance status for the various monitoring indicators. Regarding the Facility's POI for Nursing, more information was needed regarding the specific actions taken since the last review, including specific dates of implementation, as well as updates on the status of systems. In addition, the Presentation Book addressing the Settlement Agreement requirements should include all of the Nursing Department's specific supporting documentation regarding actions that the POI describes as having been taken, or that supports progress made.
	Summary of Monitor's Assessment: At the time of the review, AUSSLC had a total of 136 nursing positions with seven vacancies, including four for RNs and three for Licensed Vocational Nurses (LVNs). Effective May 1, 2011, the Facility had stopped using Agency nurses, and had restructured the work schedules of the RN II positions, the Direct Consumer Nurses, and RN III positions. AUSSLC had spent a significant amount of time building a much-needed infrastructure regarding the scheduling and tracking of nursing staffing. Since the last review, due to the clinical intensity that was needed for those individuals who were admitted to the Infirmary for acute medical issues, the Facility had changed the nursing staffing of the Infirmary to include only RNs. Also, the Facility had established minimum nursing staffing ratios for each building, and was in the process of developing a draft policy addressing daily staffing and scheduling for nursing, incorporating the minimum staffing ratios based on acuity. At the time of the review, the restructuring process of the Nursing Department was still underway with additional interventions yet to be implemented. There were few Heath Monitoring Tools that had been implemented and completed by the Nursing

	Department and the Program Compliance Nurse. However, there were data generated from a small sample in November 2010 regarding Nursing Documentation, which included a very promising format for the presentation of data. It included the overall total population (N), the sample audited from the total sample (n), and the percent of compliance graphed for some of the items contained on the tool. AUSSLC's Nursing Department should continue its efforts in implementing the Health Monitoring Tools to generate accurate clinical data focused on the quality of nursing services and documentation Consistent with the findings from the previous reviews, 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. The problematic areas continued to be related to the lack of adequate documented nursing assessments when the individual began showing symptoms of a change in status, and the lack of nursing assessments prior to the transfer to an off-site medical center, as well as upon return to the Facility. The problems in this area reflected the significant need for nursing to develop and implement Facility protocols and procedures that would guide nursing practices regarding conducting adequate and regular clinical assessments, and to clearly outline the criteria for nursing documentation, and physician notification regarding status changes. On a positive note, at the time of the review, the competency-based nursing skills training program provided by the State's Nurse Practitioner Consulting group recently had been conducted at AUSSLC with the RN Case Managers and Nurse Educators. There was no improvement found in the quality of the Comprehensive Nursing Assessments and the Health Management Plans. However, although there continued to be serious problematic issues regarding the medication administration and medication variance systems at AUSSLC, the Facility had implemented some very promising systematic processes and infrastructures regarding the medication administration system. Of special note were the Facility's new Medication Error Trend reports, which included the raw data, graphs, and pie charts for medication errors by nurse, residence, agency/facility staff, severity index, contributing factors, and type of error. These were especially impressive in that trends for a specific month, as well as trends over the course of several months could be identified easily.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status	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, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and the Facility's medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the Settlement Agreement.	Noncompliance

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	sufficient to readily identify changes in status.	Staffing Since the last review, AUSSLC had spent a significant amount of time building a much-needed infrastructure regarding the scheduling and tracking of nursing staffing. At the time of the last review, the Facility did not have a system in place to accurately reflect when and what shifts nurses' worked, or to show the staffing patterns of the Nursing Department. Since March, 2011, the Chief Nurse Executive had implemented the use of a Daily Sign-In Sheet/Daily Sign-Out Sheet process for nurses to use at each building to verify when they reported to work, took lunch breaks, and when they left the Facility. The Nurse Managers for each area were designated as responsible for ensuring that these sheets were consistently filled out and turned into the Facility's timekeeper. The Nursing Operations Officer (NOO) also had been designated to review these sheets for completion, and to assess for any problems regarding staffing patterns that warranted timely interventions. At the time of the review, the CNE reported that there were some inconsistencies regarding the use of the Daily Sign-In Sheet/Daily Sign-Out Sheets. However, these were being timely addressed with the Nurse Managers. The Facility's data indicated that it had not fallen below the minimum nursing staffing ratios, since the last review. At the time of the review, AUSSLC had a total of 136 nursing positions with seven vacancies, including four for RNs and three for LVNs. In addition, effective May 1, 2011, the Facility had stopped using Agency nurses (i.e., staffing agencies), and had restructured the work schedules of the RN II positions, the Direct Consumer Nurses, and RN III positions. The Facility's POI and CNE indicated that to decrease the Facility's dependency on Agency nurses, the RN IIs and the Direct Consumer Nursing positions were now being scheduled to work every third weekend, rather than their previous Monday through Friday schedules, to better distribute the Facility's RNs and ensure that there was adequate nursing coverage during weekends. Also, the Facility's RN IIIs and Nurse Case Managers were scheduled to work during the day shifts Mondays through Fridays to ensure that nursing staff who were the most knowledgeable about the individuals participated in the necessary meetings regarding the individuals on their caseloads. In addition, since the last review, due to the clinical intensity that was needed for those individuals who were admitted to the Infirmary for acute medical issues, the Facility recently had changed the nursing staffing of the Infirmary to include only RNs. At the time of the review, the Facility had established minimum nursing staffing ratios for each building, and was in the process of developing a draft policy addressing daily staffing and scheduling for nursing, which incorporated the minimum staffing ratios based on acuity. At the time of the review, the CNE reported that she assessed the Nursing Department to need an additional 17 LVN positions to offset having the RN II and RN III positions	

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		administer medications in addition to their current duties. From discussions with the CNE and Facility Director, if the need was appropriately justified, and there were no other possible alternatives, the Facility would consider using an Agency nurse. However, both the CNE and Facility Director indicated that in the past, the lack of a nursing staffing structure resulted in the use of Agency nurses that was not consistently and appropriately warranted. Thus, a more rigorous process for determining the need for Agency staff had been implemented by the Facility. The Facility should continue its efforts and strategies to secure adequate and consistent nursing staff to facilitate positive clinical outcomes for the individuals at AUSSLC. Although the Facility's goal was to avoid the use of Agency nurses, in the event it was necessary, the Monitoring Team conducted a review of the State's procedure entitled Competency Based Training Curriculum-Agency/Contract Nurses, dated February 2011. Given the Facility's past findings related to Agency nurses, especially regarding problems related to nursing documentation and medication variances, the State procedure did not adequately indicate the process and timeframe for the orientation of Agency/Contract Nurses. For example, there was no indication in the procedure, if Agency/Contract Nurses were to complete the entire Facility's orientation process, rather than an abbreviated process as was done in the past. In addition, the competencies listed in the procedure were not in alignment with the current competencies that were being expected of staff nurses, for example, based on the competency-based training on nursing assessment that the State Office Nurse Practitioner Consultant recently had provided at AUSSLC. The State should clarify this procedure to ensure that the specific criteria for orientation are outlined, and the expected skill competencies are in alignment with the current competencies being required at the Facility. Since the last review, nursing personnel changes at AUSSLC included the following: ▪ A full-time RN was assigned to the Physical Nutritional Management Team; ▪ The Program Compliance Nurse originally under the supervision of the Quality Enhancement Department was placed under the supervision of the CNE; ▪ The Nurse Recruiter/Schedule Coordinator reported to the NOO; ▪ Two full-time Respiratory Therapists (RT) were hired and placed under the supervision of nursing; ▪ A full-time Nurse Educator position was filled; and ▪ The part-time RN Assistant position for Infection Control was reallocated to the Medical Department. As noted above, two full-time Respiratory Therapists were hired were placed under the supervision of the Nursing Department. However, the clinical supervision of RTs by nursing was not appropriate, and the Facility should consider placing them under the supervision of the Medical Department.	

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		Since the previous review, the CNE had focused a significant amount of effort in restructuring the roles and responsibilities of the Facility's nursing positions, and the Nursing Department. At the time of the review, the restructuring process was still underway with additional interventions yet to be implemented. Although these efforts substantially diverted the Nursing Department's attention from focusing on specific compliance with the Settlement Agreement requirements, the building of a solid infrastructure for the Nursing Department was essential in order for the required changes in nursing practice as outlined in the Settlement Agreement to be consistent and enduring. From interviews with the CNE, the NOO, and the Program Compliance Nurse, the Facility had a clear plan for movement forward that included appropriate and reasonable rationales justifying the steps already taken, and those yet to be implemented. However, AUSSLC should continue its efforts in recruiting, maintaining, and evaluating the reallocations of nursing positions to ensure the needs of the individuals are consistently met. <u>Quality Enhancement Efforts</u> Since the last review, one of the QE Nurses moved into the position of the Program Compliance Nurse under the supervision of the CNE. The other QE Nurse position, under the supervision of the QE Director, recently had been vacated. The Facility's POI indicated and training rosters verified that in March 2011, training regarding the Nursing Documentation monitoring tool was provided to the RN IIs, RN IIIs, and Nurse Managers, and training regarding the Urgent Care/ER Visits and Hospitalizations monitoring tool was provided to the Hospital Liaison Nurse. From discussions with the CNE and Program Compliance Nurse, the Facility planned to have at least 60 nurses complete audits using the Health Monitoring Tools. However, at the time of the review, the Facility had not implemented a process for establishing inter-rater reliability for the monitoring tools. From the questions regarding inter-rater reliability that were asked while the Monitoring Team was on site, it was evident that the Nursing Department was unsure of how to execute this process. The Facility should develop a procedure for establishing inter-rater reliability to ensure that all disciplines are executing the process appropriately and consistently. In addition, the Nursing Department should consider decreasing the number of nurses assigned auditing duties, particularly until an inter-rater reliability process is developed and potential nurse auditors verified as competent in the areas they are assigned to audit. This is essential to ensure the Facility's data accurately reflect the quality of care being provided, and to quickly identify problematic trends and implement timely plans of correction. In addition, the CNE and Program Compliance Nurse indicated that once the monitoring system is implemented and data generated, the findings would be reviewed during the Nurses' Meetings, and integrated into performance evaluations, and into the Facility's	

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		Quality Management and Risk Management systems. As noted previously, at the time of the review, the Nursing Department and the Program Compliance Nurse had implemented few Heath Monitoring Tools. However, data had been generated from a small sample in November 2010, regarding Nursing Documentation, which included a very promising format for the presentation of data. The format included the overall total population (N), the sample audited from the total sample (n), and the percent of compliance graphed for some of the items contained on the tool. From interviews with the Nursing Department, the Facility as a whole had not implemented a consistent system for the presentation of monitoring data for interpretation. The Facility should develop a unified system to present the data generated from the Health Monitoring, so that the data can be easily analyzed and trends identified. A unified system for the presentation of data would allow all disciplines to easily review and interpret monitoring data from different disciplines and departments. The table below is just one possible example of a system for the Facility to consider as a simple structure for standardizing the presentation of their monitoring data.	

Name of the Health Care Monitoring Tool
Established Inter-rater reliability percentage range

Month/year data collected	1/11	2/11	3/11	4/11	5/11	6/11	Mean
N							
n							
% Sample							
# ITEM 1 (Item # on tool and the Item being monitored)	Compliance scores for item #1 by month						Mean Compliance score for item #1
# Item 2	Compliance scores for item #2 by month						Mean Compliance score for item #2
# Item 3	Compliance scores for item #3 by month						Mean Compliance score for item #3

N = Number of total population being reviewed (for example: Total number of

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		individuals with Hypertension) in the review month. n = Number of records audited (for individuals with Hypertension)	

Item #	Mean Previous Review Period	Mean Current Review Period
#1		

Any format the Facility implements should include information, such as the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. In addition, compliance scores should be presented for each item on the monitoring tool to reflect the compliance with the specific elements of the area being audited. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured.

In addition, it had been previously reported that the State had plans to implement a new statewide database system at the Facility. This was a very positive step, so that the format and presentation of the monitoring data were standardized, and easily reviewed at the Facility and among Facilities.

Also, based on a review of the data provided by AUSSLC, at least twice a month since May 2010, the previous QE Nurses had implemented an audit based on observations at the Cardinal Building. Some of the observations included:

- Insufficient supplies available, such as suction canisters, Yankauer suction catheters, and appropriate sized tracheostomy suction catheters;
- I-Books not accompanying individuals when they were moved from their rooms;
- Dirty equipment found in individuals' rooms;
- Individuals not positioned according to their PNMPs;
- Several individuals had dry, crusty lips; and
- The environment was too cold (67 degrees) for individuals who had hypothermia.

In addition, the narrative observation audit findings included Corrective Action Plans, which included action steps, date interventions due, responsible person, and actual date action steps completed. The findings from these audits were in alignment with a number of previous recommendations from the Monitoring Team, and were structured to indicate the timeliness of the specific corrective actions. This was a very promising auditing system in that it reflected critical observations and tracked the corrective actions through to completion. However, a number of these same problematic issues were noted in the Monitoring Team's previous report, and, based on the observations the

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		Monitoring Team conducted at Cardinal during this review, the issues continued to exist. Consequently, the corrective actions that had been implemented were not producing lasting positive outcomes. AUSSLC's Nursing Department should continue its efforts in implementing the Health Monitoring Tools to generate accurate clinical data focused on the quality of nursing services and documentation. In addition, the Facility should prioritize the implementation of the Nursing Health Monitoring Tools based on problematic areas, rather than trying to implement a number of the Health Monitoring Tools, just to generate data. A review of the limited raw data generated from the previous QE Nurse and the current Program Compliance Nurse indicated that the initial auditing processes were good critical reviews of nursing practices. As AUSSLC continues to develop its monitoring systems, as mentioned previously, it would be important for the Facility to formalize the inter-rater reliability process, and establish a unified structure for presenting the data generated from the Health Care Monitoring tools. When the QE Nurse position is secured, the QE Nurse, the Program Compliance Nurse, and the Nursing Department should prioritize which Health Monitoring Tools to implement, and have regular discussions regarding the data generated to ensure that those areas are being critically audited, and corrective actions are timely implemented and produce positive clinical outcomes. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> As noted previously, since the last review, the Hospital Liaison Nurse had received training on the Health Monitoring Tool related to Urgent Care/ER Visits and Hospitalizations. However, no audits had yet been completed for this area. From discussions with the CNE, the Facility had not implemented any system changes since the last review that would have resulted in any measurable changes regarding clinical outcomes or improvements in the nursing documentation. This was consistent with the Monitoring Team's findings for this area. A review of 11 individuals' records (Individual #223, Individual #359, Individual #260, Individual #224, Individual #450, Individual #32, Individual #426, Individual #380, Individual #103, Individual #358, and Individual #1), who had been transferred to a community hospital, or emergency room found that for all 11 individuals reviewed, there continued to be significant problems regarding the nurses' documentation in the following areas: ▪ Due to the lack of nursing documentation, unable to determine when changes in status were initially occurring; ▪ A lack of complete and appropriate nursing assessments in response to changes in vital signs, and oxygen saturations; ▪ A lack of follow-up from issues noted in previous nurses' progress notes;	

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		▪ A lack of specific description, size, and location of injuries, or bruises; ▪ Inadequate documentation of the administration and follow-up for PRNs (as needed medications); ▪ Inadequate assessments and follow-up addressing pain; ▪ No documentation of individuals' activities and tolerance for activities during the day; ▪ A lack of mental status assessments documented during status changes; ▪ A lack of lung sounds assessed and documented for respiratory issues; ▪ A lack of assessment of bowel sounds and abdomen exams for individuals with constipation or receiving PRN laxatives; ▪ Significant gaps in nursing documentation when nurses' notes stated: "will monitor"; ▪ Physician/Practitioner not timely notified of change in status due to nurses' inadequate follow-up; ▪ The type of temperatures taken not consistently documented; ▪ No documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ Lack of communication between shifts regarding status changes and need for regular assessments; ▪ The lack of specific descriptions of the individuals' behaviors and mental status, assuming that all staff reading the progress notes were familiar with the individuals; ▪ Lack of analysis of contributing problematic issues affecting changes in status; ▪ 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; ▪ A lack of regular follow-up for symptoms related to the reasons for the hospitalizations; ▪ When interventions were not effective, the lack of modifications to the Nursing Care Plans; ▪ Dates and times not consistently documented for progress notes; ▪ Lack of an adequate updated Nursing Care Plans to reflect changes in status and new interventions;	

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		▪ Many nursing progress notes and signatures were illegible; and ▪ A lack of systematic documentation addressing the care of catheters, tracheotomies, and G-tubes. Similar to the findings from the past reviews, there were a number of significant problematic issues found in all 11 records reviewed regarding complete, timely, and adequate nursing assessments for symptoms for acute changes in status for individuals. For example: ▪ Individual #426 was hospitalized at the time of the review, and had the following high-risk medical issues: respiratory compromise, aspiration, infections, and gastrointestinal problems; had been hospitalized three times since September 2010 for aspiration pneumonia, respiratory distress, and seizures with tachycardia; had a tracheostomy, GERD, a seizure disorder, occasional problems with constipation, recurring emesis; and was enterally nourished via G-tube. Listed below are some of the problems found in the nurses' documentation prior to the recent hospitalization: o There were no regular nursing assessments conducted for his respiratory status; o Respiratory Therapists did not document lung sounds before and after breathing treatments; o There were no regular nursing assessments conducted regarding skin integrity; o There were no assessments for variations in oxygen saturations and vital signs; o Respiratory Therapy was not notified for designated oxygen saturations levels; o There was no documentation regarding his activities during the day, and his tolerance for activities; o There was no documentation regarding his tolerance for feedings via G-tube; o No mental status assessment was found in the documentation; o There was no documentation of an assessment of the site of the G-tube for skin break down or infection; o There was no indication if he was bed-bound, or out of bed and up in his wheelchair during the day; o There was no assessment of daily urine output; o There was no documentation indicating that the physician was notified of changes in vital signs and oxygen saturations; o There was no documentation regarding the care of the trach; o From the nursing documentation, it could not be determined exactly which health problems were being assessed and monitored;	

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		o Significant lack of follow-up for any problems noted in the nursing documentation; and o There was no consistent frequency of any nursing assessments to indicate the status of his high-risk health issues. This individual's case reflected the significant need for nursing to develop and implement Facility protocols and procedures to guide nursing practices regarding the conduct of adequate and regular clinical assessments, and to clearly outline the criteria for nursing documentation, and physician notification regarding status changes. For the significant high-risk medical problems listed above for Individual #426, nursing staff failed to adequately assess any of them. A review of the 11 records listed above found that all had consistent significant problematic issues indicating deficits in the clinical competency of the nursing staff, a lack of nursing protocols in place, a lack of clinical judgment to guide frequency of assessments and documentation, poor communication between nurses and other clinical disciplines, a lack of reporting protocols addressing when it was necessary to notify the physician of changes in status, and an inability to analyze clinical data. Although the State had implemented a strong competency-based assessment skills training for the nursing staff, which is discussed in more detail with regard to Section M.2, it is crucial that the Nursing Department establish appropriate nursing protocols to drive nursing documentation. Such protocols are necessary to structure the nursing documentation to ensure consistency regarding clinical assessments, and to timely identify changes in status and have positive clinical outcomes for the individuals at AUSSLC. On a positive note, a review of the 11 individuals listed above found that the documentation from the Hospital Liaison Nurse was present in all (100%) of the 11 records reviewed. This was a significant improvement since the last review. Due to the significant problematic issues consistently found for individuals who had experienced changes in status that warranted Infirmary and/or hospitalization, by the next review, the Nursing Department should focus on this area for monitoring, and implementing plans of correction addressing the problematic issues related to Urgent Care/ER Visits and Hospitalizations. AUSSLC's POI indicated that the Facility was not in substantial compliance with items specific to this requirement of the Settlement Agreement, which was consistent with the findings of the Monitoring Team. <u>Availability of Pertinent Medical Records</u> Since September 2010, AUSSLC had completed the conversion of all the medical records at the Facility in alignment with the current Unified Records Guidelines. However, consistent with the past two reviews, in reviewing records onsite, it was noted that a	

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		number of documents were not in the medical records and had to be obtained from the units. Specifically, several Nursing Quarterly Assessments, Nursing Annual Assessments, and Nursing Health Management Plans were not found in the records. From a review of ten QE spot check audits, these findings were consistent with the Facility's findings. Although the Facility had finalized the Recordkeeping Policy in April 2011, finalized the Individual Notebook policy/procedure in March 2011, and the Client Records Coordinator had assumed supervision of the Unit Clerks, the Facility continued to be dependent on the use of the "green files." These "green files" contained copies of lab work, consultations, and other types of medical documentation specific to each individual, which had been created due to the number of missing medical documents from the records. From discussion with the QE Director, there was no tracking system in place to ensure that all laboratory results, consultations, or other medical documents were received and timely filed in the medical records. The Facility should develop and implement a tracking system to 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 Team's findings. Since the last review, the Facility continued to have one full-time Family Nurse Practitioner coordinating the activities for Infection Control. The part-time RN assistant position was reallocated to the Medical Department, so at the time of the review, there was no longer a part-time position allocated for Infection Control. Also, there continued to be no clerical staff assigned to assist the Infection Control Nurse. 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 any antibiotic use. Although the IC Nurse was able to describe the systems used to verify which individuals at the Facility had an infection or contagious illness, there continued to be no formalized procedure in place to ensure that the infection lists generated were reliable, and included all individuals who had either a chronic or acute issue related to an infectious or communicable disease process. As noted in the previous two reports, ensuring the reliability of the IC data is essential. The Facility should develop a procedure outlining the specific process to ensure data reliability for infection control,	

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		including how discrepancies in the data are reconciled and tracked. This will require collaboration with the Pharmacy Department, Medical Department, as well as residential services. 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 unit 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 timely and appropriate training is being provided, or initiate proactive interventions. In addition, in February 2011, the Facility acquired an IC database from another Facility. However, at the time of the review, the IC Nurse reported that the other Facility's data had not been removed from the database, and that the Facility's IT support staff was in the process of extracting the existing data and modifying the database. The IC Nurse provided the Monitoring Team a tour of the database, which appeared to be very promising for tracking and aggregating IC data. However, at the time of the review, the Facility had no comprehensive, up-to-date, and accurate database to identify and track individuals with infection control issues. The Facility should continue its efforts in developing and implementing a database system for IC that allows for reliable tracking and monitoring of the Facility's IC data. Also, at the time of the review, the Facility had not developed a schedule regarding when the immunization status of each individual would be evaluated, and updated, if needed. There had been no additional individuals reviewed regarding their immunization status. However, as noted above, discussions with the IC Nurse indicated that the Facility had acquired a database from another Facility, and was in the process of extracting the existing data. The Facility should continue to develop and implement strategies to ensure that all individuals at AUSSLC are current regarding their immunization status, in accordance with the requirements of the Settlement Agreement. In addition, a schedule addressing these issues should be developed to ensure individuals are appropriately prioritized and that no one is overlooked. Since March 2011, there had been a significant number of spot check monitoring conducted for hand washing in the residences. From discussions with the IC Nurse, she indicated that 80 spot checks for hand washing would be conducted each month. None of the spot checks identified any issues, but no summary data had been compiled. In addition, there continued to be no written formal system or structure addressing when and how frequent these spot checks would occur. Although a large number of spot checks were completed, the system continued to be informal. The Facility should consider formalizing this system to ensure regular spot checks are conducted in different areas to generate adequate data regarding the hand-washing practices of the staff.	

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		In addition, the IC Nurse indicated that she had only informally begun to use the State Infection Control Monitoring tool, but had not documented any data. At the time of the review, there were no formal 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 to ensure that individuals with MRSA were audited regarding treatment with the appropriate antibiotic in alignment with the culture and 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. In addition, there were no formal IC audits conducted for individuals who had a contagious, infectious medical issue to ensure that the appropriate infection control practices were being implemented. Consistent with the findings of the past two reviews, no formal process had been implemented for reviewing Health Management Plans addressing infectious diseases. As discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, the records of 13 individuals diagnosed with MRSA were reviewed, and of the 13, only one had a Health Management Plan addressing MRSA. However, the one Health Management Plan reviewed addressing MRSA was found to be inadequate. These findings have been consistent throughout the past two reviews, and due to the clinical ramifications of this area, are very concerning. Although the Facility's audits verified that environmental rounds were being conducted quarterly, many of the items on the auditing tools were not scored, and the findings indicated that there were no problems regarding the cleanliness of the Facility. These findings did not comport with the findings of the Monitoring Team while on site, or the Facility's own data from observations conducted at the Cardinal Building, which found a number of consistent problematic issues related to the cleanliness of the environment. Clearly, the lack of findings from the environmental rounds indicated that they were not being thoroughly or accurately conducted. Although a number of systems had not been implemented for IC, the Facility did conduct tuberculosis (TB) spot tests, which were highly sensitive blood tests, on 41 individuals at the Facility who had been designated as Tuberculin Skin Test positive. The results of the TB spot tests indicated that only 14 of the 41 individuals were actually TST positive. Since the last review, there had been minimal progress made in moving Infection Control forward to meet the requirements of the Settlement Agreement. Significant guidance and clear direction should be provided to the Facility and the IC Nurse, so that efforts are focused on priority clinical issues. Significant attention is needed in this area to build a solid infrastructure with formal operational procedures that drive the activities for Infection Control. As noted in previous reports, additional expertise in Infection Control	

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		is needed to assist in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. <u>Code Blue Drills</u> From discussions with the CNE, since the last review, there had been little change in the process of the emergency medical drills. The Competency Training and Development Department had continued to conduct Medical Emergency Drills at all homes on each shift, every month as required. As noted in the last report, the CTD Department had developed and implemented a tracking system to ensure that drills were conducted as required by the Facility's policy. However, from a review of the Medical Emergency drills from September 2010 through March 2011, there was no documentation on the drill form indicating if the drill was passed or failed. In addition, no report was found reflecting this information. However, since the last review, the CTD had initiated a tracking form for recommendations generated from the drills, which consisted of only the recommendation for a Cardiopulmonary Resuscitation (CPR) Refresher Course. As noted in the previous report, the Facility should consider including the date the staff completed the CPR refresher class to ensure that staff received the needed skills training. The CTD staff, who conducted the Medical Emergency drills, reported that a majority of staff who participated in the drills needed to attend the CPR refresher course due to inadequate execution of emergency procedures. In addition, consistent with the previous two reviews, the CTD staff reported that nurses rarely participated in the drills, and would usually walk away when the drills were initiated. In addition, they reported that physicians never participated in the drills. The Facility should ensure that the clinical staff participates in the Emergency Medical Drills. Also as noted in the previous report, at the time of the review, there was no system in place to analyze the data from the Medical Emergency drills to identify problematic trends and implement timely plans of correction. From discussions with the CNE and CTD staff, there was no nursing or medical review of the findings of the Medical Emergency drills or committee that reviewed the Facility's emergency procedures. In fact, until the Monitoring Team's interview with the CTD staff, the CNE was not aware that most nurses did not respond to the Medical Emergency drills. The Facility should implement a committee review of emergency procedures, Medical Emergency Drill findings, and actual medical emergencies to ensure that the Facility has adequate emergency procedures in place. Consistent with the findings from the past two reviews, 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	

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		injuries, or scenarios addressing first aid issues. As previously recommended, 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 staff actions, in addition to CPR. The Facility also should consider adding First Aid training to the New Employee Orientation and CPR classes. Consistent with the previous review, 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 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 purpose of conducting regular medical emergency drills is to identify the strengths and weaknesses in the Facility's response to emergencies, as well as assessing staff's knowledge and competency in executing appropriate emergency procedures. However, the CTD staff reported that since nursing did not participate in the Medical Emergency Drills, aside from the AEDs, no other emergency equipment such as oxygen was brought to the drills. Consistent with the findings from the last review, the Facility did not have AEDs available in every residence. At the time of this review, the Facility had four AEDs. The CNE reported that from her assessment of the Facility in February 2011, the Facility needed to have 22 more AEDs. From the documentation provided, it was unclear if the additional AEDs had been purchased. The Facility should purchase additional AEDs to ensure that the equipment is readily available throughout the Facility. The Facility had purchased new oxygen tanks, which did not require the use of a key to turn on the tank. The Monitoring Team's observations of emergency equipment use by staff in the Infirmary found the following problematic issues. They included: ▪ Upon the Monitoring Team's arrival to conduct the drill, there were no nurses on the floor monitoring the individuals in the Infirmary at change of shift, until the CNE requested that one stay on the floor to observe the individuals; ▪ A nurse did not know where to obtain batteries for the AED, in the event the battery needed replacement; ▪ The nurse observed reported she did not usually check the portable suction machine, and that there was no equipment check sheet indicating that it was routinely checked to ensure it was operational; and ▪ There were blanks found on the emergency check sheets indicating that the emergency equipment was not being checked daily to ensure it was operational. The Facility should implement a system in which nurses are observed checking the emergency equipment at least quarterly to ensure they are familiar with the use of the	

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		equipment. In addition, all emergency equipment, including back-up equipment should have documentation that it is being checked regularly, and it is in good 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.	AUSSLC 's POI for this requirement indicated that a comprehensive nursing assessment was to be completed by the RN Case Manager every quarter, and as indicated by the Individuals' health status. However, from a very limited spot check audit that was conducted in March 2011, the Facility found that these assessments were not being completed consistently. The Facility indicated that the oversight and monitoring of the completion of the Comprehensive Nursing Assessments were the responsibility of the Nurse Managers, and since the last review, the Facility had not yet implemented the monitoring process addressing this requirement. Consequently, there had been no changes in the Comprehensive Nursing Assessments since the last review. However, in response to the Monitoring Team's consistent past findings indicating significant problems regarding nursing competency related to overall nursing assessments, the State developed and implemented a competency-based pilot training program that was initiated in March 2011 at one of the SSLC's addressing physical assessment skills, and utilizing Nurse Practitioners with Development Disabilities experience as the trainers. At the time of the review, the training program recently had been conducted at AUSSLC with the RN Case Managers and Nurse Educators. The program consisted of a day of classroom instruction, followed by a day of competency-based demonstrations of assessment skills, which the RN participants performed on each other. Additional competency-based demonstrations of assessment skills were to be conducted for a quarterly assessment, a chronic condition follow-up, and an acute illness review or/or clinic follow-up. These demonstrated competencies would be completed with an individual assigned to the RN Case Manger's caseload, and would be supervised by the Nurse Practitioner trainers. Based on a past review of the Physical Assessment Competency Guidelines for Evaluation Criteria (draft), the curriculum and training being provided was thorough and reflective of appropriate competency-based training for nursing assessment skills. From discussions with the APRN consulting with State Office on this project, once all RNs at the SSLCs had completed the training, LVNs also would be provided competency-based training regarding assessments in alignment with their licensure. This competency-based training is essential to the forward movement towards compliance with the Settlement Agreement provisions related to nursing clinical issues. The competency-based training program that the State Office had initiated was a very promising step forward for nursing. Since the competency-based training described had only been initiated recently at AUSSLC in April 2011, with a limited group of RNs, and without any competency-based training regarding the documentation of a clinical analysis as would be found in the	Noncompliance

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		Comprehensive Nursing Assessments, there was no appreciable difference in the quality of the documentation in the Nursing Assessments since the last review. The Quarterly Nursing Assessments of 23 individuals who were identified by the Facility as being at risk for specific health indicators were reviewed including those for: Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, and Individual #6 for aspiration; Individual #340, Individual #404, and Individual #19 for cardiac issues; Individual #421, Individual #360, and Individual #74 for challenging behavior; Individual #214, Individual #390, and Individual #84 for dental; Individual #111, Individual #398, and Individual #118 for falls; Individual #90, and Individual #274 for fluid imbalance; Individual #396, Individual #302, and Individual #424 for weight issues. ▪ Of the 23 individuals' nursing quarterlies reviewed, 17 (74%) were timely completed. Assessments that were not timely completed included: Individual #426, Individual #452, Individual #65, Individual #214, Individual #84, and Individual #424. ▪ Consistent with the findings from the previous reviews, the quality of all was poor, and none of the 23 assessments (0%) were adequate, specifically regarding the nursing summary section. ▪ Overall, none (0%) of the Nursing Summaries contained in the assessments included an adequate analysis of the health/mental health data between the previous and current quarters. As noted above, there were basically no differences seen in the quality of the nursing summary sections in all assessments reviewed. There were a number of different formats that were used to write the nursing summaries, such as pasting the Nursing Health Management Plan objectives in the Summary Section with an associated analysis of the health issues included. In addition, a number of nurses were essentially just logging in sequential dates of events, such as hospital or Infirmary admissions or the dates an individual received a PRN medication for constipation, with no associated analysis of the data indicating if the health issue was getting better or worse. From the variations found in the Summary Sections of the Comprehensive Nursing Assessments reviewed, it was evident that the nursing staff completing these assessments were struggling, when trying to write an analysis of the health/mental health issues. For example: ▪ The Comprehensive Quarterly Nursing Assessment Summary for Individual #118, dated 1/10/11, stated: *Service Objective: [Individual #118] will maintain the best possible health as evidenced by -0- episodes of cardiac concerns.* *Nursing Diagnosis: Potential for infection due to impaired skin integrity. [Individual #118] had 0 episodes of skin alterations during this review period.*	

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		Date: Nursing Progress Note *1/10/2011 No episodes of skin alteration during this review.* This summary made no sense and was not reflective of any type of analysis regarding the individual's health issues related to cardiac issues, skin issues, or infections. A number of the Comprehensive Nursing Assessments reviewed included this type of inadequate documentation in the Summary Section. ▪ The Comprehensive Quarterly Nursing Assessment Summary, dated 3/24/11, for Individual #90 stated the following: *Service Objective: Action Plan #2. [Individual #90] will maintain the best possible health as evidenced by remaining free from infection and skin impairment during the next 12 months.* *Nursing Diagnosis: Risk, for impaired skin integrity, and potential for infection secondary to SIB (self injurious behavior.)* *[Individual #90] had 7 episodes of skin impairment during the review period.* In addition, the summary included a list of 21 dates of incidents of scratches and abrasions, which had occurred from April 2010 through December 2010, with no information updated to the time the assessment was completed in March 2011. Clearly, the individual had experienced a number of skin issues. However, no analysis was completed of the individual's health status as compared to the previous quarter, and/or an analysis indicating if the individual was making progress related to their health/behavior issues. As mentioned in the last report, 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 Comprehensive Nursing Assessments did not provide an adequate format leading to an appropriate clinical nursing analysis. 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. A review of the Community Living Discharge Plans completed by nursing for seven individuals including Individual #170, Individual #401, Individual #446, Individual #125, Individual #285, Individual #192, and Individual #384 found that they varied significantly regarding the amount of information contained in each. However, none (0%) were found to be adequate with regard to nursing's involvement. Further discussion of the CLDPs is found in the section of this report that addresses Section T.	

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		For example, the section of the Community Living Discharge Plan for Individual #401 that addressed current summaries and assessments was blank. Under the section of the Plan that required a medication history, there was only a list of medications, without any indication noting why they were prescribed, how long the individual took the medications, the effectiveness of the mediations, why they were discontinued, and if the individual experienced any side effects while taking them. This information is essential for community physicians/practitioners to have access to in order to safely treat the individual. In addition, under the section of the Plan that required information regarding the date and results of the Dental exam, the nurse only recorded the date of the last dental appointment, without additional information noted regarding the results of the last dental exam, the status of the individual's oral hygiene, and other important issues related to oral care that a community provider would need to know. There was essentially little to no information contained in the Community Living Discharge Plan that would guide the subsequent staff in providing the needed nursing or medical care to the individual. In addition, there was no indication that a current nursing assessment was conducted prior to the Individual transferring to the community. The lack of quality documentation regarding the nursing discharge summaries developed for the Community Living Discharge Plans indicated that the Facility did not have an adequate and consistent procedure regarding the requirements for nursing and nursing documentation. The Facility should review and revise its current nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is adequate to maintain continuity of care in the community. Consistent with the past reviews, there continued to be a significant lack of clinical assessments for critical clinical health indicators, a lack of timely and appropriate follow-up on unresolved issues, a lack of an analysis of health/mental issues, and a lack of critical thinking found in all the nursing assessments reviewed. The State's efforts in implementing the competency-based training program for nursing assessment skills should result in improvements in the documentation of nursing assessments and summaries. The Facility's POI indicated that it was not in compliance with the elements of this requirement, which was consistent with the findings of the Monitoring Team.	
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	Since the last review, the Facility's POI indicated that there had been no action steps or initiatives implemented for this requirement. The Facility continued to use the nursing protocols templates as Health Management Plans. At the time of the review, the Facility had not yet established a plan to address this requirement. Consequently, there had been no measurable difference in the quality of the Health Care Plans from the previous two reviews. The Facility should develop and implement a clinically sound competency-based training curriculum to ensure nurses are appropriately trained, and can	Noncompliance

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	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.	demonstrate the ability to develop clinically adequate nursing care plans. The records of 23 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, and Individual #6 for aspiration; Individual #340, Individual #404, and Individual #19 for cardiac issues; Individual #421, Individual #360, and Individual #74 for challenging behavior; Individual #214, Individual #390, and Individual #84 for dental; Individual #111, Individual #398, and Individual #118 for falls; Individual #90, and Individual #274 for fluid imbalance; Individual #396, Individual #302, and Individual #424 for weight issues. Of the 23 individuals' Health Management Plans (HMPs) reviewed: ▪ Thirteen (56%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a related HMP included: Individual #426, Individual #452, Individual #6, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, and Individual #111. ▪ None (0%) of the nursing interventions contained in the HMPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. ▪ None (0%) of the HMPs were found to be clinically adequate. ▪ None (0%) of the HMPs included proactive interventions addressing the health indicator. ▪ None (0%) of the HMPs were adequately individualized. As noted during previous reviews, the HMPs reviewed continued to lack any individual-specific interventions based on the individuals' needs, and did not provide adequate direction for caring for individuals who were identified as being at high risk related to their health/mental issues. In addition, the nursing interventions contained in the HMPs included no proactive interventions directed at preventing or minimizing the specific health risks. For each health indicator that was designated at high risk for the Individuals listed above, such as aspiration, cardiac issues, challenging behaviors, falls, and weight issues, the Health Management Plans were essentially the identical protocol template for each individual with the same health issue, with only minimal modifications, if any. Consistent with the previous reviews, the interventions contained in the HMPs were clinically inadequate, and did not address any preventative interventions, or interventions that would minimize the individuals' identified health risks. In order for the Facility's HMPs to be appropriate and clinically adequate, the Health Care	

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		Protocols/Nursing Care Plans have to be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the intervention will be reviewed and by whom. In addition, as required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur regardless of the format, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all health management plans. Consideration should be given to the use of an integrated health management plan that would incorporate all clinical disciplines' goals and interventions into one plan. An additional sample of individuals' records was requested for review to determine if individuals with infectious diseases had appropriate care plans to address their needs. Specifically, the Facility data indicated that 13 individuals (Individual #332, Individual #202, Individual #393, Individual #358, Individual #430, Individual #61, Individual #310, Individual #268, Individual #84, Individual #356, Individual #81, Individual #199, and Individual #402) had MRSA, since the last review period. ▪ Of the 13 individuals reviewed, one (8%) had Nursing Care Plans addressing the infectious issue. Those that did not have a related Nursing Care Plan included: Individual #332, Individual #393, Individual #358, Individual #430, Individual #61, Individual #310, Individual #268, Individual #84, Individual #356, Individual #81, Individual #199, Individual #402. ▪ Of the one Nursing Care Plan reviewed addressing infectious diseases, none (0%) were found to be adequate. Some of the deficiencies noted included: o The significant lack of individualization of the Nursing Care Plan template; o The lack of criteria for documentation, including who was to document, how often, where the documentation was to be done, who was to review the documentation, and how often it would be reviewed; o No goal was written; o The lack of interventions addressing teaching and education for staff, as well as the individual regarding prevention of the spread of the infection; o The lack of proactive interventions; and o The lack of documentation demonstrating that interventions were actually being implemented. It is clinically and professionally unacceptable for individuals who have a contagious, infectious disease not to have a Nursing Care Plan implemented. Without having a guide outlining the precautions to take, how to prevent the infection from spreading, and what	

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		education should be provided to the individuals and staff regarding these critical issues, the risk of re-infection, and transmission of the organism to other individuals, family members, and staff significantly increases. As noted in the past two reports, due to the clinical ramifications of not having adequate nursing care plans addressing infectious and communicable diseases, it is imperative that nursing staff develop and implement clinically sound individualized Nursing Care Plans. Consistent with the findings of the previous reviews, there continued to be no system in place that ensured that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. Nursing Administration, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the Nursing Care Plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently.	
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.	AUSSLC 's POI indicated that since the last review, the Facility had begun providing training regarding the State Office policies addressing Documentation Guidelines, and the Management of Acute Illness and Injury. As of 3/29/11, the Facility indicated that 92% of the nurses had received these in-service trainings during Nursing Meetings held in March 2011. In addition, the nurses could receive one hour of Continuing Education Units for the training addressing Nursing Documentation. The Facility also provided staff training in the following areas: ▪ Bowel Management and Bowel Record; ▪ Seizure Management; ▪ At Risk Individuals; ▪ Monitoring of Side Effect Scale (MOSES); ▪ Medication Administration Guidelines; ▪ Hospital Bed Ordering Procedure; and ▪ Hypothermia and Use of External Warming Devices. AUSSLC's POI and training rosters indicated that 100% of staff attended the above training except for the Seizure Management, which 97% of staff attended. Also, the Facility developed and implemented in April 2011 a competency-based training in conjunction with the Respiratory Therapist addressing Tracheostomy Care that included a skills lab and a return demonstration in the clinical setting under the supervision of the Respiratory Therapist. Although this training is extremely valuable, since a number of individuals at the Facility have tracheostomies, the current curriculum should be reviewed to ensure it is in alignment with the competency-based training being provided by the State Office Nurse Practitioner group. Although the Facility provided these important in-service training sessions since the last review, there had been no modifications made to the procedures and protocols contained	Noncompliance

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		in the resource books obtained by the Facility. Such modifications were needed to bring them into alignment with the Facility's structure and systems. These modifications should include the specific responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, the frequency of these assessments, and the parameters and time frames for the reporting of symptoms to the practitioner/physician. From review of the Documentation Guidelines that were sent from the State Office, although valuable and accurate in and of themselves, they did not address the Facility' urgent need for specific protocols that defined criteria for documentation requirements. At the time of the review, the Facility did not have a plan for when these procedures and protocols would be developed/modified, and implemented. Without appropriate nursing protocols in place, AUSSLC had no system guiding the nursing documentation to ensure that appropriate nursing assessments were conducted and documented at the appropriate frequency, and that there was timely communication with practitioners/physicians regarding changes in status. The overwhelmingly consistent negative findings described with regard to Section M.1 related to the nursing assessment and documentation of individuals with acute changes in status reflected the lack of protocols in the Nursing Department. From discussions with the CNE; Connie Horton, APRN, State Office Consultant; and Valerie Kipfer, RN, MSN, State Office Nursing Discipline Coordinator, there seemed to be an initial lack of understanding regarding the elements of this requirement. However, after joint discussions with the State Office Nursing Discipline Coordinator, the State Office Consultant, and the Monitoring Team as well as State Office staff's attendance at an onsite medical record review conducted by the Monitoring Team reviewer of the nursing documentation for an individual, who experienced an change in status that resulted in hospitalization, it appeared that the needed elements for meeting this requirement had become clearer. In light of the consistent findings discussed in detail above with regard to Sections M.1, M.2, and M.3 of the Settlement Agreement, it is crucial that the Facility develops and implements nursing protocols. Consequently, the findings from this review and the previous two reviews indicated that AUSSLC was continuing to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility's POI indicated that it was not in compliance with this requirement, which was in alignment with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of	Since the last review, the State and the SSLCs had developed a policy for At-Risk Individuals. The policy included Risk Guidelines, which contained criteria to serve as a guide to assist the teams in determining appropriate risk levels for designated risk categories. The review of risks and the assignment of the risk levels were to occur during PST meetings. At the time of the review, the Facility reported that all the individuals at	Noncompliance

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	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.	AUSSLC had been reviewed using the new At Risk process. The new At-Risk policy indicated that nursing, in conjunction with the PCP, was responsible for assessing risk factors in the following categories: ▪ Aspiration; ▪ Respiratory Compromise; ▪ Cardiac Disease; ▪ Constipation/Bowel Obstruction; ▪ Diabetes; ▪ Gastrointestinal Problems; ▪ Osteoporosis; ▪ Seizures; ▪ Skin Integrity; ▪ Infections; ▪ Fractures; ▪ Fluid Imbalance; ▪ Hypothermia; ▪ Urinary Tract Infections; and ▪ Circulatory. The Facility's POI indicated that although the At Risk process had been implemented in January 2011, and training regarding the policy was provided on 1/13/11, and 1/26/11, on-going training for nursing was needed, since the Facility had found there were inconsistencies in completing the required documentation in preparation for the PSP meetings. At the time of the review, there had been no plan formalized for when additional training was to be provided. To assess the Facility's risk screening process, members of the Monitoring Team observed three individuals' PSP meetings (Individual #107, Individual #102, and Individual #82) while on site. Overall, the Monitoring Team noted slight improvements, although not consistent, in the clinical discussions, as well as the use of supporting clinical data and the new Risk Guidelines, when the PSTs were discussing and determining the individuals' risk levels. Some of the problematic areas identified by the Monitoring Team included (more specific findings are provided with regard to Section I.1 of the Settlement Agreement): ▪ All appropriate disciplines were not present at the PSPs; ▪ When determining risk levels, the PSTs did not consistently use the Risk Level Guidelines; ▪ When determining risks levels, PSTs did not consistently use supporting clinical data; and ▪ The Risk levels the PSTs designated were not consistently appropriate	

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		Since the Monitoring Team noted only minimal positive improvements in the At-Risk process from the previous reviews, the Facility should conduct additional training with PSTs to ensure that the at-risk process adequately identifies critical issues, and so that appropriate and clinically sound action plans are developed. A review of the Comprehensive Nursing Assessments for 23 Individuals (Individual #426, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #340, Individual #404, Individual #19, Individual #421, Individual #360, Individual #74, Individual #214, Individual #390, Individual #84, Individual #111, Individual #398, Individual #118, Individual #90, Individual #274, Individual #396, Individual #302, and Individual #424) found that none (0%) were adequate assessments, because they did not specifically addressed the high risk health indicators and were not updated regarding health issues related to the high risk health indicators. Specific findings and examples are provided with regard to Section I.1 of the Settlement Agreement. Based on an interview with the State Coordinator for Specialized Services, State Office Nurse Practitioner Consultant, and Nursing Discipline Coordinator, there was no indication that the current Comprehensive Nursing Assessment form had been reviewed to determine if it would appropriately meet the requirements of an adequate assessment tool for addressing risk areas. It also did not appear that the need for the information contained in the Comprehensive Nursing Assessments to be updated in response to the identification of health risks had been identified specifically as a necessary component of the process. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. Establishing an adequate At-Risk system is essential in ensuring that those individuals who warrant the most clinical intensity are appropriately identified and provided adequate care. Several examples have been provided throughout the findings in Sections M.1, M.2, and M.3 of the significant deficits regarding aggressive and timely implementation of clinical interventions for individuals who were at risk due to their health/mental health issues. At the time of the review, AUSSLC's POI indicated that they were not in compliance with this requirement of the Settlement Agreement, which was consistent with the Monitoring Team's findings.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement	Since the last review, the Facility's POI indicated that on 5/1/11, the State policy addressing Medication Administration Guidelines was fully implemented. In addition, on February 16, 17, 24, and 25, 2011, training sessions were held regarding medication transcription. According to the Facility's POI, 23 nurses had not passed the initial	Noncompliance

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	nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	training and were required to repeat the course with one-to-one training. AUSSLC's training rosters indicated that as of 3/29/11, 100% of the nursing staff had attended and passed the training. Also, since the last review, the Facility had initiated a medication observation schedule managed by the Nurse Educator for each building. It clearly tracked if medication observations had been conducted for each nurse each quarter, as well as a form tracking the problems identified during the observations and corrective actions. Although there were few problems identified from the medication administration observations conducted since that last review, this was a promising system for the Facility to track and trend problematic issues regarding medication administration, which should then be reported in the minutes of the Medication Error Committee. From discussions with the CNE, a number of nurses were assigned to conduct the medication observation audits, including RNIIs, RNIIIs, Nurse Educators, and Unit Nurse Managers. At the time of this review, there had been no process validating the competency of each nurse that was assigned the duty of auditing medication administration, or a process implemented to establish inter-rater reliability for medication administration observations. The CNE and Program Compliance Nurse reported that the current process for establishing inter-rater reliability did not consist of having the nurse auditors observe the same nurse at the same time and compare compliance ratings, which would have been the appropriate process to establish inter-rater reliability. Since the Facility was using several different nurses to audit the medication administration observations, an adequate inter-rater reliability process should be conducted. Inter-rater reliability was necessary to ensure that each auditor for this area was competent, and accurately scoring compliance for the medication observations. This was necessary to ensure that the Facility had reliable data to accurately identify areas of strength and weakness regarding medication administration. As mentioned above, these data then should be analyzed for trends, plans of correction implemented to address deficient areas, and reviewed in the Medication Error Committee. A review of the raw data from the Medication Administration Observations audits from January through March 2011, and the Medication Observation reports from each building indicated that very few problematic issues were identified. This did not comport with the Monitoring Team's findings during a medication administration observation while on site. When observing medication administration while on site for individuals in the Infirmary, the following significant issues were identified. These also were found during the previous two reviews, most of which placed the most medically compromised individuals at risk. Specifically, the nurse did not:	

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		▪ Know the correct degree of elevation individuals should be placed in to receive their medications; ▪ Ensure individuals were in the proper positioning prior to and after medication administration; ▪ Utilize the PNMP when administering medications; ▪ Know that an individual had a G-tube due to dysphagia and risk of aspiration; ▪ Use privacy methods consistently, when administering medications; ▪ Listen to lung sounds for individuals coughing before, during, or after receiving medications; ▪ Use gloves consistently when manipulating tubes; ▪ Tell individuals what he was doing and what medications he was administering; and ▪ Complete training on the PNMPs for individuals for whom he was responsible for administering medications. The following provide more specific examples of the concerns noted: ▪ The RN administering medications did not review the positioning photos in the individual's I-Books prior to or after medication administration to ensure the appropriate positioning was maintained. In the case of Individual #62, the I-Book indicated that a chain was attached to her bed to verify how staff should determine the correct degrees of elevation. However, the bed in the Infirmary did not have a chain attached to it to verify the prescribed elevation the PNMT had determined. The Nurse Educator auditing this medication administration did not address this issue while conducting her observations. Consequently, there had been no verification that Individual #62 was in the correct position, during the time she spent in the Infirmary. ▪ While giving Individual #356 his medications, the nurse used a plastic spoon to feed him his medications that were mixed with pudding. The PNMP for this Individual clearly stated that he was not to be administered his medications with a plastic spoon to prevent him from biting the spoon, and choking on it. When this was pointed out to the RN administering the medication and the Nurse Educator auditing this medication administration, both stated that they had not seen any problems using a plastic spoon for medications indicating that, this prohibited method had been done previously. This placed this individual at risk of harm. When individuals were transferred to the Infirmary, no competency-based training on individual-specific PMNP interventions had been provided to the Infirmary staff; nurses auditing medication observations did not appropriately audit compliance regarding positioning and interventions for medication administration on the PNMPs; and, that	

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		there continued to be a significant lack of understanding within the Nursing Department of the purpose and non-negotiable nature of the implementation of the PNMP. Although the Facility had implemented having the diet textures and positioning information added to the MARs, and the medication administration and oral care information added to the PNMPs, the importance of consistently reviewing and implementing this information had not impacted nursing's provision of care to the individuals at AUSSLC. The Facility should develop and implement a system to ensure that prior to any nurse providing care to individuals transferred to the Infirmary, nurses are provided competency-based training regarding the PNMPs and the use of the I-Books. In addition, training should be provided to nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and medication administration, including following the instructions in the PNMPs and I-Books. A review of the Facility's Medication Error Report noted the following medication variances per month: ▪ October 2010 – no data found; ▪ November 2010 – no data found; ▪ December 2010 – no data found; ▪ January 2011 – 143; ▪ February 2011 – 50; and ▪ March 2011 – 286. As noted above, for October, November, and December 2010, medication variance data were not included in the documentation the Facility provided without explanation. In addition, there was a discrepancy in the number of variances listed in the Medication Error Committee minutes dated 2/17/11, and 3/22/11 regarding the January variance numbers. More specifically, 135 were noted in the February minutes, and 143 were noted in the March minutes. Although this discrepancy was found, the February and March 2011 Medication Error Committee meeting minutes included a good initial analysis of the January and February 2011 variances with documentation of the associated plans of correction. The minutes indicated the following: ▪ Of the 135 errors for January 2011, 73% were omissions. ▪ A total of 21% of the documentation errors were from missing initials on the MARs. ▪ Timbercreek had the most medication errors (87), mainly from omissions and one improper dose/quantity. ▪ Campus-wide, 91% of variances were made by agency staff and 8% by Facility staff.	

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		▪ One nurse who had 19 documented variances for January 2011 generated the majority of the agency nurse errors. The associated plans of correction included in the minutes indicated that the Facility implemented some positive actions, including that a mandatory nurses meeting was held in February 2011 for training regarding the MARs and noting physician orders (as was mentioned at the beginning of this section); the Nurse Educators were designated as responsible for tracking and ensuring that medication observations for Facility and agency nurses were conducted; Nursing Administration was establishing minimum staffing requirements to maintain appropriate nurse-to-resident ratios; a Facility plan was in place to decrease the use of agency nurses; and the specific agency nurse responsible for a number of the errors no long worked at the Facility and was placed on a "do not return" status. Interestingly, the breakdown of the medication variances for February 2011 (50) indicated that Facility nurses generated 42% (21), and agency nurses generated 28% (14). However, no discussion of change in trend was found in the minutes. Since the baseline review, the Facility's medication variance data indicated that the Facility had a significant problem with the under-reporting of medication variances. Based on discussions with the CNE and notes from AUSSLC's Medication Error Committee meeting minutes for February, the Facility also recognized this issue. In addition, the committee indicated that there were problematic issues found on the Medication Error forms, such as the name of the nurse involved in the error, inaccuracies identifying the particular category related to severity of the errors, Medication Error forms not being timely turned in, and plans of correction not consistently being generated by Nurse Managers. At the time of the review, the Nurse Operations Officer had been designated to review all Medication Errors reports submitted by the Nurse Managers. This should help ensure the completion and accuracy of the Medication Error forms completed. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the MARs, and documenting these as audits. Although there continued to be serious problematic issues regarding the medication administration and medication variance systems at AUSSLC, since the previous review, the Facility had implemented some very promising systematic processes and infrastructures regarding the medication administration system including: ▪ Redefining the purpose of the Medication Error Committee; ▪ Restructuring the minutes of the Medication Error Committee to include Analysis/Discussion of Issues, Plans of Correction or Follow-up, Staff member responsible, Projected Dates of Completion, Desired Outcome, and Plan for	

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		Further Monitoring; ▪ The inclusion of a Nurse Educator, a clinician prescriber, and the rotation of nurses who administer medication on the Medication Error Committee; ▪ Increased collaboration between the Pharmacy, Nursing, and Habilitation Therapies; ▪ The implementation of Medication Room inspections conducted monthly by Nursing and also by Pharmacy; ▪ The implementation of Medication Error Trend reports by nurse, home, agency/facility staff, severity index, contributing factors, and type of error. Of special note, the Facility's new Medication Error Trend reports included the raw data, graphs, and pie charts for medication errors by nurse, home, agency/facility staff, severity index, contributing factors, and type of error. These were especially impressive in that trends for a specific month, as well as trends over the course of several months were easily identified. As the Facility progresses in assessing the issues in the overall medication system, the Medication Error Trend reports should provide an exceptional infrastructure to assist the Facility in aggregating important data to adequately analyze issues related to medication variances, and drilling down to the causative factors of variances. In addition, these data also should provide the impetus to implement proactive strategies addressing potential medication variances. At the time of the review, the Facility was in the beginning process of building and restructuring the medication variance systems. Implementing a solid process that lends to a critical review of the overall medication system should result in the identification of system breakdowns. This will provide the opportunity for the development and implementation of policies and procedures to ensure the reliability of the Facility's entire medication system and safe medication practices. The minutes of the Medication Error Committee meetings and the Medication Error Trend reports provided a limited initial analysis of the medication variance data. Building on this, the Facility should continue to expand its analysis of the data. Once additional reliable data is collected with regard to the Facility's medication system, the medication variance data should be thoroughly analyzed to identify trends and plans of correction generated, as needed. As previously noted in the past two reports, as required by Section N.8 of the Settlement Agreement, the Facility should expand its medication error system into a medication variance system that would significantly extend the scope of the review of the medication system. AUSSLC's current medication error system was limited to the reporting and the reviewing of errors addressing the wrong patient, wrong time, wrong dose, wrong route,	

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		wrong drug, wrong technique, and omitted medications. A medication variance system expands the review to include not only these issues, but also issues related to the entire medication system such as pharmacy issues, physician/practitioner's issues, as well as proactively reviewing areas of potential variances. Although the Facility had made progress since the last review, consistent with the findings of the past two reviews, the Facility indicated that it was not in compliance with the elements of this requirement, which comported with the Monitoring Teams findings.	

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

1. Adequate and consistent nursing staff should be secured to facilitate positive clinical outcomes for the individuals at AUSSLC. (Section M.1)
2. The State should clarify the procedure addressing Agency/Contract Nurses to ensure that the specific criteria for orientation are outlined, and the expected skill competencies are in alignment with the current competencies being required at the Facility. (Section M.1)
3. The Facility should consider placing the Respiratory Therapists under the supervision of the Medical Department, rather than the Nursing Department. (Section M.1)
4. The Facility should develop a procedure for establishing inter-rater reliability to ensure that all disciplines are executing the process appropriately and consistently. (Section M.1)
5. Nursing should consider decreasing the number of nurses assigned auditing duties, until an inter-rater reliability process is developed, and potential nurse auditors are verified as competent in the areas they are assigned to audit. (Section M.1)
6. The Facility should develop a unified system to present the data generated from the Health Monitoring Tools, so that the data can be easily analyzed and trends identified. Any format the Facility implements should include information such as the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample to indicate the relevance of the compliance scores. In addition, compliance scores should be presented for each item on the monitoring tool to reflect the compliance with the specific elements of the area being audited. (Section M.1)
7. The Facility should prioritize the implementation of Nursing Health Monitoring Tools based on problematic areas, such as Urgent Care/ER Visits and Hospitalizations, rather than trying to implement a number of the Health Monitoring Tools in an attempt to show progress by generating data. (Section M.1)
8. The Facility should develop and implement a tracking system to 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 decisions regarding treatments and health care services. (Section M.1)
9. 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 unit reporting falls in the data collection system. (Section M.1)
10. The Facility should continue its efforts in developing and implementing a database system for IC that allows for reliable tracking and monitoring of the Facility's IC data. (Section M.1)
11. The Facility should continue to develop and implement strategies to ensure that all individuals at AUSSLC are current regarding their immunization status, in accordance with the requirements of the Settlement Agreement. In addition, a schedule addressing these issues should be developed to ensure individuals are appropriately prioritized and that no one is overlooked. (Section M.1)
12. The Facility should consider formalizing the hand washing spot check system to ensure that regular spot checks are conducted in different

areas to generate valuable data regarding the hand-washing practices of the staff. (Section M.1)

13. Additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. (Section M.1)
14. The Facility should ensure that the clinical staff participates in the Emergency Medical Drills. (Section M.1)
15. The Facility should implement a process of a committee review of emergency procedures, Medical Emergency Drill findings, and actual medical emergencies to ensure that the Facility has adequate emergency procedures in place. (Section M.1)
16. The Facility should expand its emergency drills to include a variety of scenarios in addition to CPR, so that the emergency drills are more reflective of emergencies that warrant staff action. (Section M.1)
17. The Facility should purchase additional AEDs to ensure that the equipment is readily available throughout the Facility. (Section M.1)
18. The Facility should implement a system in which nurses are observed checking the emergency equipment at least quarterly to ensure they are familiar with the use of the equipment. In addition, all emergency equipment, including back-up equipment should have documentation that it is being checked regularly, and it is in good working condition. (Section M.1)
19. 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. (Section M.2)
20. The Facility should review and revise its current nursing discharge procedures and documentation requirements to ensure that documentation addressing discharges is adequate to maintain continuity of care in the community. (Section M.2)
21. The Facility should develop and implement a clinically sound competency-based training curriculum to ensure nurses are appropriately trained, and can demonstrate the ability to develop clinically adequate nursing care plans. (Section M.3)
22. As required by Sections 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. (Section M.3)
23. Nursing Administration, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the Nursing Care Plans addressing infectious and communicable diseases are clinically adequate, individualized, and are consistently being implemented. (Section M.3)
24. The Facility's newly developed curriculum addressing Tracheostomy Care should be reviewed to ensure it is in alignment with the competency-based training being provided by the State Office Nurse Practitioner group. (Section M.4)
25. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. (Section M.5)
26. Problematic trends that are identified from the medication administration observations should be reported in the minutes of the Medication Error Committee. (Section M.6)
27. The Facility should develop and implement a system to ensure that prior to any nurse providing care to individuals transferred to the Infirmary, nurses are provided competency-based training regarding the PNMPs and the use of the I-Books. (Section M.6)
28. Training should be provided to nurses designated as auditors for medication administration observations regarding how to appropriately assess compliance related to positioning and medication administration, including following the instructions in the PNMPs and I-Books. (Section M.6)
29. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the MARs, and documenting these as audits. (Section M.6)
30. To be consistent with Section N.8 of the SA, a medication variance system should be developed and implemented that would expand the scope of the review of the Facility's medication systems. (Section M.6)

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

1. The Facility should include the date staff completed the CPR refresher class in the Medical Emergency Drill tracking data to ensure that staff completed the needed emergency skills training. (Section M.1)
2. The Facility also should consider adding First Aid training to the New Employee Orientation and CPR classes. (Section M.1)

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 For the past year, number of medication errors/variances per month; o Medication Errors by Nurse: Discovered January 2011; o Medication Errors by Nurse: Discovered February 2011; o Unit data for Woodhollow, Cardinal, Castner, Sunrise, Timbercreek: 2011 Medication Error Trend Report, variances by residence, variances by agency versus staff, variances by specific nurse, variances by severity index, and variances by contributing factors; o AUSSLC Corrective Action Plan (CAP) for Nursing, problems identified on 1/28/11, and 3/14/11; o Communication between Pharmacy and Nursing Departments concerning medication errors/variances; o Medication Error Committee Meeting Notes, dated 2/17/11, and 3/22/11; o Medication Observation Schedule for 2011 (Cardinal, Sunrise, Infirmary, Castner, Timber Creek, Wood Hollow); o For past two months [February, March], reports and/or summaries of any medication administration observations; o Copies of the last 10 medication error forms completed with plans of action; o Curricula used to train staff, including training materials: February nurses meeting agenda, Alendronate Tablet Crushing/Suspending, Phenytoin suspension dose cup, pharmacy update March 2011 (new information in MARs notes section), Keppra oral solution packaging, ordering bulk medication refills, residents transferred to the Infirmary or local hospitals, returning medication to the pharmacy, pink slip, and yellow slip; o Documentation for each emergency chemical restraint, since last monitoring visit; o Summary list of all chemical restraints last six months: STAT orders from 10/1/10-328/11; Drug Order Report by individual from 10/1/10 – 3/28/11; o Trend Analysis of chemical restraint use: Restraint Reduction Committee (RRC) Meeting notes, dated 2/15/11; Restraint Review Meeting notes, dated 3/14/11, and 3/28/11, and Restraint Monitors Meeting notes, dated 2/17/11; o Handwritten tracking sheets [restraints], from October 2010 to March 2011; o SSLC Procedure: medication errors/incidents for November 2009; o Austin SSLC Health Services Operational and Policy Manual: Medication Error Policy Addendum, dated 1/10; o Austin SSLC Health Services Operational and Policy Manual: Medication Error Committee, dated 6/2008, reviewed and updated 2/11; o SSLC Procedure: Medication Administration Guidelines, dated 2/11; o Procedure for Returning Medication to the Pharmacy, dated 4/1/11; o Austin SSLC Policy: Pharmacy Communication of Suspected or Actual Medication Discrepancies, dated 2/25/11;

	○ Quarterly Drug Regimen Reviews (40 most recent) for the following individuals with dates of QDRR: Individual #92, dated 2/10/11; Individual #84, dated 3/9/11; Individual #224, dated 3/9/11; Individual #3, dated 2/17/11; Individual #81, dated 11/9/10; Individual #31, dated 11/9/10; Individual #287, dated 7/15/10; Individual #287, dated 11/9/10; Individual #200, dated 11/9/10; Individual #328, dated 7/14/10; Individual #328, dated 11/9/10; Individual #3, dated 11/9/10; Individual #434, dated 3/3/11; Individual #113, dated 12/1/10; Individual #347, dated 12/1/10; Individual #347, dated 3/9/11; Individual #269, dated 12/1/10; Individual #22, dated 12/1/10; Individual #22, dated 3/10/11; Individual #16, dated 3/7/11; Individual #196, dated 12/1/10; Individual #196, dated 3/10/11; Individual #323, dated 12/1/10; Individual #358, dated 2/21/11; Individual #85, dated 2/21/11; Individual #270, dated 2/21/11; Individual #161, dated 2/21/11; Individual #98, dated 3/7/11; Individual #12, dated 3/8/11; Individual #254, dated 3/8/11, Individual #429, dated 3/7/11; Individual #370, dated 3/8/11; Individual #396, dated 3/1/11; Individual #65, dated 3/1/11; Individual #426, dated 3/1/11; Individual #286, dated 3/1/11; Individual #72, dated 3/1/11; Individual #50, dated 3/1/11;Individual #402, dated 3/1/11; and Individual #182, dated 3/1/11; ○ Single Patient Intervention Reports; ○ Notes Extract associated with single patient intervention reports; ○ For the past six months, any adverse drug reaction (ADR) reports completed; ○ Adverse Drug Reaction Monitoring Policy and Procedure AUSSLC (old, undated policy); ○ AUSSLC Policy and Procedure: Adverse Drug Reaction Reporting, revised 5/4/11, including attachments: "Medication Adverse Reaction Report," "Medication Adverse Drug Reaction Reporting Form," and "ADR Report access process in Avatar software"; ○ AUSSLC Pharmacy and Therapeutics Committee: meeting calendar and drug utilization evaluation (DUE) schedule for 2011; ○ AUSSLC DUE Program: Divalproex Sodium/valproic acid, dated October 2010, including Data collection worksheet, Data Collection Guidelines, Report: Basis of choice, Sample, and Results; ○ AUSSLC DUE Program: Clozapine, dated February 2011, including Report: Basis of choice, Sample, and Data Collection worksheet; ○ Pharmacy and Therapeutics Committee meeting agenda for 5/12/11, including handouts; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 9/28/10; and ○ Quarterly Drug Regimen Review schedule. ▪ **Interviews with**: ○ Kenda Pittman, Pharm D, Pharmacy Director; and ○ Zach Corbell, Pharm D.
	Facility Self-Assessment: The Facility determined it was not in compliance with any of the subsections of Section N. However, according to the Facility's POI, it had made considerable strides in several areas. For example, the POI indicated that: ▪ By 9/1/10, the communication with the PCP concerning new orders needing review for significant interactions, side effects, allergies, need for labs, and dosage adjustments had begun to be

	documented in the intervention field of the WORx system. ▪ As of 10/15/10, additional clinical notes were recorded as part of this communication with PCPs. ▪ Starting on 1/10/11, the pharmacy began to review medication dosage forms for compatibility with the diet texture ordered. This review was completed by 3/31/11, and 108 individuals had medication dosage forms changed as a result of this program. ▪ Review of lab data concerning new orders was begun on 3/21/11. ▪ A process had been started on 9/15/10 to identify all "stat" chemical restraints, and by 12/1/10, a monthly report of these orders was forwarded to the Director of Behavioral Services to ensure all chemical restraints were properly identified and appropriate follow up forms were generated. ▪ The Adverse Drug Reaction protocol was still in draft stage. ▪ Medication errors remained a significant concern, and the pharmacy was assisting in determining the cause of medication errors, by such mechanisms as medication room inspections, and participation in nurse education meetings. All these steps were essential to move the Facility toward compliance of Section N. Although important narrative information was provided in the POI, it was not supplemented with data to substantiate compliance or noncompliance findings. As the Facility expands its self-assessment process, it will be essential that data from record reviews, as well as other sources of data, such as databases, is included as part of the POI.
	Summary of Monitor's Assessment: The Pharmacy Department had both advances and setbacks in progress toward compliance. The combining of information from the WORx system and AVATAR continued to improve screening of new orders. However, there was a continuing lack of documentation concerning communication with the PCPs. The completion of QDRRs was not possible after March 2011, although the process had been developed. This was due to staffing issues, and it was unclear when the process would resume. There remained difficulty in the identification and tracking of "stat" medication orders used as chemical restraints, with lack of pharmacy review and guidance. The pharmacy completed an ambitious project to ensure that all medications dispensed were compatible with the texture and thickened liquids prescribed for individuals. This required collaboration with many departments, and appeared to be highly effective with excellent positive impact. The adverse drug reaction reporting system had not been finalized, but there was a draft presented at the latest Pharmacy and Therapeutics Committee meeting, which appeared to be a final draft document. Medication errors remained problematic, but the Pharmacy Department had been aggressive in providing medication room sweeps, in-service training to nurses, and implementing other action steps, which should have a positive impact in reducing medication errors as the system moves forward.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The pharmacy used the WORx software to review any new medication orders, significant drug interactions with the individual's current medication regimen, side effects, allergies, need for labs, and potential dose adjustments. The addition of lab review and potential need for lab orders were part of the Avatar system, and began to be introduced to the pharmacy review of new orders as of 3/21/11. As part of the review, on 1/10/11, the pharmacy began to collaborate with Habilitation Therapies to address compatibilities between diet textures and liquid consistencies with medication forms administered (i.e., liquid, tablets, crushable pills, etc.). This process was introduced on 3/1/11, and at the time of each new medication order, or refill, a determination was made as to whether the proper dosage form was being utilized for each individual based on diet texture needs. The Pharmacy Department initiated changes of medications that should not be altered by crushing when being given to the individual. The diet order began to be included on the MAR. At the time of the Monitoring Team's visit, 108 medication orders had been changed based on this information. Communication with prescribers was documented in the WORx system through the "single patient intervention reports," and "notes extracts." In reviewing the submitted sample, several observations were made, including the following: ▪ Some of the patient intervention entries provided no information as to what was shared with the PCP. ▪ Few intervention entries documented the communication and the PCP response. ▪ Some of the entries did not identify the medication that prompted the intervention. ▪ Additionally, the notes extracts did not appear to relate to the single patient intervention reports, but the notes might not have been intended to provide details of the intervention reports. It was unclear when the notes extracts were to be completed (i.e., what was the indication for completing a notes extract versus a patient intervention entry). ▪ Many of the patient intervention reports reviewed the changes in orders based on diet textures. The patient intervention reports have the potential to provide evidence of immediate communication between the pharmacy and the PCP, and should include sufficient pertinent information (i.e., drug with dosage, concern, PCP response, and change in order) to reflect the concern of the pharmacist and the prompt resolution of the issue. However, the current documentation did not consistently provide these important parameters to make a determination of the adequacy and timeliness of pharmacy	Noncompliance

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		communication with the prescribing PCP. Additionally, the pharmacy should consider a policy or protocol that outlines when the "notes extract" section should be utilized versus documenting in the single patient intervention report. The pharmacy also should review the policy to ensure it provides guidance as to the severity of risk that would require/indicate the need for communication with the prescriber to ensure compliance with the parameters listed in this section of the Settlement Agreement (e.g., drug interaction, side effect profile, need for lab, dosage adjustment, etc.).	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	The 40 most recent Quarterly Drug Regimen Reviews (QDRRs) were submitted. The dates of completion ranged from 7/14/10 to 3/10/11. Due to staffing issues, there had been no QDRRs completed since 3/10/11, according to the submitted documents. From discussion with the Pharmacy Director, it was not clear when systematic completion of QDRRs would resume. For the 40 QDRRs that were submitted, laboratory information was reviewed. All had documented lab results listed. However, important lab results were missing from two QDRRs. For Individual #269, the QDRR of 12/1/10 did not list thyroid lab results that would be expected, as he was taking Levothyroxine. Similarly, for Individual #22, the QDRR of 12/1/10 did not list thyroid lab results that would be expected, as he was taking Levothyroxine. Based on these 40 submitted QDRRs, lab result documentation met compliance in 38 out of 40 QDRRs (95%). However, as mentioned, there were no QDRRs submitted after 3/10/11, which was two months prior to the Monitoring Team's onsite review. For the 40 QDRRs submitted, there was evidence that some of the QDRRs were not done in a timely manner (i.e., they exceeded the 90-day time period). These included Individual #3 with QDRRs dated 11/9/10 and 2/17/11, Individual #287 with QDRRs dated 7/15/10 and 11/19/10, Individual #328 with QDRRs dated 7/14/10 and 11/9/10, Individual #347 with QDRRs dated 12/1/10 and 3/9/11, Individual #22 with QDRRs dated 12/1/10 and 3/10/11, and Individual #196 with QDRRs dated 12/1/10 and 3/10/11. The Pharmacy Department should create a system to ensure QDRRs are completed in a timely manner, within the cycle of 90 days.	Noncompliance
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	On 9/15/10, the pharmacy included "STAT" as a frequency in the orders, to define those medications used on an emergency basis and used as chemical restraints. This occurred presumably to determine a valid list of chemical restraints used across campus, and a monthly report of these chemical restraints began to be forwarded to the Director of Behavioral Services for comparison of information collected through that Department. However, from the data submitted, a number of irregularities were noted. STAT orders from 10/1/10 through 3/28/11 were submitted. This list totaled 41 STAT orders.	Noncompliance

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	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.	However, for six of these, no indication was listed, and for one of these, emesis was listed as a reason, suggesting a medical reason for the use of the STAT order rather than a psychiatric diagnosis or symptom. Other entries for indications were also unhelpful, such as "promote healing" or "stat." Five individuals had more than one medication given STAT during an event, representing 12 STAT orders. A separate drug order report was provided per individual for the STAT orders. Each was listed in the STAT orders list, but the dates were not synchronous for 27 out of 41 (66%). For most of these, the dates were different by one day. For those individuals receiving chemical restraints serially daily for a time period, this made it confusing as to which restraint was being described. For one chemical restraint (Individual #425), the STAT order list indicated 1/6/11, and the Drug Order Report indicated 12/30/10. However, this appeared to be for the same event. This discrepancy in dates needed review to determine the reason for the inconsistency in data. Separately, documentation for each emergency chemical restraint for the prior six months was submitted. A total of 26 completed chemical restraint forms (restraint checklist forms) were submitted. Three of these were not within the time period of the STAT orders list (10/1/10 through 3/28/11). Only 12 of the chemical restraint orders on this STAT orders list (10/1/10 through 3/28/11) were included in these 26 completed chemical restraint forms. However, 29 of the 41 (71%) did not have a chemical restraint form submitted. Additionally, of those falling within the timeframe of the STAT orders list, 13 with chemical restraint forms completed were not represented in the STAT orders list (13 out of 23, or 57%). This suggested considerable disagreement between the two lists and need for further review. Of the 26 chemical restraint forms submitted, the Pharmacist had completed only seven the "Chemical Restraint Clinical Review" sections. This resulted in a compliance rate of seven out of 26 (27%). Additionally, one individual (Individual #425 on 10/9/10) received a chemical restraint (intramuscular Zyprexa) that might have been intended for another individual. The appropriate departments need to review this event to create a systems approach to ensure this does not occur again. Three different meetings/committees reviewed the use of restraints. The Restraint Reduction Committee (RRC) met on 2/15/11. Data was reviewed by quarterly and annual intervals. The committee noted an increase in physical restraints during the beginning of the fiscal year, but it had declined since December 2010. Obstacles were noted in attempting to reduce restraint use. These included certain challenging individuals, resident moves from residence to residence, and also as the total number of staff that were out increased (due to allegations, on the job injury, personal injury), so did the number of restraints. This was to be tracked for further review. Also identified was the need to provide in-service training for restraint documentation. A separate	

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		committee was formed to review restraints with the staff involved in that restraint. Attached to the Restraint Reduction Committee minutes were graphs of restraint use by residence over several quarters, as well as copies of the raw data for restraint use from October 2010 through March 2011. The chemical restraints listed appeared to match the STAT orders list mentioned previously. As mentioned in the minutes of the Restraint Reduction Committee (RRC), a Restraint Review Committee meeting was held on 3/14/11 and 3/28/11. High priority individuals were reviewed, focusing on approximately one to two individuals at each meeting. In the minutes, there was summary of the discussion, with findings and follow-up action steps to be completed with assignment to committee members. A third committee also met to review aspects of restraint use. A Restraint Monitors Meeting was held on 2/17/11. The majority of the meeting focused on formal training on the face-to-face debriefing form in documenting restraints, as well as the mechanism to ensure timely completion of all sections of this multidisciplinary form. This committee appeared to meet on an as-needed basis. The pharmacy monitored the use of benzodiazepines through the QDRR process. Of the 40 submitted QDRRs, 19 individuals were prescribed benzodiazepines. Diagnoses were listed that justified the use of the benzodiazepine in all cases. Monitoring of anticholinergics was also accomplished through the QDRR process. Of the 40 submitted, 25 QDRRs indicated there was an anticholinergic drug load effect (along with the risk of effect – mild, moderate, etc.), and documented the medications contributing to the anticholinergic effect, along with a list of side effects. This was documented in all cases. Polypharmacy was documented in 23 QDRRs, and included both psychotropic and non-psychotropic medication. However, there were some irregularities in documentation. For example: ▪ For Individual #161, although there was the assessment that there was no polypharmacy, there was also the statement that the individual was receiving psychotropic medication. However, the current medication list did not include psychotropic medications, suggesting a gap of information, which would make polypharmacy difficult to determine. ▪ Similarly, Individual #286 was noted to be taking psychotropic medication, but none was listed. Clinical justification of medications was determined by providing the diagnosis for each medication prescribed, but the lack of inclusion of psychotropic medication on the lists did not allow for the clinical justification of these medications to be listed.	

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		Pharmacy also monitored the metabolic and endocrine risks associated with the use of new generation antipsychotic medications through the QDRR process. Of the 40 submitted QDRRs, seven individuals were prescribed atypical antipsychotic medications. Additionally, there were at least two QDDRs with incomplete listings of psychotropic medications (Individual #161 and Individual #286). For those with atypical antipsychotics listed, metabolic risk was assessed with documentation of glucose levels and lipid panels routinely, and Hgb A1C levels were included on some QDRRs in addition to glucose levels. When atypical antipsychotic medications were listed, metabolic and endocrine risks were reviewed in all cases by pertinent lab findings. However, as mentioned with regard to Section N.2, no QDRRs were submitted after 3/10/11 (the submission dated was 4/15/11), indicating pharmacy staffing issues had an impact on timely completion of these documents.	
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.	For the 40 submitted QDRRs, there was agreement from the PCP or psychiatrist in the majority of documents. There was disagreement in seven cases, and agreement/ disagreement was not checked off in one case (Individual #98's QDRR, dated 3/7/11). However, the QDRR also had sections for the PCPs and psychiatrists' responses to the clinical pharmacist's recommendations. In each case, there was justification provided, and at times action steps recorded when there was agreement. For QDRRs in which there was more than one recommendation, each recommendation was followed by a response from the PCP for agreement/disagreement, which allowed for documentation of agreement with some recommendations and disagreement with other recommendations. In reviewing the 40 submitted QDRRs, the main concern was the lapse of time between the date of the QDRR, and the date of the PCP or psychiatrist's review. There were eight QDRRs in which the review by the PCP or psychiatrist was completed approximately one month later (Individual #92 on 2/10/11; Individual #3 on 2/17/11; Individual #358 on 2/21/11; Individual #85 on 2/21/11; Individual #286 on 3/1/11; Individual #72 on 3/1/11; Individual #50 on 3/1/11; Individual #402 on 3/1/11, and Individual #182 on 3/1/11). Additionally, 15 QDRRs had PCP signatures without dates. Timely review of the QDRRs is important, as many of the recommendations could be implemented immediately, and many recommendations were important for monitoring and risk reduction. The Medical Director should ensure timely reviews of QDRRs. Timely review with completion of signatures with dates could be incorporated into the medical morning meetings, given that the PCPs and staff psychiatrists attend these meetings.	Noncompliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure	As required by Section J.12, provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of	Noncompliance

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	quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. This review also analyzed the latency between the time that the exam was completed by the nurse and subsequently reviewed by the prescribing physician. The findings from Section J.12 are repeated here. The review of the sample of the records of 34 individuals who were prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months), had been performed at least every six months, and had been reviewed by the prescribing physician within two weeks of completion was present for the following 11 (32%) individuals: Individual #80, Individual #175, Individual #270, Individual #338, Individual #126, Individual #289, Individual #238, Individual #424, Individual #77, Individual #109, and Individual #82. The records of the following individuals contained documentation that the MOSES evaluation had been completed as specified, but there was a delay of greater than two weeks between the completion of the evaluation by the nurse, and the review by the prescribing physician. This information only pertains to those instances for which there were delays in the review by the prescribing physician. The actual MOSES evaluations for these individuals were completed as specified in the Settlement Agreement.	

INDIVIDUAL NUMBER	DATE MOSES WAS COMPLETED	DATE OF SIGNATURE SIGNIFYING REVIEW BY PRESCRIBING PHYSICIAN
Individual #421	8/12/10	9/15/10
	2/4/11	2/25/11
Individual #406	7/1/10	8/12/10
Individual #16	9/3/10	9/29/10
	12/2/10	1/3/11
Individual #341	8/16/10	9/13/10
	11/5/10	12/7/10
Individual #139	8/12/10	9/22/10
	11/12/10	12/20/10
Individual #74	8/5/10	9/13/10
Individual #83	12/9/10	1/13/11
Individual #360	8/2/10	9/2/10
	11/12/10	12/2/10
Individual #19	7/15/10	8/12/10
Individual #350	7/8/10	8/12/10

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	12/13/10	1/13/11
Individual #8	8/17/10	9/13/10
	11/5/10	12/7/10
Individual #355	8/2/10	9/24/10
Individual #210	7/1/10	8/12/10
Individual #320	8/10/10	9/13/10
	11/2/10	12/2/10
Individual #369	12/3/10	1/13/11
Individual #283	11/4/10	12/2/10
Individual #108	12/3/10	1/13/11
Individual #291	10/1/10	11/4/10
Individual #271	3/5/10	4/1/10

The individual records that did not contain documentation of completed MOSES evaluations that adhered to the time schedule specified in the Settlement Agreement were as follows:

INDIVIDUAL NUMBER	MISSING DOCUMENTATION
Individual #208	No 2nd page with signature for 6/29/10; only MOSES in record was dated 6/29/10
Individual #301	No 2nd page with signatures for all MOSES in file
Individual #152	No signature page for 5/16/10 MOSES; no signature documenting review by prescribing physician for 5/16/10
Individual #158	Gap from 2/9/10 to 11/8/10 (nine months)

The purpose of the DISCUS is to detect emergent motor side effects related to the use of antipsychotic medication. The review of records of the sample of 33 individuals (Individual #80 was not receiving antipsychotic agents and no DISCUS was necessary) identified documentation that the DISCUS was current, had been performed quarterly for the past year, and had been reviewed by the prescribing physician within two weeks of completion of the evaluation by the nurse, in the records of eight of the 33 records (24%). This included the following individuals: Individual #109, Individual #175, Individual #208, Individual #301, Individual #126, Individual #77, Individual #289, and

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		Individual #152. Those individuals whose records contained documentation of a current DISCUS (within the last three months), as well as quarterly over the past year, but for whom there was a delay of greater than two weeks between the date the evaluation was completed by the nurse and signed by the prescribing physician were as follows:	

INDIVIDUAL NUMBER	DATE DISCUS COMPLETED BY NURSE	DATE DISCUS REVIEWED AND SIGNED BY PRESCRIBING PHYSICIAN
Individual #210	7/1/10	8/12/10
Individual #355	8/2/10	9/2/10
Individual #8	8/17/10	9/13/10
	11/5/10	12/7/10
Individual #320	8/10/10	9/13/10
	11/12/10	12/2/10
Individual #421	6/1/10	7/1/10
	8/12/10	9/13/10
Individual #406	7/1/10	8/12/10
Individual #16	9/3/10	9/29/10
	12/3/10	1/3/11
Individual #270	5/31/10	6/29/10
Individual #338	12/21/10	1/25/11
Individual #139	6/16/10	7/1/10
	8/12/10	9/20/10
	11/12/10	12/22/10
Individual #74	8/5/10	9/13/10
Individual #83	12/9/10	1/13/11
Individual #108	12/3/10	No prescriber Signature or date
Individual #283	11/4/10	12/2/10
Individual #369	12/3/10	1/13/11
Individual #19	7/15/10	9/12/10
Individual #360	8/2/10	9/2/10
Individual #350	7/8/10	8/12/10
	12/13/10	1/13/11
Individual #341	8/16/10	9/10/10
	11/5/10	12/7/10

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		The records of the following individuals did not contain documentation that the DISCUS had been completed quarterly, as specified in the Settlement Agreement: **INDIVIDUAL NUMBER** / **MISSING DOCUMENATION OF QUARTERY COMPLETION** Individual #291 — Most recent DISCUS 1/25/11 Individual #158 — Most recent DISCUS 11/8/10 Individual #424 — Gap of four months between 11/10/10 and 3/24/11 Individual #82 — Most recent DISCUS 12/29/10 Individual #271 — Gap of six months between 6/18/10 and 12/9/10 Individual #238 — Most recent DISCUS 1/21/11 The numbers and specific information 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 being 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. The DISCUS and MOSES are also necessary to monitor for the side effects of Reglan, which although prescribed for GERD, has pharmacological properties that are similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS and MOSES for those individuals who were receiving psychotropic medication. Thus, a Psychiatric Nurse would monitor an individual for side effects who was receiving, Reglan as well as a psychotropic medication. A Nurse from their Residential Unit performed the monitoring for those individuals who were receiving Reglan, but were not also receiving psychotropic medication. Accordingly, a list was obtained from the Pharmacy of all individuals who were receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to create a list of individuals who were receiving Reglan, but who were not also prescribed psychotropic medication. The following random sample of five individuals (50 percent) of those who fit the above criteria was selected, including: Individual #454, Individual #426, Individual #452, Individual #65, and Individual #62. The review of the records of these individuals for documentation related to the MOSES is presented below:	

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INDIVIDUAL NUMBER	DOCUMENTATION OF MOSES IN RECORD
Individual #454	None present
Individual #426	Current MOSES, dated 5/4/11, but no prescriber review signature or date; additional MOSES in record not signed by Nurse and not dated
Individual #452	None present
Individual #65	Two identical MOSES in record; neither signed or dated by Nurse who performed the evaluation
Individual #62	Current MOSES, dated 11/5/10, signed by prescribing physician on 11/5/10; prior MOSES dated 5/7/10 signed by prescriber 5/17/10; prior MOSES dated 2/24/10 signed by prescriber 2/24/10

Thus, only one individual (i.e., Individual #62) of these five records (20%) contained documentation of the MOSES being completed as specified in the Settlement Agreement.

The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review are contained in the following Table:

INDIVIDUAL NUMBER	DOCUMENTATION OF DISCUS IN THE RECORD
Individual #452	Current (4/7/11) and quarterly for the last year with all forms signed by prescriber within two weeks
Individual #454	Only DISCUS in record dated 2/8/11, and signed by Prescriber 2/8/11
Individual #65	None present
Individual #426	None present
Individual #62	Most recent 11/5/10 (signed by prescriber 11/5/10), with prior 5/7/10 (signed 5/17/10)

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		Thus, only one individual (i.e., Individual #452) of these individuals (20%) was monitored with the DISCUS as specified in the Settlement Agreement. The subject of the latency between the completion of the MOSES and DISCUS, and the date they were reviewed and signed by the prescribing physician was discussed with the Psychiatric Specialty Nurse during the 5/9/11 interview. She indicated that any abnormal findings on these examinations were reported immediately to the prescribing physician. However, there did not appear to be any documentation of this process. In light of the number of Psychiatric Nurses and full-time Psychiatrists, it should be possible to develop a system that would ensure that these evaluations are reviewed by the prescribing physician within two weeks, if not sooner. To the extent that new abnormal findings on an evaluation are identified and reported immediately to the prescribing physician, it would be useful to devise a mechanism to document this process. The monitoring of individuals who are prescribed Reglan and who are not also receiving a psychotropic agent clearly needs to be improved, as this medication can cause significant side effects. These may include acute extrapyramidal motor side effects (EPS), which might require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	At the time of the document request for the current Monitoring Team visit, the Pharmacy Department indicated that there was nothing to report with regard to this provision. The pharmacy was in the process of implementing an electronic tracking system through the Avatar software. The old undated policy entitled "Adverse Drug Reaction (ADR) Monitoring Policy and Procedure for AUSSLC" was to be replaced by AUSSLC Policy and Procedure entitled "Adverse drug reaction reporting," with a revision date of 5/4/11. This was discussed as an agenda item at the Pharmacy and Therapeutics Committee meeting of 5/12/11. There were two subsections to the reporting form. In Section A, the RN/LVN was to list the symptoms suggesting an adverse drug reaction. There was also a Naranjo Probability Score questionnaire, but it was not clear who would complete this section. Due to the information required to complete this questionnaire, the pharmacist would likely be the one to most comprehensively complete it. If this were to occur, it should be defined as a step for pharmacy completion under Section A. Section B required completion by the physician. At the end of Section A and B was an area for P&T Review and Recommendations. Attached to the policy was a copy of the "Medication Adverse Reaction Report," as well as the document used to report a possible ADR, entitled "Medication adverse drug reaction reporting form." Also attached were copies of the computer screens to the Avatar software indicating the steps to access the ADR report. The minutes of the P&T	Noncompliance

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		Committee meeting of 5/12/11 will reflect the outcome of the discussion in the process of finalizing this policy and procedure. The next step will be implementation of the policy, including training of staff.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Pharmacy Department attempted a drug utilization evaluation for valproic acid. This was initiated on 9/27/10. Dated October 2010, a basis of choice of drug was documented, and sample size was chosen. Data collection guidelines were determined, and each department was assigned a section of the data collection worksheet, which totaled 22 questions. This required the cooperation of the medical, nursing, dental, pharmacy, and psychiatry departments. However, the undated results indicated that the DUE was not completed, because the Nursing and Medical Departments did not complete assigned sections. For reasons that were not documented, the sample size also was reduced. According to the Pharmacy and Therapeutics Committee meeting minutes, the results of the valproic acid DUE were unable to be reviewed due to missing data collection sheets. A second DUE was conducted from November 2010 through January 2011. The drug audited was clozapine. Questions focused on maximum dosage, and also on laboratory testing for metabolic effects. There were 11 individuals taking Clozapine, and all were eligible for the DUE. No tabulated results were submitted to the Monitoring Team. An update on the DUE study was on the agenda for the 5/12/11 Pharmacy and Therapeutics Committee. There was also a DUE calendar submitted. However, it only listed Clozapine for the January 27, 2011 P& T Committee review, and Lithium for July 28, 2011. A new DUE should be completed each quarter. Follow-up reviews are an important aspect of each DUE, and need to be ongoing until improvement is shown. Many follow-ups will occur simultaneously. These, however, are different from initiating a new DUE. The formulary is sufficiently large that a DUE should focus on a different medication each quarter.	Noncompliance
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.	Data was submitted concerning medication errors for January and February 2011. The request for medication errors/variances per month was for the past year. There was no submission of data prior to January 2011, suggesting a lack of a database, but the reason was not indicated. In January 2011, there were 143 medication variances recorded in the database, and in February 2011, there were 50 medication variances recorded. Information collected included the nurse responsible for the error, whether the nurse was staff or agency, date of discovery of the error, date of the error, the shift/time of the error, the unit/residence, the type of error, contributing factors, the severity index category, the medication, and therapeutic class. There were three additional fields of information that were part of the table of information, but for which no data entry had	Noncompliance

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		been completed. These additional fields included: number of individuals nurse responsible for, corrective action plan, and date of medication observation post-medication error. These three fields were important to the resolution of the medication error problem, and the Facility should ensure this information is included in the database. From the policies and corrective action plans submitted, it was likely some of the fields had been completed, but the submitted documents did not include this information. From these two months of data, information concerning medication errors was broken down by unit and type of error per month, variances by residence per month, variances by agency versus staff per month, variances by specific nurse per month, variances by severity index per month, and variances by contributing factors per month (listed categories included: Staff/agency, staff distractions, staff floating, staff inexperienced, staff agency/temporary, none noted, blank, nothing checked, and staff insufficient). For visual interpretation, pie charts were provided. From the data provided, all medication errors/variances occurred in three units: Castner, Sunrise, and Timbercreek. The Pharmacy Department submitted a follow-up of a significant medication variance. On 1/28/11, an excess of Dilantin (455 unopened containers/cups) was found in a Medication Room by Pharmacy. Meetings with nursing and medical administration were held, and a Corrective Action Plan was created and implemented. Possible causes were reviewed, as well as increased labeling by pharmacy of the unit dosage containers, with increased monitoring by nurses for seizures. Competency-based training was provided to nursing on that residence, and there was heightened monitoring of the residence. On 4/1/11, a policy was completed for returning unused and excess medications. Nurse managers were to visit the pharmacy three times per week to review excess medication information. As of the Monitoring Team visit, nurse managers had not implemented this step. Additionally, the monitoring that was put in place due to the 1/28/11 discovery of excess Dilantin led to the discovery of additional Dilantin overages on 3/14/11 and 3/15/11. This led to continuation of the corrective action plan, including training and consideration of changing the times of medication administration, because the morning dose was at the change of shift. This appeared to be an ongoing corrective action plan. Based on review of the AUSSLC Corrective Action Plan for Nursing, dated 3/14/11, for several of the action steps there was no due date or date completed, making interpretation of impact difficult. However, as noted above, since the creation of this plan, a policy was implemented on 4/1/10 concerning the return of unused/excess medications. Additionally, the February Nurses Meeting included an in-service on medication administration and physician orders (processing/transcribing orders, transcribing orders to and discontinuing orders on the Medication Administration	

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		Record, review of documentation on the MAR, and review of specific medication administration practices for Dilantin and Fosamax). Pharmacy attended the February Nurses Meetings and the March Nurses Meetings. At the March meeting, pharmacy provided updates concerning dietary restrictions and medications, Keppra oral solution, bulk medication refills, routing of medication for individuals transferred to the Infirmary or the local hospital, returning medication to the pharmacy, order changes, the use of the medication excess/shortage form (pink slip) and the use of the yellow slip to document pharmacy miscounts or receipt of incorrect medication. Other action steps might have been completed, but the copy the Facility provided was not the most current copy, and did not reflect changes for April and May 2011. Copies of the last 10 medication error forms that were completed were submitted. Four of the medication errors were Category B an error occurred, but the medication did not reach the individual). Four were considered Category C (an error occurred that reached the individual, but did not cause individual harm), one medication error (a cluster of medications prepared by a previous shift and given earlier than ordered) represented a Category D error (an error occurred that reached the individual and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm), and one Category E (an error occurred that might have contributed to or resulted in temporary harm to the consumer and required intervention). Plans of action were noted on each of the medication error forms, suggesting a timely nursing administration approach to resolving and preventing further similar errors. As an additional approach to eradicate medication errors, a schedule of medication observations for medication passes was submitted. It included a schedule in which each unit nurse campus-wide was to be observed every three months, and more frequently as needed. Data for February and March were submitted, with findings. This provided important detailed information to nursing administration as systems approaches to medication error reduction are considered. For each concern identified, recommendations and corrective actions were documented. The Medication Error Committee meeting minutes of 2/17/11 and 3/22/11 were submitted. At the 2/17/11 meeting, it was documented that oversight responsibility of medication observation was assigned to the nurse educators in collaboration with each nurse manager. The minutes documented that 73% of the 135 errors were due to omissions, and the reasons/causes were attributed to agency staff, inexperienced staff, and floating staff. A total of 21% of the errors were due to documentation irregularities with the MAR not being initialed. For the month of January, 91% of errors were due to agency nurses. The minutes documented the need for a plan of correction by the nurse managers on each medication error form. From the medication error forms reviewed,	

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		this was being completed. However, the meeting minutes indicated the plan of correction "at a minimum should include a medication pass assessment (for every medication error discovered). This needs to be completed before a nurse is allowed to pass meds again." This information did not appear on the medication error forms and it was not clear whether this was considered mandatory for all medication error incidents. There was also the general statement that the reporting system did not reflect 100% of the medication errors. As one systems approach to medication error reduction, counting medication carts was suggested, and the minutes indicated there was no policy for this, but that it would be considered in the future. The March 22, 2011 meeting minutes documented that there were only 50 errors reported. The underreporting was discussed. One nurse reported that not all medication error forms had been turned in for the month of February. There was also concern about accurate categorization of the medication error by severity. It was documented that not only would pharmacy continue the monthly medication room inspections, but also that nursing would complete formalized weekly medication room inspections. Pharmacy discussed including the diet texture on the MAR, and the medications that should not be crushed would be posted in all medication rooms. Additionally, nurse managers were given the responsibility to ensure nurses did not crush medications on this list. A number of policies have been created or updated concerning medication variances. These policies included: ▪ SSLC Procedure: Medication Administration Guidelines, dated 2/11, for implementation 5/1/11; and ▪ AUSSLC Policy: Pharmacy Communication of Suspected or Actual Medication Discrepancies, dated 2/25/11. Current policies concerning medication errors and variances included: ▪ SSLC Procedure: Medication Errors/Incidents, dated 11/09; ▪ AUSSLC – Health Services: Medication Error Policy Addendum, dated 1/10; ▪ AUSSLC - Health Services: Medication Error Committee, dated 6/08, reviewed and updated 2/11; and ▪ Procedure for returning medication to the pharmacy, dated April 1, 2011. Although some progress had been made in identifying and addressing medication variances, AUSSLC did not have an adequately functioning medication variance system, in which medication variances were routinely reported. Better reporting will allow more complete analysis of the information, and development and implementation of corrective actions.	

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

1. The patient intervention reports should provide evidence of immediate communication between the pharmacy and the PCP, including such pertinent information as the name of the drug, the concern, the PCP response, and the change in order. (Section N.1)
2. The pharmacy should revise/develop and implement a policy or protocol that outlines when the "notes extract" section should be utilized versus documenting in the single patient intervention report. (Section N.1)
3. The pharmacy should review and update the policy to provide guidance as to the severity of risk that would require/indicate the need for communication to the PCP and to ensure compliance with the parameters listed (i.e., drug interaction, side effect profile, need for lab, dosage adjustments, etc.). (Section N.1)
4. The Pharmacy Department should create a system of implementation and monitoring to ensure the QDRRs are completed cyclically at 90-day intervals. (Section N.2)
5. The discrepancy in dates of STAT medication administration in the various pharmacy documents should be reviewed to determine the reason for the inconsistency in data entries. (Section N.3)
6. The pharmacist should routinely complete the "Chemical Restraint Clinical Review" section of the "Restraint Checklist" form. (Section N.3)
7. Given the seriousness of the implications, through interdepartmental collaboration, a systems approach should be created to ensure a chemical restraint is not given to the wrong individual. (Section N.3)
8. In the QDRR, the pharmacy should ensure all psychotropic medications are listed, along with clinical justification for each medication. (Section N.3)
9. The Medical Director should ensure timely review of QDRRs. Timely review with completion of signatures with dates could be incorporated into the morning medical meetings. The PCPs would then need to ensure agreed upon recommendations are ordered, as the records would not be available at the time of the morning medical meeting. (Section N.4)
10. 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. (Section N.4)
11. The system to ensure that the MOSES and DISCUS screening is completed for individuals who are receiving Reglan and are not receiving psychotropic medication needs to be significantly improved. (Section J.12 and N.5)
12. A mechanism should be developed to ensure that the prescribing physician reviews the MOSES and DISCUS side effect evaluations in a timely manner. (Section J.12 and N.5)
13. The need to cooperate in the completion of DUEs should be made clear to all relevant departments. (Section N.7)
14. The DUE calendar should list a different drug for evaluation each quarter. This should be separate from ongoing tracking of results and future implementation steps following the initial completion of a DUE. (Section N.7)
15. For the medication error database, three fields need data entry completion, including: number of individuals nurse is responsible for, corrective action plan, and date of medication observation post-med error. (Section N.8)

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 Presentation for Settlement Agreement Monitoring Team Visit for Section O, not dated; o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology Evaluations, Aspiration Pneumonia/Enteral Nutrition Evaluation, Nutrition Evaluation; OT/PT/SLP consultations for the last year, Personal Support Plan and PSP Addendums for the last year, including PSPA for Risk Assessment, OT/PT/SLP Consultations for past year; Physical and Nutritional Management Plan with pictures, PST Integrated Risk Rating Form, PST Action Plan for Risk Assessment, person-specific monitoring, PNMP Clinic Notes for the past year, competency-based training for staff, supporting documentation for PST Risk Assessment and Action Plan and PNMT Action Plan implementation, Health Management Plans (Nursing), and current Medication Administration Record documentation for the following 12 individuals: Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #413, Individual #107, Individual #430, and Individual #194; o The following documents: APEN Evaluation, Head of Bed Elevation Evaluation, PNMT Assessment and Updates, PNMT Action Plan, PSP and PSPAs for PNMT Action Plan, PNMP with pictures, Integrated Risk Rating Form, competency-based staff training by PNMT, individual-specific monitoring by PNMT and supporting documentation for implementation of PNMT Action Plan for the following seven individuals: Individual #396, Individual #72, Individual #402, Individual #199, Individual #182, Individual #398, and Individual #426; o The following documents: Integrated Risk Tracking from and Action Plan completed by PST prior to PNMT initial meeting, PNMT Integrated Risk Tracking From and Action Plan and Transition Plan from hospital to Infirmary for Individual #54; o The following documents: OT/PT/SLP Evaluations, Aspiration Pneumonia/Enteral Nutrition Evaluation, Nutrition Evaluation, PSP and PSPAs for past year, PNMP with pictures, pleasure/therapeutic feeding program/plan, person-specific monitoring, staff competency-based training and OT Consultations for the past year for the following eight individuals: Individual #51, Individual #28, Individual #117, Individual #178, Individual #121, Individual #223, Individual #188, and Individual #385; o PNMP and dining plan for the following 30 individuals: Individual#334, Individual#62, Individual#356, Individual#79, Individual#64, Individual#215, Individual#264, Individual#372, Individual#193, Individual#64, Individual#381, Individual#100, Individual#16, Individual#323, Individual#265, Individual#450, Individual#222, Individual#239, Individual#213, Individual#178, Individual#318, Individual#385,

	Individual#353, Individual#224, Individual#433, Individual#84, Individual#243, Individual#297, Individual#312, and Individual#280; o 6C and 6D transition plan documents for Individual #72 and Individual #50; o Pneumonia Target Group, not dated; o Personal Support Plan Meeting Agenda, not dated; o List of state seminars conducted by Karen Hardwick, since the last review; o PNM (Physical and Nutritional Management) Team Members and Curriculum Vitae, not dated; o PNM Policies and Procedures, dated 3/11/11; o PNM Team Member Roles and Responsibilities, not dated; o PNMT Continuing Education (CE) Sessions and Activities, dated 2/15/11; o PNM PSP Signature Sheets, Follow Up Sheets, Meeting Sheets and Minutes, from 10/10 through 4/11; o PNMT Evaluations, from 1/11 through 4/11; o PNMT Evaluations, revised 2/15/11; o PNM Health Risk Level Criteria, dated 2/18/11; o PNM Health Risk Level Tools (blank), dated 12/29/10; o List of PNM Assessments and Updates, from 8/10 through 4/11; o PSPs for Multiple Individuals, from 7/10 through 3/11; o PNM Tools used to Monitor Procedures/Plans (blank), not dated; o PNM Monitoring List, from 1/11 through 3/11; o Dining Plan Template, dated 4/11; o Competency-based Training Sheets for Dining Plans (blank), not dated; o PNM Spreadsheets, from 3/10 through 3/11; o PT Wounds-Decubitus List, from 1/10 through 3/11; o List of Individuals with Skin Breakdown and Active Pressure Ulcers, from 4/10 through 3/11; o Lifting/Transfer Instructions, not dated; o Level of Assistance for Dining, not dated; o List of Individuals with Falls, from 3/10 through 4/11; o POI Data Report, dated 4/1/11; o List of Individuals with Diabetes, dated 4/18/11; o PNM Spreadsheets, not dated; o List of individuals on modified diets/thickened liquids, dated 4/16/11; o List of individuals who require mealtime assistance, not dated; o List of individuals who receive nutrition through non-oral method, not dated; o List of individuals who have had a choking incident, from 6/09 through 8/10; o List of individuals who have had an aspiration and/or pneumonia incident, from 5/09 through 2/11; o List of individuals who have had skin breakdown and/or active pressure ulcer within past six (6) months, from 4/10 through 3/11; o List of individuals who have had a fall during past 12 months, from 3/10 through 4/11;

	○ List of individuals who have experienced a fracture during past 12 months, from 5/09 through 12/10; ○ List of individuals considered to be at risk for: choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, from 1/11 through 3/11; ○ List of individuals who are non-ambulatory or require assisted ambulation, not dated; ○ List of individuals with poor oral hygiene, from 10/10 through 3/11; ○ List of individuals who have received a video fluoroscopy, modified barium swallow study (MBSS), or other diagnostic swallowing evaluations, from 4/10 through 4/11; ○ Schedule of Meals-by Home, revised 3/14/11; ○ PNM Curricula used to train staff (blank), not dated; ○ Agenda and Curriculum for Foundational In-services (blank), not dated; ○ Competency-based Training Information/Instructions, dated 12/21/10; ○ Tools and Checklists used to provide Competency-based Training, PNMPs and Dining Plans, dated 4/11; ○ Two At Risk lists, one provided on site and the second provided after the review, not dated; ○ Infirmary Admissions, Medical Observation and Local Hospital list, dated 5/10/11; ○ List of Tube Fed Individuals, dated 5/10/11; ○ Agenda for New Staff Orientation; and ○ List of individuals admitted to the hospital, emergency room and Infirmary, not dated. ▪ **Interviews with**: ○ Kim Ingram, MEd, CCC/SLP, Habilitation Therapies Director; ○ Karen Hardwick, State Coordinator for Specialized Services; ○ Chris Strickling, OT, PhD, dedicated PNMT member; ○ Susan Chmiel, MS, PT, dedicated PNMT member; ○ Shelley Conroy, MA, CCC/SLP, dedicated PNMT member; ○ Christina Little-Manley, RD, LD, part-time PNMT member; ○ Jamie Pittman, RN, dedicated PNMT member; and ○ Kyle Kresta, QMRP, dedicated PNMT member. ▪ **Observations of**: ○ PNMT Administrative meeting, on 5/9/11; ○ PNMT Review meeting, on 5/9/11; ○ Core PNMT meeting, on 5/10/11; ○ PNMT Assessment Planning meeting with PST for Individual #54, on 5/12/11; and ○ Residence and dining room for 732P; dining rooms for 732D, 732E, 779F, 779H, 779R, Infirmary and 727C.
	Facility Self-Assessment: The AUSSLC Plan of Improvement, updated 4/27/11, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in noncompliance with each of the provisions. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance.

	The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: As of 3/1/11, the Facility established a fully dedicated PNMT, which included an Occupational Therapist, Physical Therapist, and Speech Language Pathologist. On 3/22/11, a nurse was hired and assigned full-time to the PMNT. On 5/2/11, a QMRP was hired and transitioned to the PNMT. A Dietician was available part-time at the time of the review. In addition, a Physical and Nutritional Management Plan Coordinator (PNMPC) worked with the PNMT. Members of the PNMT reported that the Medical Director had made positive contributions to the team's work, and a constructive working relationship had been developed. Two respiratory therapists had been hired, and provided valuable support not only to individuals with significant respiratory challenges, but to the PNMT members as well. The Facility Administration, in collaboration with Habilitation Therapies Director, were to be applauded for realigning resources to form a dedicated PNMT, as well as adding a QMRP and Physical and Nutritional Management Plan Coordinator (PNMPC) to the dedicated PNMT. It did not appear that PST members understood the criteria for referral to the PNMT and/or the PNMT process, as documented by individual examples contained within the report. Training should detail the criteria for referral of individuals to the PNMT; indicators for immediate referral to the PNMT; information to be provided to the PNMT for individuals being referred; philosophy of the PNMT process; and explanation of the PNMT process, including the components of the comprehensive assessment, development of action plans, and integration of PNMT action plans into PSPs and related documents, such as the PNMP, Behavior Support Plan, Health Management Plan, etc. Within a short period of time, the dedicated PNMT had developed and implemented a comprehensive PNMT action plan format, as well as individual-specific monitoring forms to document implementation of the action plan. During the onsite review, the PNMT was initiating the assessment process with an individual who was currently hospitalized. The PNMT developed a transition plan for this individual, which identified action steps to be completed during her hospitalization, upon discharge from the hospital on the day of her return, and subsequent days. In the process of assessing individuals, the PNMT had identified systemic issues that needed resolution. The PNMT was to be commended for their approach to identifying and resolving systemic issues, and should continue to seek the support of Facility Administration to resolve these issues as they arise. As the PNMT processes continue to evolve, the PNMT will need to focus on clearly documenting the PNMT evaluation and action plans, including when the referral was received for an individual and the PNMT action plan development and implementation date; ensuring documentation of staff competency-based training and check-offs for all areas identified on the action plan; ensuring individual-specific monitoring is

	completed per the action plan; implementing a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan and/or make modifications to the plan; and establishing a review process to determine the efficacy of individuals' strategies, resulting in the attainment of identified recommendations and measurable outcomes. The Monitoring Team did not observe staff to be consistently implementing strategies in the PNMP and/or dining plan. Staff were not competent in implementing PNMP and/or dining plan strategies. Staff engaged in unsafe mealtime practices, which posed an undue risk of harm for individuals identified at risk of aspiration and/or choking. The Facility Administration should consider the development of an interdisciplinary problem-solving to address identified mealtime concerns. The Habilitation Therapies Department was to be commended for her leadership in the development and implementation of procedures for competency-based training. Although efforts had begun to provide competency-based training on individuals' PNMPs, this initiative was at the initial stages of implementation, and considerable additional training was needed.

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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	Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the Settlement Agreement, 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 Settlement Agreement. <u>The PNM team consists of qualified Speech Language Pathologist, Occupational Therapist, Physical Therapist, Registered Dietician, and, as needed, ancillary members [e.g., MD, Physician's Assistant (PA), Registered Nurse].</u> As of 3/1/11, the Facility established a fully dedicated PNMT, which included an Occupational Therapist, Physical Therapist, and Speech Language Pathologist. On 3/22/11, a nurse was hired and assigned full-time to the PMNT. On 5/2/11, a QMRP was hired and transitioned to the PNMT. A Dietician was available part-time at the time of the review. In addition, a Physical and Nutritional Management Plan Coordinator worked with the PNMT. Members of the PNMT reported that the Medical Director had made positive contributions to the team's work, and a constructive working relationship had been developed. Two respiratory therapists had been hired, and provided valuable support not only to individuals with significant respiratory challenges, but to the PNMT members as well. The Facility Administration, in collaboration with Habilitation	Noncompliance

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	PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, Physical Therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	Therapies Director, were to be applauded for realigning resources to form a dedicated PNMT as well as adding a QMRP and Physical and Nutritional Management Plan Coordinator to the dedicated PNMT. Currently, AUSSLC had two dieticians providing support to 361 individuals. The addition of another dietician would be beneficial to lower the current caseloads of the two dietitians. This would enable the dietician assigned to the PNMT to lessen her caseload, and provide additional support to the PNMT members and individuals on the PNMT caseload. Per report, the dedicated PNMT reassessed seven individuals (Individual #396, Individual #72, Individual #402, Individual #199, Individual #182, Individual #398, and Individual #426) who the previous PNMT had assessed. In the section of this report that addresses Section O.2 of the Settlement Agreement, the Monitoring Team's review of these seven individuals is discussed. The PNM Team Protocol, not dated, identified the following initiatives: ▪ Reassess/fill in gaps for individuals seen by the PNMT up to this time then all other individuals in Cardinal and target list; ▪ Develop process/protocol for triggers; ▪ Perform competency-based training with all current staff responsible for care of individuals on target list/Cardinal and all new staff before working with high-risk individuals; ▪ Establish clinical versus compliance monitoring forms and teams; ▪ Correlate monitoring with outcome data reported to State Office; and ▪ Synchronize with QA. At the time of the review, the current AUSSLC census was 361 individuals. Based on interview and document review, the following chart identifies the current caseloads and/or responsibilities of the PNMT members. The assigned caseloads of the members of the dedicated PNMT's were the individuals who lived in Cardinal, as well as some individuals who resided outside of Cardinal. However, per report, all individuals were to transition from Cardinal to other residences on campus. Until this transition occurred, the PNMT would provide support to the individuals living in Cardinal, as well as the individuals on their caseload. At the time of the onsite review, the PNMT was accepting Individual #54 to their caseload. It should be noted that these caseloads generally consisted of individuals with the most medical complexities, many of whom the PNMT would support:	

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PNMT Members	Current Caseloads and Responsibilities
Registered Nurse	Supporting 10 individuals (Cardinal - seven individuals, Wood Hollow - one individual, Castner – one individual, and Infirmary - one individual)
Physical Therapist	Supporting 10 individuals (Cardinal - seven individuals, Wood Hollow - one individual, Castner - one individual, and Infirmary - one individual)
Occupational Therapist	Supporting 10 individuals (Cardinal seven individuals, Wood Hollow - one individual, Castner - one individual, and Infirmary - one individual)
Dietician	Supporting 10 individuals (Cardinal - seven individuals, Wood Hollow - one individual, Castner - one individual, and Infirmary - one individual) and at the time of the review was part-time on the PNMT and carried a caseload of over 100 individuals
Speech Pathologist	Supporting 10 individuals (Cardinal - seven individuals, Wood Hollow - one individual, Castner - one individual, and Infirmary - one individual)
QMRP	Supporting 10 individuals (Cardinal - seven individuals, Wood Hollow - one individual, Castner - one individual, and Infirmary - one individual)

The Physical Nutritional Management Core Team Training, dated March 2010, which the State Coordinator for Specialized Services presented, consisted of ten clinical instructional domains with multiple components, including:

- Physical Nutritional Management Teams;
- Nutritional Management/GI Issues;
- Clinical Assessment Technologies;
- Seating and Positioning for Dysphagia;
- Evaluation of Seating and Positioning;
- Wound Investigation Protocol;
- Communication Issues/Strategies;
- Nursing Issues in PNMP;
- Dietary Issues with PNMP; and

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		▪ Respiratory Therapy. The following State Offices PNMT Webinars were presented since the last onsite review: ▪ PNMT and Risk Issues (12/15/10); ▪ PNMT and Risk Issues (1/28/11); ▪ GI Issues in Individuals with Developmental Disabilities (3/24/11); ▪ VAC-PAC [method of positioning individuals during medical procedures], Positioning and Video fluoroscopy (3/22/11); ▪ Introduction to PNMT (3/24/11); ▪ PNMT: Identification of Risk and Development of Interventions (3/24/11); ▪ Video fluoroscopy-Positioning, administration and interpretation (4/13/11); and ▪ PNMT Forms Training (4/13/11). PNMT members (OT, PT, SLP, and RN) submitted continuing education documentation. No continuing education documentation was submitted for the PNMT RD. It should be noted that the PNMT OT, PT, and SLP began their PNMT assignments on 2/15/11. As a result these team members did not attend the PNMT Risk Issues training presented on 12/15/10 and 1/28/11. The PNMT Nurse was hired on 4/22/11, and the QMRP was hired and began transition to the PNMT on 5/2/11. As a result, they were not on staff when any of the above listed training was offered. Review of training rosters for the PNMT OT, PT, SLP and RN for state-sponsored clinical instruction webinars revealed the following: ▪ Four of five (80%) PNMT members (OT, PT, SLP and Nurse) attended the VAC-Pac, Positioning and Video fluoroscopy, on 3/22/11; ▪ Four of five (80%) PNMT members (OT, PT, SLP and Nurse) attended the GI Issues in Individuals with DD, on 3/24/11; ▪ Four of five (80%) PNMT members (OT, PT, SLP and Nurse) attended the PNMT: Identification of Risk and Development of Interventions, on 3/24/11; ▪ Four of five (80%) PNMT members (OT, PT, SLP and Nurse) attended Introduction to PNMT, on 3/24/11; ▪ Four of five (80%) PNMT members (OT, PT, SLP and Nurse) attended the Video fluoroscopy Positioning administration and interpretation, on 4/13/11; and ▪ Four of five (80%) PNMT members attended PNMT Forms Training on 4/13/11; The dedicated PNMT members (OT, PT, SLP and Nurse) were to be commended for attending the state-sponsored clinical instruction courses that were presented after they became dedicated PNMT members. The attendance of PNMT members at PNMT state webinars should be non-negotiable and mandatory. All PNMT team members have a responsibility to participate in on-going continuing education opportunities to expand	

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		their knowledge and skills, and ensure they are knowledgeable about current trends within their respective fields, as well as other team members' fields of expertise. Team members should be held accountable to attend continuing education courses. A continuing education tracking system for PNMT members and other therapists should be implemented to consistently document attendance through training rosters and/or certificate of completion for state-sponsored webinars, off-site clinical instruction, and conferences. The Habilitation Director should review the information regularly to ensure that PNMT members were attending state-sponsored clinical instructions webinars. <u>PNMT meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> According to documentation submitted, the dedicated PNMT was meeting regularly to address change in status and update action plans for individuals on their caseloads. However, at the time of the review, they had only reviewed seven individuals. The Referral Process to PNMT Protocol, not dated, provided the following sections with supporting information: ▪ Purpose; ▪ Relates to; ▪ Definitions; ▪ PST Risk Process; ▪ Risk Assessments; ▪ Generating the Action Plan; ▪ Implementing the Action Plan; ▪ Resolution through the PST; ▪ Referral to the PNMT; ▪ Flags for Immediate Referral to PNMT or BSC; ▪ PNMT Process; ▪ Action Planning; and ▪ PNMP Action Plan Implementation. According to the Draft Referral Process to PNMT Protocol, flags for immediate referral to PNMT were as follows: ▪ Documented changes in status resulting in a high-risk rating; ▪ Determination that the risk requires immediate specialized intervention; ▪ Placement of an enteral feeding tube; ▪ Sudden decline in health and/or functional mobility; and ▪ If the team requested immediate assistance from the PNMT, the PST did not have to develop and implement an action plan prior to referral.	

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		The Monitoring Team supported the content of the Referral Process for the PNMT Protocol, as well as the flags for immediate referral to the PNMT. However, as illustrated in the examples below, these established guidelines were not being consistently followed. It did not appear that PST members understood the criteria for referral to the PNMT and/or the PNMT process. For example: ▪ Individual #334 had been admitted to the Infirmary for medical observation prior to the placement of a gastrostomy tube on 5/10/11, but he had not been referred to the PNMT prior to the placement of his tube. ▪ On 4/26/11, Individual #54 was admitted to the hospital with the diagnoses of status post (S/P) placement of gastrostomy tube, resolving UTI, resolved pneumonia, resolving diarrhea and hypothermia. The PNMT had initiated the assessment process for Individual #54 during the week of the onsite review, but Individual #54 had not been referred to the PNMT prior to the placement of her gastrostomy tube. PSTs need training on the content of Referral Process to PNMT Protocol. Training should detail the criteria for referral of individuals to the PNMT; indicators for immediate referral to the PNMT; information to be provided to the PNMT for individuals being referred; philosophy of the PNMT process; and explanation of the PNMT process, including the components of the comprehensive assessment, development of action plans, and integration of PNMT action plans into PSPs and related documents, such as the PNMP, Behavior Support Plan, Health Management Plan, etc. In addition to the seven individuals the PNMT had reviewed, which is discussed in further detail with regard to Section O.2, an individual record sample was drawn from the AUSSLC hospitalization list, individuals at high risk for aspiration, and the pneumonia target group. The sample included the following 12 individuals: Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #413, Individual #107, Individual #430, and Individual #194. None of these 12 individual records reviewed (0%) documented that the PST members had followed the at-risk process outlined in the SSLC At Risk Individuals policy, approved 12/29/10. The PSTs had not met regularly to review and update the implementation of the Risk Action Plan, and/or develop measurable outcomes to determine if the action plan successfully minimized, and/or reduced high-risk indicators. Professional staff had not provided competency-based training for direct support professionals responsible for implementation of the plans, nor was monitoring documented. The following individual examples illustrate some of the concerns:	

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		▪ Individual #430 was identified on the Pneumonia Target Group list as having had aspiration pneumonia, and she received intermittent feedings through her gastrostomy tube. Her Integrated Risk Rating Form, dated 1/6/11, identified her at medium risk for aspiration, respiratory compromise, constipation/bowel obstruction, gastrointestinal (GI) problems, osteoporosis, seizures, infections, polypharmacy/side effects, and dental. She should have been placed at high risk for aspiration, given her recent diagnosis of aspiration pneumonia. Her Risk Action Plan, dated 1/6/11, identified action steps, but the implementation date, monitoring frequency completion date, and follow up/outcomes were blank. ▪ Individual #100's Integrated Risk Rating Form, not dated, acknowledged the following high-risk ratings: aspiration, respiratory compromise, osteoporosis, and polypharmacy/side effects. The action steps for aspiration were anti-reflux positioning, complete aspiration pneumonia trigger sheet, and continue thickened liquids. No aspiration triggers sheets were submitted, and no competency-based staff training had been completed for anti-reflux positioning. Her PNMP, revised 5/3/11, did not identify her high risk for aspiration, respiratory compromise, and osteoporosis. Her HMP Care Plan, dated 3/15/11, stated: "keep upright at least 1 hour after meals." Her PNMP, revised 5/3/11, acknowledged "right sidelyer for 1 hour after all meals/snacks." These plans should have been integrated to ensure staff instructions are consistent. ▪ Individual #452's Interim Staffing, dated 1/25/11, identified her at high risk for choking, aspiration, gastrointestinal problems, and dental. The PST agreed to "follow action plans, follow monitoring schedules, and meet again at [Individual #452's] annual meeting, unless the team deems it necessary to meet before then." Her Risk Action Plan, dated 1/25/11, was blank under the implementation date, monitoring frequency, completion date, and follow up/outcome. There were no updates to her Risk Action Plan after 1/25/11. ▪ Individual #194 was hospitalized on 5/6/11 with a diagnosis of aspiration pneumonia and urinary tract infection. Her Integrated Risk Rating Form, dated 4/8/11, identified her at medium risk for choking, aspiration, respiratory compromise, weight, constipation/bowel obstruction, skin integrity, infections, fractures, and urinary tract infections. The Pneumonia Target List, not dated, documented a diagnosis of aspiration pneumonia on 3/19/10 and 1/11/11. Individual #194 should have been rated at high-risk for aspiration. No action plans had been developed to address her risk categories. It was of concern that Individual #194 had been hospitalized again for aspiration pneumonia without the development of an aggressive action plan to address her ongoing risk for aspiration pneumonia.	
O2	Commencing within six months of the Effective Date hereof and with	<u>A process is in place that identifies individuals with PNM concerns.</u> As noted in Section I, Section O.1 and Section P, PST members had completed a risk	Noncompliance

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	full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	assessment for individuals in the record sample, but did not consistently follow the risk guidelines in the assignment of risk ratings. In addition, the At Risk Process had not been implemented as defined in the At-Risk Individuals policy. It was essential that teams accurately followed this process, because the At-Risk Individuals policy had made PSTs responsible for making referrals to the PNMT. The purpose of the Referral Process to PNMP Protocol, not dated, was "to provide guidelines for development of physical nutritional management programs and to outline the responsibilities of the Physical Nutritional Management Team, and outline the referral process to the Physical Nutritional Management Team." The protocol outlined the referral process to the PNMT, which included the responsibilities of the PST, and the PNMT. The following flags for immediate referral to the PNMT were: ▪ Documented changes in status resulting in a high risk rating; ▪ Determination that the risk required immediate specialized intervention; ▪ Placement of an enteral feeding tube; ▪ Sudden decline in health and/or functional mobility; ▪ If the team requested immediate assistance from the PNMT, the PST did not have to develop and implement an action plan prior to referral; ▪ If identified risks did not warrant immediate referral, the PST could request assistance in developing an action plan. The PNMT could be invited to any PST risk meeting to facilitate development and implementation of an action plan. The protocol further defined the PNMT process with the presentation of guidelines for the PNMT assessment, risk action planning, and PNMT action plan implementation. As noted above, although these seemed appropriate, they were not being followed consistently. <u>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day, and during nutritional intake.</u> Since the last compliance review, the PNMT reviewed the following seven individuals: Individual #396, Individual #72, Individual #402, Individual #199, Individual #182, Individual #398, and Individual #426. A review of the PNMT evaluations, PNMPs, action plans, monitoring, and other evidence submitted for these seven individuals revealed the following: ▪ In one of the seven records reviewed (14%) (Individual #182), there was documentation of correct risk identification levels completed by the PNMT based upon physical and nutritional history, current status, and specific criteria for guiding placement of individuals in specific risk levels. ▪ In five of the seven records reviewed (71%) (Individual #72, Individual #189,	

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		Individual #396, Individual #402, and Individual #426), there was documentation of a comprehensive assessment. ▪ In one of the seven records (14%) (Individual #182), the PNMT evaluation included an analysis to consistently provide a rationale for the development of recommendations and measurable, functional outcomes for individuals at highest risk to minimize and/or reduce the identified health risk(s). This indicator was impacted by individuals not being identified at high risk for aspiration pneumonia, which impacted their PNMT evaluation and action plan, which did not address their high risk for aspiration. ▪ In five of the seven records (71%) (Individual #72, Individual #182, Individual #199, Individual #402, and Individual #426), a PSP Addendum for the PNMT meeting was present, which included the integration of the PNMT Action Plan. ▪ In six of the seven records (86%) (Individual #72, Individual #182, Individual #199, Individual #396, Individual #402, and Individual #426), there was documentation of development of implementation strategies. ▪ In none of the seven records (0%) was there documentation of competency-based training for all the individual strategies as recommended in the PNMT Action Plan. ▪ In three of the seven records (43%) (Individual #199, Individual #396, and Individual #426), there was documentation of a PNMT monitoring completed for individuals at highest risk. ▪ In three of the seven records (43%) (Individual #199, Individual #396, and Individual #426), there was documentation in Integrated Progress notes of progress, and/or lack of progress with the Action Plan. ▪ In none of the seven records (0%) was there documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. In the Monitoring Team's review of the seven individuals evaluated by the PNMT, the following observations were made: ▪ Individual #199: o His Integrated Risk Rating Form, dated 3/4/11, assigned a risk rating of medium for aspiration, although the Pneumonia target group list documented he was hospitalized on 8/10/09 and 2/17/10 for aspiration pneumonia. There was no signature page attached to determine if the PNMT had been involved in the completion of the risk ratings. The PNMT Evaluation, dated 4/15/11, stated: "His aspiration risk is rated medium because there are measures in place that limit aspiration risk." Individual #199's aspiration risk should have been rated as high per the established guidelines. o His APEN Evaluation, dated 3/15/11, did not assess his ability to	

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		transition to a less restrictive form of receiving enteral nutrition. The PNMT should be involved in supporting this type of transition. o The Facility list of hospitalizations within the last year did not coincide with the APEN's documentation of aspiration pneumonia. This list needed to be accurate to provide essential information to Quality Assurance, Risk Management, as well as the PNMT. o PNMT Monitoring Forms documented noncompliance with tracheal suctioning and aerosol trach collar. The instructions for the resolution of noncompliance with tracheal suctioning, dated 4/20/11, were to check MAR forms, and the RT [respiratory therapist] was to retrain staff every time they suction. The resolution for noncompliance with the aerosol trach collar was nursing training on respiratory treatment. There was no further documentation to determine if these issues of noncompliance had been resolved. It should be noted that PNMT members should not have full responsibility to resolve issues of noncompliance, nor do they have supervisory authority to remediate issues of noncompliance. The PNMT must have the support of administration to ensure that issues of staff noncompliance are addressed swiftly. ▪ Individual #72: o The Integrated Risk Rating Form, dated 3/17/11, rated her at medium risk for aspiration pneumonia, although the Pneumonia Target List documented aspiration pneumonia on 12/8/10. The PNMT should review the Integrated Risk Rating Form, and document if risk ratings were revised and provide a clinical rationale. Individual #72's Integrated Risk Rating Form did not consistently provide a clinical rationale for a risk rating. ▪ Individual #398: o The PNMT Evaluation, dated 10/21/10, did not contain recommendations and/or measurable outcomes. ▪ Individual #396: o The Integrated Risk Rating Form, dated 2/10/11, documented her risk rating for aspiration as medium. The Pneumonia target list documented that Individual #396 had been diagnosed with aspiration pneumonia on 7/4/09, 2/28/10, and 12/28/10. Her risk rating for aspiration should have been high. This error would impact the PNMT evaluation and action plan. ▪ Individual #426: o The Integrated Risk Rating Tool, dated 1/4/11, did not provide consistent clinical rationale for risk ratings. ▪ Individual #182:	

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		○ The PNMT Evaluation, dated 9/30/10, did not include recommendations and/or measurable outcomes, but a comprehensive PNMT Action Plan had been developed to address his high-risk rating for aspiration. ▪ Individual #402: ○ The Facility Hospitalization record documented that Individual #402 was discharged from the hospital on 1/21/11 with a diagnosis of aspiration pneumonia. His Integrated Risk Rating Tool, dated 3/17/11, rated aspiration as medium with the rationale "Hospitalized 1/13/11-1/21/11. Risk being addressed in HMP, PNMP and PNMT Action Plans." Individual #402 was at high risk for aspiration. As stated above, this error impacted his PNMT evaluation and action plan. The following positive observations related to the work products of the PNMT were made: ▪ The PNMT Action Plan provided a comprehensive format and identified the individual's identified risk ratings, long-term goals, risks, outcomes, identified triggers, actions, rationale, timeline (completed by), training, staff responsibilities, monitoring (frequency/staff), documentation (to be provided to the team for review and staff/frequency), and progress. ▪ The PNMT Monitoring Form documented the environment during monitoring, including physical location, positioning, staff present, and physical status. Equipment/action to be monitored was specific to individual action plan steps to be monitored by the PNMT. These indicators were monitored as compliant and/or noncompliant. A field was provided to document the provision of competency-based training. The form acknowledged "competency based training MUST BE PROVIDED for staff who do not exhibit competency during monitoring." The form had a column for issues noted during monitoring and stated: "if any issues are found or staff is not exhibiting competency to complete tasks, training must be provided and issues should have a resolution. Complete the back of the form and return to the PNMT therapist." The back of the form had a table to document competency-based training, and sections for resolution and follow up needed. ▪ The PNMT during the course of providing supports to individuals also identified systemic concerns that needed to be addressed. The PNMT was to be commended for this approach. This showed that the PNMT understood their role as not only providing supports to individuals on their caseload, but also in resolving systemic issues which impacted the health and safety for individuals campus wide. For example, the PNMT identified infection control issues at Cardinal, including items that needed daily cleaning: IV poles, side rails, bedside tables, oxygen concentrators, feeding pumps, and gastrostomy tube syringes.	

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		This also required nurses to perform a unit-wide cleaning per shift. The PNMT developed a series of action steps, and training was completed in December 2010. The PNMT reported the training had been completed, but to their knowledge there was "no system in place to check that these actions were occurring as needed (i.e., no tracking, checklist, etc., which would hold people accountable). Again, the PNMT needed to seek the support of Facility Administration to resolve these issues. In addition, these systemic issues should be raised to Risk Management, as well as Quality Assurance. ▪ The PNMT began the assessment process for Individual #54 during the week of the onsite compliance review. The PNMT met with Individual #54's PST to review and revise her risk ratings, if appropriate. The following risk ratings were revised: choking changed to low risk from medium; weight changed to high from medium; cardiac disease changed to medium from low; skin integrity changed to high from low; infections changed from low to high; polypharmacy/side effects changed from low to medium; fractures changed from low to medium; fluid imbalance changed from low to high, and urinary tract infections changed from low to high. The changes in her risk ratings during this meeting illustrated the importance of this first step in the PNMT assessment process. An accurate clinical accounting of Individual #54's risk factors will provide the foundation for a PNMT assessment and action plan. The PNMT was to be commended for the development of a transition plan for Individual #54, who was currently in the hospital for her return to the Infirmary. The plan identified action steps during her hospitalization, upon discharge from the hospital on the day of her return, and subsequent days. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, PNMT members should: ▪ Clearly document on the PNMT evaluation and action plan when the referral was received for an individual; ▪ Clearly document the PNMT action plan development date and implementation date; ▪ Ensure staff complete performance check-offs to document competency for identified skills recommended on the PNMT action plan; ▪ Implement a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan, and/or make modifications to the plan; and ▪ Establish a review process to determine the efficacy of individual strategies as measured by progress toward or the attainment of identified PNMT outcomes. A review of the records of twelve individuals who were enterally nourished, hospitalized,	

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		on the Pneumonia target list and were at risk for aspiration pneumonia (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #413, Individual #107, Individual #430, and Individual #194) revealed the following: ▪ In none of the 12 records (0%) was documentation found of PST and/or PNMT review/analysis of the findings of relevant discipline-specific assessment(s), including but not limited to PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. Such a 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 during nutritional intake. ▪ In none of the 12 records (0%) were measurable, functional outcomes identified. ▪ In none of the 12 records (0%) was documentation found of PNMPs developed with input from the PNMT for those individuals at highest risk. ▪ In none of the 12 records (0%) was congruency found between Strategies/Interventions/Recommendations contained in the PNMP, and the concerns identified in the comprehensive assessment. ▪ In none of the 12 records (0%) were comprehensive summary results integrated into the design of the appropriate PNM support plans, as outlined in HCG VI and VIII and Settlement Agreement O.3 through O.8. ▪ In none of the 12 records (0%) were PNMT updates provided as needed until the individual was discharged from the PNMT. Individual examples are provided in the section that addresses Section O.1 of the Settlement Agreement.	
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	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> A review was conducted of 11 individuals identified at high risk, including: Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194. The record review included review of the individuals' PNMPs. Although many of the components of an adequate PNMP were present for these individuals, there were components missing. More specifically: ▪ In 11 of 11 records (100%), positioning instructions for wheelchair and	Noncompliance

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	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.	alternate positions instructions were included. ▪ In 10 of 10 records (100%), transfer instructions were included. ▪ In 11 of 11 records (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks, and/or addressed receiving nutrition through a feeding tube. ▪ In 11 of 11 records (100%), the mealtime/dining plan included food/fluid textures, and/or addressed receiving nutrition through a feeding tube. ▪ In 11 of 11 records (100%), the time was identified that an individual needed to remain upright after eating, and/or receiving enteral nutrition. ▪ In 11 of 11 records (100%), the mealtime/dining plan included behavioral concerns related to intake, and/or addressed receiving nutrition through a feeding tube. ▪ In 8 of 11 records (73%), strategies for medication administration were included. ▪ In 9 of 11 records (82%), strategies for oral hygiene were included. ▪ In 11 of 11 records (100%), individual adaptive equipment was included. ▪ In 11 of 11 records (100%), bathing/showering positioning and related instructions were included. ▪ In none of 10 records (0%), personal care instructions for elevation during checking and changing were included. ▪ In 11 of 11 records (100%), communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included: ▪ According to the Settlement Agreement, PNMPs must incorporate strategies for medication administration, oral care, and personal care for those individuals identified at risk. The PNMPs of individuals who received enteral nutrition, had been diagnosed with aspiration pneumonia, and/or were at risk of aspiration pneumonia needed to include staff instructions for medication administration, oral hygiene, and personal care (i.e., checking and changing) to ensure individuals were not in a flat, supine position during personal care. ▪ PNMP strategies needed to be integrated within an individual's nursing care/health management plan, and competency-based training provided to nursing staff to support nurses during medication administration, as well as other procedures requiring attention to individual triggers, adaptive equipment, positioning, and presentation techniques. ▪ Furthermore, for individuals who must be elevated and not be placed in a flat supine position, current strategies in PNMPs should be reassessed to identify appropriate elevation levels. PNMPs should reflect elevation strategies in every environment for those individuals who are at risk of aspiration pneumonia, have a diagnosis of GERD, or have other related health risk indicators (i.e., respiratory concerns).	

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		PNM plans were incorporated into individual's Personal Support Plans. In 11 records reviewed (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194), none of the PNMPs (0%) were incorporated into individuals' Personal Support Plans. Information from the PNMP should be integrated within the PSP, not simply referenced and/or listed. Examples of where individual PNMPs were not incorporated in PSPs included: ▪ Individual #212's PNMP, revised 2/17/11, discontinued the use of her elevated mat table with Geo Mat overlay for alternate positioning. There was no PSPA to discuss the rationale for the discontinuation of this adaptive equipment and alternate positioning. ▪ Individual #107's PNMP, revised 4/29/11, was changed for the use of a black wedge between mattresses for sleep and positioning. Staff were instructed that the black wedge could be removed only during brief change. Pictures were provided. There was no PSPA to address these changes. ▪ Individual #65's PNMP revised 5/5/11 indicated the following changes: "risks for aspiration, respiratory compromise, fracture and skin integrity with identified triggers for each risk; use of two staff for transfers, bathing, and positioning; do not lay flat, may lower head of bed for check and change; lowest position head of bed may be placed is marked with red tape on chain (15°); place feeding pump on hold before lowering head of bed to reposition and change (helps prevent reflux); remember to re-start the pump once positioning is complete." His team identified him at high risk for aspiration, respiratory compromise, and polypharmacy. The team identified skin integrity as a medium risk and fractures as a low risk. It was unclear why the PNMP reflected fractures as a risk. There was no PSPA to address these changes to his PNMP, nor did staff receive competency-based training related to these changes. PNMPs are developed with input from the PST, home staff, medical and nursing staff. In 11 records reviewed (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194), none (0%) of the PNMPs were developed with input from the PST, with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Examples of where individual PNMPs were not developed with input from the IDT included: ▪ Individual #14 was diagnosed with aspiration pneumonia on 3/9/10 and 1/16/11. His PNMP was revised on 5/8/11, with the following changes: "elevated head of bed to max 25° for sleep and all positioning (see angle finder and instructions attached to bed or by chain); do not lay flat; may lower head of	

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		bed for no lower than 15° for check and change (marked by red tape on chain or angle finder)." There was no OT/PT update to document the justification for these changes, nor was there a PSPA to integrate these changes. ▪ Individual #100 was diagnosed with aspiration pneumonia on 3/3/10 per the Pneumonia target list, not dated. Her PNMP documented a staffing date of 7/15/10, and a revision date of 5/3/11. Her PNMP did not document her risk of aspiration pneumonia. Her OT/PT Update, dated 7/14/10, did not discuss her diagnosis of aspiration pneumonia on 6/11/10, nor discuss strategies to minimize her risk of aspiration pneumonia. There was no PSPAs to integrate her revised PNMP, which did not indicate that any changes had been made. <u>PNMPs are reviewed annually at the PSP meetings, and updated as needed.</u> In none of 11 records reviewed (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194) (0%) were PNMPs reviewed annually at the PSP meeting, updated as needed, and integrated within the PSP. As discussed above, there was no evidence that the PNMPs were actually reviewed, discussed, and integrated into skill acquisition programs, BSPs, health management care plans, and/or daily routines at the PSP meetings. 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 none of 11 records reviewed (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194) (0%) 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: ▪ Individual #194 was diagnosed with aspiration pneumonia on 3/19/10 and 1/11/11. She had been admitted to the hospital on 5/6/11, with a diagnosis of aspiration pneumonia. Her Integrated Risk Rating Form, dated 4/8/11, rated her at medium risk for aspiration, which was not consistent with the criteria on the risk guidelines, because she had a diagnosis of aspiration pneumonia within the past year. There was no PSPA to discuss her recurrent hospitalizations, or re-assess her PNMP, revised 8/27/10, or her dining plan, dated 8/26/10 to ensure the stated strategies were sufficiently aggressive to address her recurrent episode of aspiration pneumonia. ▪ Individual #121 was diagnosed with aspiration pneumonia on 9/15/10. Her PNMP staffing date was 6/15/10, and was revised on 4/26/11. Her PNMP was not assessed subsequent to her change in status due to her diagnosis of	

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		aspiration pneumonia on 9/15/10. ▪ Individual #413 was diagnosed with aspiration pneumonia on 6/1/10 and 10/1/10. He died on 1/10/11. His PNNP staffing was 9/7/10, and was revised on 11/19/10, but the PNMP did not discuss his high risk for aspiration pneumonia or identify triggers and/or specific strategies for staff to minimize his risk of aspiration pneumonia. There was one PSPA on 1/7/11 to "discuss" the fact that he was in the hospital.	
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> The Monitoring Team did not observe staff to consistently implement strategies in the PNMP and/or dining plans. Staff were not competent in implementing PNMP and/or dining plan strategies. Staff engaged in unsafe mealtime practices, which posed an undue risk of harm for individuals identified at risk of aspiration and/or choking. The following provides additional details regarding the observations: ▪ In none of 19 observations (0%) were staff following dining plans. ▪ In none of six observations (0%) were staff following positioning instructions, while individuals were receiving enteral nutrition. ▪ In none of 15 observations (0%) were staff following wheelchair-positioning instructions. ▪ In none of one observation (0%) was staff following alternate positioning instructions. ▪ In none of two observations (0%) were nursing staff following the PNMP, including diet texture/fluid consistency, positioning instructions, and use of appropriate adaptive equipment for medication administration. Examples of where staff did not implement interventions and recommendations outlined in the PNMPs and/or mealtime plans were as follows: ▪ Individual #62 was observed in bed with her head in hyperextension. Her PNMP, revised 12/3/10, did not address what staff were to do if she placed her head in hyperextension, while in her bed, wheelchair and/or shower trolley. ▪ A presented nurse Individual #356 his medications with a plastic spoon. The precautions in his dining plan, dated 4/7/11, stated: "Never use disposable plastic spoons-he will bite & swallow pieces." This observation illustrated that nursing was not aware of these PNMP precautions, which had the potential to place Individual #356 at risk for choking. ▪ The focuses listed in Individual #64's dining plan, dated 9/23/10, were "reduce risk of choking w/diet texture, equipment & monitoring and reduce risk of respiratory problems from reflux w/positioning & equipment." Individual was in poor position, and staff did not correct his position during the meal	Noncompliance

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		observation. ▪ Individual #381 was being presented fluids with her head in hyperextension. The risks listed in her dining plan, dated 5/3/11, were choking due to poor oral control, and aspiration due to reflux and problems with digestion. Presentation of fluids with her head in hyperextension placed her at risk of choking and aspiration. Her dining plan did not provide strategies for staff to ensure her head was not in hyperextension during the presentation of food and fluid. ▪ Individual #323 had staff assistance with a pivot transfer, but staff did not allow time for him to bear weight during the transfer. ▪ Individual #213 was observed to be poorly positioned in his seating system, and was leaning to the right. Individual #213 cannot see. Dining plan instructions were to position plate, cup, utensils, and food on his plate, so he could feed himself. His plate was not anchored with a non-skid mat. His plate kept moving on the table surface as he attempted to scoop food from his divided, high side dish. The absence of a non-skid mat impacted his ability to know the precise location of his plate. ▪ Individual #178 was observed to be receiving enteral nutrition. She was not in optimal alignment and support in her seating system. Staff did not reposition her during the observation. Her PNMP, revised 1/14/11, was to reduce the risk of complications from reflux with positioning and equipment. The majority of individuals within this sample resided in the Castner and Phoenix residences, where multiple individuals were identified at high and/or medium risk for aspiration. These observations reinforced the importance of continuing competency-based training, as well as performance check-off for staff to support compliance with the dining plan strategies. To support an interdisciplinary mealtime safety initiative, the Facility should: • Identify staff responsible for mealtime supervision in the dining rooms; ▪ Provide competency-based training for mealtime supervisors, including a mealtime training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas: o Mealtime position and alignment; o Diet texture and fluid consistency; o Presentation techniques to enhance nutritional intake and hydration; o Care and use of adaptive equipment; o Aspiration and choking precautions and rationale; o Understanding a swallow study; o Risk indicators and problem solving; and o Techniques to promote optimal levels of independence and skill	

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		acquisition during mealtimes. ▪ Develop and implement competency-based performance check-offs for mealtime supervisors to ensure competency with mealtime learner objectives. ▪ Develop competency-based training and performance skills check-off for mealtime monitors. ▪ Establish a validation and re-revalidation process for mealtime monitors, which involves auditing mealtime supervisors to ensure competency with mealtime indicators; ▪ Establish protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems. ▪ Establish compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic. ▪ Ensure a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk due to aspiration pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc. AUSSLC administration might want to consider developing a method to identify staffing ratios for mealtimes/snacks. For example, in another State, a Facility had used the following eight weighted descriptors, which were assigned to each individual, to determine staffing ratios: ▪ Dysphagia with a weight of 0.1; ▪ PNM - no weight; ▪ Enteral - no weight; ▪ Independent with a weight of 0; ▪ Minimal assist with a weight of .25; ▪ Moderate assist with a weight of .50; ▪ Maximum assist with a weight of .75; and ▪ Dependent with a weight of 1.0. Each individual was scored using each of the eight indicators. An individual score was calculated for each individual. The individual score for each individual was totaled for all individuals within the residence to produce the number of staff needed for each meal and/or snack. This information would be helpful to managers in the development of staffing schedules for mealtimes to ensure staffing ratios were sufficient to support mealtime safety.	

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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> The Habilitation Therapy Director (HT) was to be commended for her leadership in the development and implementation of procedures for competency-based training. The Competency Based Training Procedures and Initial Training Information, not dated, identified the following sections, which included additional guidelines: ▪ Target group; ▪ Competency Check Sheet; ▪ Initial training; ▪ Competency based training procedures; ▪ Competency thresholds; ▪ Efficient training methods; and ▪ Monitoring/validation checks. According to staff, competency-based training was initially focused on the individuals identified on the lists of individuals who were identified as having had aspiration pneumonia, and/or received enteral nutrition. At the initial implementation of the Competency Based Training (CBT) procedures by Habilitation Therapies staff, risk ratings were not available to assist in prioritizing training. Future CBT efforts will consist of training those at highest risk first, at medium risk next, and so on. The competency check sheet was a task analysis of steps needed to appropriately complete a specific PNMP task. The steps within each competency would be modified to be appropriate for each individual. Competency check sheets were to be maintained in individual's I-Book. The following 26 competency check sheets were developed: ▪ Trigger Data Sheet Competencies; ▪ Ankle Foot Orthoses (AFO) Competency; ▪ Assistive Dining Equipment Competency; ▪ Bath Transfer Bench Competency; ▪ Bath Trolley Competency; ▪ Bed Positioning Competency; ▪ Booties Competency; ▪ Elbow Pad Competency; ▪ Elbow Splint Competency; ▪ Gait Belt Competency; ▪ Helmet Competency; ▪ Hosiery/Compression Sock Competency; ▪ Lemon Ice Competency; ▪ Mealtime Competency; ▪ Mechanical Lifting Competency; ▪ Palm Protector Competency;	Noncompliance

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		▪ Positioner and Wheelchair Positioning Competency; ▪ Putty Splint Competency; ▪ Rolling Shower/Toilet Chair Competency; ▪ Shower Chair Competency; ▪ Simply Thick Competency; ▪ Stand Pivot Transfer Competency; ▪ T [trolley] Transfer Competency; ▪ Two Person Manual Transfer Competency; ▪ Walking Program/Walking Individuals Competency; and ▪ Wrist/Hand Splint Competency. This list did not include training performed by the PNMT on specific and unique skills necessary to carry out the PNMT Action Plan and PNMP for those individuals supported by the PNMT. Additional information on PNMT training is provided with regard to Section O.2. A therapist would train an initial training group comprised of the PNMP Coordinator, QMRP, Home Supervisor, and at least one direct support professional from their assigned homes. Each therapist received home assignments to complete. The training was initiated in the Castner building. Competency-based training procedures were defined as follows: ▪ "Demonstrate the task to the staff member(s) and discuss each step as you perform it; ▪ Ask the staff member to perform the same task utilizing the demonstrated steps; ▪ Check that each of the steps were performed accurately; ▪ One Competency Check sheet completed for each staff member for each individual served; ▪ Turn in results of training/monitoring to identified staff person; ▪ Results filed in specific training folders by individuals served for evidence; ▪ Results entered in a tracking system; and ▪ Results will be considered in outcome evaluation per the individual's identified specific risks and needs." A staff member had three attempts to pass each competency piece, as the established competency threshold. If a person did not pass during the third attempt, the staff person was considered to be unable to perform his/her job duties. The inability to perform the task was documented on the competency check sheet, and reported to the appropriate supervisor or department head. If a monitor/observer observed a staff member not performing a task correctly during a	

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		monitoring check, the immediate intervention was to refer back to the competency checklist for that individual for that task. Retraining was to be documented, and a new competency check sheet was to be completed. The Monitoring Team reviewed a competency check sheet tracking entitled List of Competency-Based Training by Title, Name and Location, not dated. According to this document, staff of ninety-five (95) individuals had completed competency-based training check sheets. Staff for the following 16 individuals from the Pneumonia Target List staff had completed competency check sheets: Individual #262, Individual #72, Individual #178, Individual #430, Individual #426, Individual #54, Individual #396, Individual #336, Individual #81, Individual #199, Individual #182, Individual #121, Individual #286, Individual #402, Individual #265 and Individual #2. Staff for an additional 18 individuals (Individual #252, Individual #6, Individual #321, Individual #304, Individual #404, Individual #22, Individual #100, Individual #89, Individual #452, Individual #194, Individual #14, Individual #107, Individual #117, Individual #28, Individual #27, Individual # 231, Individual #51, and Individual #316), on the Pneumonia Target List, had not completed competency check sheets. Staff for an additional 79 individuals, who were not on the target list, had completed competency check sheets. The Habilitation Therapies Department did not follow the established procedures, which stated: "this is a list of individuals [target list] who have been determined as a first priority for the initial round of competency based training currently being performed." The following examples identify concerns noted for those individuals on the target list for whom staff had completed competency check sheets: ▪ Individual #178 was diagnosed with aspiration pneumonia on 12/7/10 and 12/19/10. Staff completed competency check sheets for two-person mechanical lift, mealtime, and bed positioning. No competency check sheets were completed for wheelchair positioning, bathing trolley, oral care, or medication administration positioning for nursing. ▪ Individual #121's staff completed competency check sheets for wheelchair positioning (one PNMP Coordinator for positioning, and one for bed positioning). There were no competency check sheets to address PNMP strategies for bathing, transfers, movement instructions, medication administration, and oral care/dental care. Per established procedures, a therapist was to train one PNMPC, Home Supervisor, and at least one direct support professional from the individual's assigned home, but this did not occur. ▪ For Individual #286, competency check sheets were completed for elbow pads for three PNMPCs, and gait belt for one PNMPC. His PNMP, revised 4/8/11, provided staff instructions for wheelchair positioning while receiving enteral nutrition, mechanical lift transfers, bathing trolley, head of bed elevation and positioning for bed, medication administration positioning for nursing, oral care	

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		positioning for nursing, and movement instructions for changing and hygiene. There were no competency check sheets for these strategies. Individual #286 had been admitted to the hospital on 5/6/11 to rule out aspiration pneumonitis, and had a diagnosis of a UTI. ▪ For Individual #265 competency check sheets were completed for two-person mechanical lift for one Mental Retardation Assistant II, and two PNMPCs; palm protector for one PNMPC; Adaptive Dining Equipment for one PNMPC; and bath trolley for two PNMPCs. Individual #265's PNMP had strategies for wheelchair positioning, alternate positioning for a recliner and bed/mat table, rolling shower chair and shower trolley, medication administration positioning for nursing, oral and dental care for positioning, and multiple staff instructions for dining. There were no competency check sheets for these PNMP strategies. Orientation and Pre-Service Training Schedule for new employees dedicated 19 hours for instruction by Habilitation Therapies staff, which was an increase of approximately seven hours of instruction related to physical and nutritional supports. The following agenda was presented: ▪ Orientation and Mobility - one hour (new addition); ▪ Dietician/Food Texture - two hours (increase of one hour from last review); ▪ Communicating with People who live here - two hours (increase of 30 minutes from last review); ▪ Augmentative Communication - two hours (new addition); ▪ Therapeutic Handling and Positioning - four hours (increase of one hour from last review); ▪ PNMP Practicum/Lifting and Transfer - four hours; and ▪ Basic Sign Language - four hours (increase of 2 hours and 25 minutes since last review). In addition, schedules for ongoing in-service training for March and April 2011 included lifting and transfer in-services. The Monitoring Team continued to have concerns about the limited amount of time dedicated to mealtime practices, given the multiple observations that staff were not competent in implementation of dining plans. New employees completed the following written tests: ▪ PNMP Training - new employees were given a PNMP packet and asked five questions; ▪ Dry Ear Precautions - written test with five questions; ▪ Hearing Aid Use, Care, and Maintenance - written test with five questions; ▪ Case Studies/Developmental Disabilities - presentation of three written case, studies with attached multiple choice questions after each case study; and ▪ Case Studies/Therapeutic Handling and Position - presentation of three case	

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		studies with attached multiple-choice questions after each case study. The HT Department should re-evaluate the New Employee Orientation (NEO) PNM sections that only had a written test, and develop a staff performance check-off for foundational PNM skills. Staff verbalization and/or completion of written test of a learned skill do not meet the standard of competency-based training. The Monitoring Team observed multiple individuals who were not in optimal alignment and support in their seating systems. This led the Monitoring Team to the conclusion that staff were not competent in positioning individuals, or that they did not understand the importance of it, which should be a component of the training. To ensure staff competency in positioning and alignment, staff must demonstrate this skill. Competency-based training should identify learning objectives/outcomes that define what a staff person must do, and provide the opportunity for staff to demonstrate the mastery of the learned skill. <u>All foundational trainings are updated annually</u>. In relation to physical and nutritional supports, the AUSSLC March and April 2011 Calendar for Competency Training and Development only included lifting and transfer refresher training. <u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u> Based on a review of staff PNMP training records for 11 individuals, competency-based individual-specific training was documented as being provided by appropriately trained personnel, but as noted below, the 11 individual records reviewed did not have comprehensive competency-based training for PNMP strategies. <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 none of the 11 individual staff training records reviewed (0%), for staff providing assistance to individuals determined to be at an increased level of risk (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194), had staff successfully completed competency-based training. Individual examples are provided below. <u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u> Based on a review of staff training for 11 individual identified at risk of aspiration pneumonia, none of the of 11 individual records (for Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6,	

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		Individual #212, Individual #107, Individual #430, and Individual #194) (0%) revealed that staff had completed competency check sheets for all PNMP strategies, and/or when changes occurred to the PNMP. As stated above, staff verbalization of a change in a PNMP did not meet the standard of competency-based training. The following provide a few examples: ▪ Individual #100 was rated at high risk for aspiration, respiratory concerns and osteoporosis. She was diagnosed with aspiration pneumonia on 3/3/10. No competency-based training and/or competency check sheets were completed. ▪ Individual #14 was diagnosed with aspiration on 7/28/09, 3/9/10 and 1/16/11. No competency-based training and/or competency check sheets had been completed. ▪ Individual #121 was rated high for aspiration, gastrointestinal problems, osteoporosis, and respiratory concerns. A bed-positioning competency check sheet for one PNMPC, and positioner and wheelchair-positioning competency check sheet for one PNMPC were submitted. Her PNMP, revised 4/26/11, contained staff strategies for mobility, transfers, movement, wheelchair and alternate positioning, medication administration positioning for nursing, skin care, bathing/dressing, oral and dental care positioning, and compressive socks. Staff for Indivudal#121 had not received comprehensive competency-based training to address PNMP strategies. ▪ For Individual #430, the mealtime competency check sheet had been completed for eight direct support professionals, one PNMPC, and four additional staff who were not identified by job title. Her PNMP, revised 3/30/11, contained strategies for mobility, head of bed positioning, shower chair, neck precautions, skin precautions, medication administration positioning for nursing, oral care positioning, and multiple dining plan instructions. No competency-based training and/or competency check sheets had been completed beyond the mealtime competency check sheets.	
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.	A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). The monitoring section in DADS Policy #012.1 for Physical and Nutritional Management, effective date 3/11/11, stated: "PNMPs should be monitored as determined by need and risk level. Individuals at highest risk shall be monitored at greater frequency to reduce the impact of high risk conditions and to prevent recurrences if possible." The policy provided six steps to further define monitoring, but did not provide specific directions to implement PNMP and PNMT monitoring. It will be the responsibility of the Facility to develop a step-down policy to ensure the PNMT conducts comprehensive monitoring.	Noncompliance

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		AUSSLC did not have a policy/protocol that addressed the monitoring process for the following monitoring forms that the Facility submitted: ▪ Mealtime/Snack Observation Form; ▪ Individual/Shared Communication Equipment Monitoring; ▪ Habilitation Therapies PNMP Observation & Training Roster; ▪ PNMP Monitoring Form-Bathing; and ▪ Lifting-Transfer Monitoring Form. According to the Presentation Book for Section O (O.6.3) deficiencies were corrected when identified through the monitoring process, however, evidence did not currently exist to support this statement. A database was being designed, in conjunction with State Office Data Management, to address tracking and trending of all monitoring results using the future State Supported Living Center PNMP Monitoring form. This form would be utilized for all aspects of PNMP/Dining monitoring in the near future, once instructions were developed and staff trained on its use. As stated below with regard to Section P.4, hundreds of monitoring forms were submitted for a two-month time period. The Monitoring Team was concerned with the significant number of hours involved in monitoring, especially when the Monitoring Team's observations did not support staff compliance with PNMPs and dining plans. In addition, these forms had not been audited to determine if the monitor(s) were completing the forms accurately. Monitors had not completed competency-based training and performance check-offs, inter-rater reliability checks had not been completed to ensure accuracy and consistency, and an analysis had not been completed to identify individual-specific and systemic issues. The absence of established guidelines/protocols for monitoring forms likely will result in the inconsistent scoring, as well as lack of follow-up for identified issues/concerns. This was reinforced upon the review of multiple completed monitoring forms for the 11 individual records reviewed. The following are a few examples of monitoring not being completed, or forms submitted for which identified concerns/issues were not resolved: ▪ Individual #452 was rated at high risk for aspiration, choking, dental, and gastrointestinal problems. No individual-specific monitoring had been completed. ▪ Individual #100 was rated at high risk for aspiration, osteoporosis, polypharmacy, and respiratory concerns. No individual-specific monitoring had been completed. ▪ Individual #14 had two Habilitation Therapies PNMP Observation & Training Roster forms completed. The form dated 5/10/11 documented: "two person change and dress not followed," and documentation was not completed, as there were "multiple missing signature on multiple dates." The bottom of the form	

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		sated "reminded staff to follow PNMP instructions," but no further documentation for resolution of staff non-compliance with PNMP strategies. ▪ The following forms were completed for Individual #107: one PNMP Monitoring Form - Bathing, dated 5/12/11; three HT PNMP Observation & Training Roster, dated 4/23/11, 4/25/11, and 5/2/11; and two Lifting/Transfer Monitoring Forms, dated 4/25/11 and 5/2/11. The Lifting and Transfer forms had multiple indicators marked as "N/A," which should have been answered by staff. These monitoring forms did not provide discrete monitoring information to ensure staff were competent in following PNMP strategies. As discussed in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include: ▪ Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, tooth brushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.); ▪ A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability; ▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; ▪ Formal schedule for monitoring to occur; ▪ Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors; ▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; ▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and ▪ Establishment of thresholds for staff re-training. <u>All members of the PNM team conduct monitoring.</u> Additional discussion of PNMT individual-specific monitoring is provided with regard to Section O.2 of the Settlement Agreement. <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 the Quality Assurance Department, did not illustrate that a mechanism was in place to ensure timely data was provided to the PNMT for analysis leading to the identification of potential issues, and ensuring the provision of supports to individuals with the most complex physical and nutritional	

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		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 QA/QI, Incident Management and Risk Management systems. Immediate intervention is provided if the person is determined to be at risk of harm. Examples are provided above with regard to Section I.2 and I.3, as well as Section O.1 of individuals who were at risk, but had not been reviewed by their PST and/or referred to the PNMT.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. For none of the 11 individual records reviewed (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194) (0%), had their PSTs completed a comprehensive assessment leading to the development of strategies for these individuals. These individuals received enteral nutrition, had been diagnosed with aspiration pneumonia, and/or were at risk of aspiration. In addition, individual PSTs did not refer these individuals to the PNMT. The PST did not document progress of individual strategies on a monthly basis to ensure the efficacy of those strategies in minimizing and/or reducing PNM risk indicators. In none of the 11 records was documentation found to support if strategies were not effective, that these strategies and the PNMP were revised. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. Based on review, in none of the 11 individual records (Individual #286, Individual #14, Individual #100, Individual #452, Individual #121, Individual #65, Individual #6, Individual #212, Individual #107, Individual #430, and Individual #194) (0%) did the PST provide adequate supports for these individuals to minimize their risk of aspiration. Individual-specific examples are provided with regard to Sections I.2, I.3, O.1, O.2, O.3, O.4, O.5 and O.6.	Noncompliance
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	All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status. According to State policy, all individuals who received enteral nutrition would receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation. Assessment information was to be obtained from the PCP, RN, Habilitation Therapies, Dietary, and PST members.	Noncompliance

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	shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	The Nurse Case Manager would compile the APEN evaluation document. The major elements of the APEN Nutrition Evaluation were: ▪ History to be completed by Primary PCP and RN, including diagnosis, comorbidities, history of aspiration pneumonia, other respiratory infections/conditions, hospitalizations for aspiration pneumonia/respiratory conditions, tracheostomy, reflux, emesis, and dental/oral heath issues (to be completed by dentist); ▪ Risk Level - Health Status to be completed by Team (risk level and rationale); ▪ Method of eating to be completed by PCP and Dietician (nasogastric tube, gastrostomy tube, jejunostomy tube, type of enteral feeding and oral eating); ▪ Reason/rationale for enteral eating to be completed by PCP, RN, and Habilitation Therapies; ▪ Diagnostic tests performed to be completed by PCP, RN, and Habilitation Therapies; ▪ Attempts to return to oral or least restrictive method of eating to be completed by Habilitation Therapies; ▪ Current treatment; ▪ Analysis of findings to be completed by team; ▪ Recommendations; ▪ Measurable outcomes; and ▪ Action plan. The evaluation format stated: "not all sections will be applicable to every individual." Based on the review of seven individual records (Individual #51, Individual #117, Individual #178, Individual #121, Individual #223, Individual #188, and Individual #385), who were enterally nourished and/or received supplemental tube feedings, five (71%) of these individuals had received an APEN evaluation, although the intent of the APEN evaluation was not met. The individuals within this sample were selected from the "Tube Fed Clients list," dated 5/10/11. The following are examples of the concerns that were noted: ▪ Individual #178 and Individual #223 did not have an APEN evaluation completed. ▪ For Individual #385, the section of the undated APEN evaluation entitled "attempts to return to oral or least restrictive method of eating" stated: "Last attempt was 9/93. Videoesophagram showed very poor oral motor function with liquids/thin puree, better with apple crisp texture; occupational therapist recommended that she continue using a G-tube for liquids as a primary source of nutrition. Allow oral feedings of pureed foods other than pudding or mild products. 10/93 NMC [Nutritional Management Committee] decided no food at	

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		this time." The recommendations were: "HT [Habilitation Therapies] - continue with G-tube for all nutrition and medication as [Individual #385] has significant history of aspiration pneumonia prior to G-tube placement. Too great of an aspiration risk to perform swallow study." The APEN evaluation did not provide adequate documentation to support the appropriateness of receiving enteral nutrition, justification to continue receiving enteral nutrition, or current strategies that had been implemented to determine the appropriateness of a less restrictive approach to eating. The OT/PT Evaluation Update, dated 8/5/10, did not assess her potential for a less restrictive approach to eating. ▪ Individual #121's APEN evaluation, not dated, stated: "Due to decline in oral motor skills, ongoing issues with aspiration pneumonia, and results from last video [3/23/05] attempts to return to oral feeding have not been made." The APEN evaluation did not provide adequate documentation to support the appropriateness of receiving enteral nutrition, justification to continue receiving enteral nutrition, or current strategies that had been implemented to determine the appropriateness of a less restrictive approach to eating. The purpose of an APEN Evaluation was to determine if receiving nutrition by tube was medically necessary, and, where appropriate, to implement a plan to return the individual to a less restrictive form of receiving enteral nutrition and/or a return to oral feeding. As illustrated above in individual examples, the APEN evaluations did not evaluate the medical necessity of the tube, and/or determine if a less restrictive approach to receiving enteral nutrition was possible and, if appropriate, recommend the development and implementation of a plan to return an individual to oral eating. <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 seven records, individuals were provided with a PNMP that: ▪ In seven of seven records (100%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In seven of seven records (100%), transfer instructions were included. ▪ In seven of seven records (100%), staff instructions were provided to identify the prescribed time an individual was to remain upright after receiving enteral nutrition. ▪ In three of seven records (43%), strategies for medication administration were included. Individual #178, Individual #121, Individual #188 and Individual #385 needed additional staff instructions for medication administration. ▪ In seven of seven records (100%), strategies for oral hygiene were included. ▪ In seven of seven records (100%), individual adaptive equipment was included. ▪ In seven of seven records reviewed (0%), bathing/showering positioning and	

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		instructions were included. ▪ In none of seven records (0%), personal care instructions for elevation during checking and changing were included. ▪ In seven of seven records reviewed (100%), communication strategies were included. The following provide examples of concerns identified as a result of this review: ▪ The dining plan instructions in Individual #385's PNMP, revised 9/13/10, were to provide all nutrition, fluids, and medication by gastrostomy tube. The wheelchair was to be "reclined if needed to maintain upright posture during G-tube feedings." Additional staff instructions were needed for elevation in wheelchair during medication administration and degree of reline, if needed, while receiving enteral nutrition. Staff instructions for personal care were also needed. ▪ Individual #188's PNMP, revised 6/25/10, stated: "wheelchair may be reclined during G-tube feedings," but did not state how far the wheelchair could be reclined. The PNMP also stated: "DO NOT lay flat," which might be confusing to staff. It would have been more helpful to identify the position that could be used during personal care (check and change). ▪ Individual #117's PNMP, revised 3/14/11, wound precautions stated: "check & change every 2 hours DAY & NIGHT." No staff instructions were provided for safe degree of elevation during check and change. The draft Head of Bed Elevation Assessment Protocol, undated, stated: "All individuals who require elevation for GERD, enteral eating, respiratory/breathing concerns, medication administration, oral care, hygiene, etc. must be evaluated for a range of appropriate elevation levels. A maximum and minimum elevation is determined to accommodate various activities." This protocol was in the initial stages of implementation. The results of the HOBE assessment might necessitate changes to individuals' PNMPs to identify the appropriate elevation range to support safety during activities throughout the 24-hour day. <u>The need for continued enteral nutrition is integrated into the PSP.</u> Based on a review of seven individuals' PSPs who received enteral nutrition, none (0%) of the individuals' PSPs documented the rationale for the continued need for enteral nutrition, attempts to return the individual to oral intake, or the least restrictive method of receiving nutrition. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).</u>	

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		The DADS At-Risk Individuals policy (Policy Number 006, dated 11/02/10) stated: "a regular risk assessment and management system will be used to identify persons at risk of illness and injury." A component of the At-Risk Individuals policy required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition. The assessment is designed to reduce the incidence of aspiration pneumonia and its complications and to assess continued need for enteral eating." All individuals who were enterally nourished were to be evaluated using the APEN evaluation format. According to the documentation provided, five of the seven individuals within this sample had received an annual APEN evaluation, but these evaluations were not adequate, as documented above. <u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.</u> The following provides an example of an individual for whom efforts were made to promote oral intake. However, concerns were noted with regard to the process used. ▪ A Consultation Request/Report, dated 11/4/10, for Individual #430 requested "Videoesophagram to assess client's ability to return to oral food. [Individual #430] had aspiration pneumonia (4/09) and MBS in hospital that showed 'mild aspiration and penetration.' She has been seeking food and liquid recently. Please evaluate." The consultation described the results of the videoesophagram. The second Consultation Request/Report, dated 12/22/10, requested: "OT to trial snack by mouth daily." Trial oral snacks were initiated on 12/23/10. A Consultation Report included recommendations from a team meeting on 2/15/11 to discuss Individual #430's progress, and to discuss her transition to meals by mouth. A Proposal for transition to Meals by Mouth for [Individual #430], dated 2/15/11, presented a brief history of meals by mouth, the G-tube, her current status of snack and meal trials with assessment, and two options for moving her forward in this process. An OT/PT service log was submitted with nine entries from 1/10/11 to 4/27/11. Six of the entries reported on her progress with snacks, one entry related to a team meeting, two entries discussed a trial of a meal, and the last entry stated: "[Individuals #430] reached her goal of eating by mouth 3 meals/day. DCS has been trained to assist her, her oral intake is fair to good and she's discharged from active OT services. Extensive records are in her POR." No Integrated Progress notes were submitted for review. The Facility was to be commended for the implementation of snack and mealtime trials to transition Individual #430 from enteral feeding to oral intake,	

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		but her plan was not comprehensive nor were there identified timelines for reporting her progress in this transition. The implementation of the plan to return her to oral eating had significant gaps in documentation and monitoring. For example, a tracking form for Meals by Mouth to document breakfast and noon meals by mouth from 3/7 to 3/10/11 was blank. A formal plan should have included action steps to the achieve recommendations, identified staff who were responsible for implementing action steps, identified anticipated completion dates, and defined the supporting documentation that was needed to determine if recommendations were achieved. Multiple recommendations were made without final resolution. In addition, no formal monitoring was conducted to document her success. It was unclear if the intermittent OT documentation in a service log was documented in her integrated progress notes.	

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

1. A continuing education tracking system for PNMT members should be implemented to consistently document attendance through training rosters and/or certificate of completion for state-sponsored webinars, off-site clinical instruction, and conferences. The Habilitation Director should review the information regularly to ensure that staff were attending continuing education sessions as appropriate. (Section O.1)
2. PSTs should receive additional training to understand and implement the guidelines documented in the Referral Process to PNMT Protocol. This training should detail the criteria for referral of individuals to the PNMT; indicators for immediate referral to the PNMT; information to be provided to the PNMT for individuals being referred; philosophy of the PNMT process; and explanation of the PNMT process, including the components of the comprehensive assessment, development of action plans, and integration of PNMT action plans into PSPs and related documents, such as the PNMP, Behavior Support Plan, Health Management Plan, etc. (Section O.1)
3. The addition of another dietician would be of beneficial to lower the current caseloads of the two dietitians, and enable the dietician assigned to the PNMT to lessen her caseload and provide additional support to the PNMT members and individuals on the PNMT caseload. (Section O.1)
4. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs, PNMT members should:
    a. Clearly document on the PNMT evaluation and action plan when the referral was received for an individual;
    b. Clearly document the PNMT action plan development date and implementation date;
    c. Ensure staff complete performance check-offs to document competency for identified skills recommended on the PNMT action plan;
    d. Implement a mechanism to report a change in an individual's status to the PNMT to enable the PNMT to evaluate the plan, and/or make modifications to the plan; and
    e. Establish a review process to determine the efficacy of individual strategies as measured by progress toward or the attainment of identified PNMT outcomes. (Section O.2)
5. For individuals who must be elevated and not be placed in a flat supine position, current strategies in PNMPs should be reassessed to identify appropriate elevation levels. PNMPs should reflect elevation strategies in every environment for those individuals who are at risk of aspiration pneumonia, have a diagnosis of GERD, or have other related health risk indicators (i.e., respiratory concerns). (Section O.2)
6. PNMP strategies should be integrated within an individual's nursing care/healthcare plan, and competency-based training provided to nursing staff to support nurses during medication administration, as well as other procedures requiring attention to individual triggers, adaptive equipment, positioning, and presentation techniques. (Section O.2)

7. To support mealtime safety, the Facility should:
    a. Provide competency-based training to mealtime supervisors/coordinators, including a mealtime training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas:
        - Mealtime position and alignment;
        - Diet texture and fluid 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;
        - Risk indicators and problem solving; and
        - Techniques to promote optimal levels of independence and skill acquisition during mealtimes.
    b. Develop and implement competency-based performance check-offs for mealtime supervisors/coordinators to ensure PNMPCs are competent with mealtime learner objectives.
    c. Develop competency-based training and performance skills check-off for mealtime monitors.
    d. Establish a validation and re-revalidation process for mealtime monitors, which involves auditing mealtime supervisors/coordinators to ensure competency with mealtime indicators;
    e. Establish protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems.
    f. Establish compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic.
    g. Ensure a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk due to aspiration pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc. (Section O.4)
8. The HT Department should re-evaluate the New Employee Orientation (NEO) PNM sections that only had a written test, and develop a staff performance check-off for foundational PNM skills. (Section O.5)
9. As was recommended in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include:
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, tooth brushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.);
    b. A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;
    f. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    g. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
    h. Establishment of thresholds for staff re-training. (Section O.6)
10. 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 QA/QI, Incident Management and Risk Management systems. (Section O.6)

11. The PNMT and PSTs should integrate measurable, functional outcomes into action plans and skill acquisition programs, and provide documentation on a monthly basis to address the progress of individuals relative to their action plans and skill acquisition programs. (Section O.7)
12. Aspiration Pneumonia/Enteral Nutrition Evaluations should evaluate the potential for moving an individual to a less restrictive form of receiving enteral nutrition. (Section O.8)
13. Information gained from the APEN evaluations should be integrated, as appropriate, into individuals PSPs, Risk Action Plans, nursing care plans and PNMPs. Any plans developed to modify the individual's feeding should be accompanied by measurable, functional outcomes, which should be used to measure the efficacy of the plan. (Section O.8)

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

1. The Facility Administration, in collaboration with Habilitation Therapies, might want to consider developing a method to identify staffing ratios for mealtimes/snacks. (Section O.4)

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 Presentation for Settlement Agreement Monitoring Team Visit for Section P, not dated; o The following documents requested: OT/PT Evaluations, OT/PT Consultations for the past year, supporting documentation for individuals receiving direct OT/PT services, PST Integrated Risk Rating Form, PST Action Plan for Risk, PSP and PSPAs for the past year, PNMP with pictures, PNMP Clinic Notes for the past year, person-specific monitoring, competency-based training for staff, dining card/diet card, for the following 15 individuals: Individual #334, Individual #43, Individual #147, Individual #395, Individual #285, Individual #142, Individual #433, Individual #262, Individual #430, Individual #389, Individual #188, Individual #336, Individual #81, Individual #423, and Individual #194; o OT/PT Evaluation for Individual #109; o List of OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and AT Staff, dated 4/15/11; o OT/PT CE Courses, from 2/10 through 2/11; o List of Individuals who use Wheelchair as Primary Mobility, dated 4/13/11; o List of Individuals with Transport Wheelchairs, dated 4/14/11; o List of Individuals with other Ambulation Assistive Devices, dated 4/14/11; o List of Individuals with Orthotics and/or Braces, dated 4/14/11; o List of Individuals who have had a Decubitus/Pressure Ulcer, from 1/10 through 3/11; o List of Individuals who have experienced a Falling Incident, from 3/10 through 4/11; o OT/PT Assessments and corresponding PSPs, from 2/11 through 3/11; o Wheelchair Seating/PNM Clinic Assessments along with corresponding PNMPs, from 2/10 through 4/11; o Wheelchair and PNM Clinic Assessment Templates (blank), not dated; o OT/PT Monitoring Forms, from 3/11 and 4/11; o PNM Maintenance Log utilized to Track Modifications made to Individuals' Adaptive/Assistive Equipment, from 10/10 through 2/11; o OT/PT-related Spreadsheets, not dated; o Assistive Equipment/PNMP Checklist, dated 5/11; o List of Individual with Decubitus, dated 4/18/11; o Wheelchair Quarterly Maintenance Log, from 1/11 through 3/11; and o List of Individuals receiving Direct OT/PT Services, not dated. ▪ **Interviews with**: o Kim Ingram, MEd, CCC/SLP, Habilitation Therapies Director; and o Karen Hardwick, State Coordinator of Specialized Therapies.

	▪ **Observations of**: o Residence and dining room for 732P, and dining rooms for 732D, 732E, 779F, 779H, 779R, Infirmary, and 727C.
	Facility Self-Assessment: The AUSSLC Plan of Improvement/Self Assessment, updated 4/26/11, provided comments/status for Section P. Compliance for each of these sections was documented as noncompliance. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: According to the current census, there were 361 individuals living at AUSSLC. A list of therapy staff with titles, caseloads, and license numbers was requested. There were five budgeted positions for Occupational Therapy. The Facility had five full-time Occupational Therapists. A newly hired Occupational Therapist would not assume responsibility for a full caseload until June or July. There were no unfilled Occupational Therapist positions. AUSSLC had 4.7 budgeted positions for physical therapy. At the time of the review, these positions were filled. The OT and PTs attended a wide variety of continuing education courses and conferences, but did not consistently attend state-sponsored continuing education courses. As stated above with regard to Section O.1 of the Settlement Agreement, PNMT members (OT, PT, SLP and Nurse) attended these courses, but OTs and PTs should attend these courses as well, because they are responsible for providing assessments for individuals identified at risk. A number of concerns continued to be noted with regard to the provision of OT/PT supports. Direct and indirect therapy interventions should be analyzed, during the assessment and/or update process, as well as in clinical progress notes to determine if progress is being made and/or if changes need to be instituted. Justification for therapy interventions should be outlined in the analysis of findings section to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies. As appropriate, therapy plans should be integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. These supports should be defined in an individual's PSP. Monthly documentation should justify the initiation, continuation or discontinuation of assessment recommendations, and provide a status on the achievement of measurable outcomes. Quarterly documentation should be provided for the provision of indirect supports. There should be a formal process for implementing changes in an individual's supports, when progress is made and/or a lack of progress is noted, including a timeframe for re-evaluation.

<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><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 361 individuals living at AUSSLC. A list of therapy staff with titles, caseloads, and license numbers was requested. HT staff titles, current home assignments and license numbers was submitted. There were five budgeted positions for Occupational Therapy, and these positions were filled. A newly hired Occupational Therapist would not assume responsibility for a full caseload until June or July. There were no unfilled Occupational Therapist positions.

AUSSLC had 4.7 budgeted positions for physical therapy. At the time of the review, these positions were filled. The following chart represented the current therapists' caseloads, as reported for 361 individuals:

<table>
<tr><th>Occupational Therapist(s)</th><th>Current Caseloads and Responsibility</th></tr>
<tr><td>OT #1</td><td>Dedicated to PNMT, and supporting individuals in 727-C</td></tr>
<tr><td>OT #2</td><td>Lead OT, and supported individuals in residences 783, 779-H, 779-R, and 732-D</td></tr>
<tr><td>OT #3</td><td>Supported individuals in residences 732-E, 729, 786, 791, 793, 730, 772, 784, 785, 788, 789, 797, and 782</td></tr>
<tr><td>OT #4</td><td>Supported individuals in residences 732-M, 779-F, 781, 787, 792, 796, 794, and 795</td></tr>
<tr><td>OT #5</td><td>To assume a full caseload in June or July 2011</td></tr>
<tr><th>Physical Therapist(s)</th><th>Current Caseload</th></tr>
<tr><td>PT #1</td><td>PNMT Member, and supporting individuals in 727-C, 730, 772</td></tr>
<tr><td>PT #2</td><td>Lead PT and supported individuals in residences 732-E and 782</td></tr>
<tr><td>PT #3</td><td>Supported individuals in residences 783, 785, 788, 789, 797, 794 and 795</td></tr>
<tr><td>PT #4</td><td>Supported individuals in residences 729, 791, 793, 732-M, 779-F, and 781</td></tr>
<tr><td>PT #5</td><td>Supported individuals in residences 786, 787, 792, 796, 779-H, and 779-R</td></tr>
</table>

Staffing was potentially one factor that resulted in the inadequate provision of occupational and physical therapy supports to individuals. As is documented throughout this section of the report, individuals were not receiving needed supports.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		In sum, therapists were not active members of the PSTs, as evidenced by their collective absence from annual PSP meetings, insufficient provision of direct therapy, lack of completion of comprehensive OT/PT Evaluation updates, lack of a provision of an update when a change in status occurred, insufficient development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the lack of development of informal strategies to reinforce assessment recommendations and measurable outcomes. The OT and PTs attended a wide variety of continuing education courses and conferences, but did not consistently attend state-sponsored continuing education courses. As stated above with regard to Section O.1 of the Settlement Agreement, PNMT members (OT, PT, SLP and Nurse) attended these courses, but OTs and PTs should attend these courses as well, because they are responsible for providing assessments for individuals identified at risk. Per report, three of the 361 individuals (Individual #43, Individual #147, and Individual #199) residing at AUSSLC (less than 1%) were receiving direct OT/PT services for wound care. Fifteen (15) records were reviewed, including those for: Individual #334, Individual #43, Individual #147, Individual #395, Individual #285, Individual #142, Individual #433, Individual #262, Individual #430, Individual #389, Individual #188, Individual #336, Individual #81, Individual #423, and Individual #194. These 15 individuals had identified needs related to, but not limited to choking, movement, mobility, range of motion, independence, regression of functional skills, a change in status, identified high risk indicators, and/or community transition. However, as is discussed in further detail below, AUSSLC was not providing them with adequate OT/PT services. <u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u> Since the last review, there was one individual (Individual #109) admitted to AUSSLC. Individual #109 received an OT/PT evaluation within 30 days of admission. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> The AUSSLC OT/PT Evaluation template, not dated, included the following sections: ▪ General information; ▪ Behavioral consideration; ▪ Motor/functional evaluation/PNMP to include physical management information, reflexive/orthopedic abnormalities, range of motion, muscle	

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		tone/strength, handling/transferring, mobility/locomotion, respiratory function, sensorimotor function, fine motor function, and activities of daily living; ▪ Oral motor/eating ability/nutritional status to include nutritional status, oral/developmental abnormalities, oral control, diet texture/method of feeding, behavioral considerations, eating equipment, and mealtime techniques; ▪ Assistive/supportive devices; ▪ Summary/recommendations; ▪ Measurable objectives; ▪ Responsible persons; ▪ Monitoring schedule/staff; and ▪ Reassessment schedule. The evaluation template provided guidelines for the OT/PT assessment and acknowledged: "all sections will not be applicable to all individuals." The following instructions were provided: ▪ Always provide analysis of findings and rationale for recommendations. Include functional, measurable objective, as applicable. ▪ Ensure that recommendations are clearly stated and include responsible persons for implementation and criteria to monitor and assess efficacy of the program. ▪ Ensure that recommendations for supports or activities other than direct therapy requiring a licensed professional are incorporated into the PSP so they may be integrated into the individual's daily routines. As detailed below, the Monitoring Team recommends additional information be added to the OT/PT template. The template for OT/PT/ST Habilitation Therapies Update, undated, included the following sections and within each section there were subsections: ▪ Risk levels; ▪ Consultations/evaluations in past year; ▪ Assistive equipment; ▪ Other services/supports; ▪ Physical Nutritional Management Plan; ▪ Eating/dining/swallowing; ▪ Recommendations; and ▪ Measurable objectives. The majority of the sections included the incorporation of rationale/assessment findings, efficacy, recommendations, and measurable objectives. However, the template	

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		did not include the guidance necessary to ensure a complete evaluation was conducted. The following guidance should be incorporated into the AUSSLC OT/PT evaluation and update templates: ▪ Assessment processes should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment; ▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; ▪ There should be an analysis of findings to provide a rationale for functional recommendations and intervention strategies; ▪ Recommendations should be integrated into an individual's PSP; ▪ Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and ▪ A process should be delineated for implementing changes in an individual's supports when progress is made or a lack of progress is noted. The lack of progress would identify a re-evaluation timeframe. <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 a subset of the sample previously identified, 11 of these 12 individuals (Individual #142, Individual #285, Individual #334, Individual #395, Individual #81, Individual #389, Individual #188, Individual #336, Individual #262, Individual #194, Individual #433 and Individual #423) (92%) had an OT/PT evaluation completed within the past three years. However, the following are examples of concerns that were noted: ▪ Individual #142 experienced a change of status when she transitioned from AUSSLC to a community residential placement in November 2010. Her OT/PT Evaluation Update, dated 1/14/10, did not address her potential for community transition. She did not receive an update prior to her transition to provide essential information to her community provider. ▪ Individual #334 was admitted to the hospital on 5/9/11 for placement of a gastrostomy tube. His OT/PT Update, dated 10/22/10, did not discuss his history of medication refusal. A PSP Addendum, dated 4/15/11, stated the PST had met and discussed assessing Individual #334 for placement of a gastrostomy tube. The PST "discussed and agreed that [Individual #334] will have his g-tube placement done on him for administration of medication due to a long history of refusing to take his medication via his mouth." It was unclear why an interdisciplinary assessment involving nursing, psychology, and therapy services was not completed to develop and implement strategies for medication administration prior to placement of a gastrostomy tube.	

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		▪ Individual #194's Integrated Risk Rating Form, dated 4/8/11, documented her at medium risk for aspiration pneumonia, even though she was diagnosed with aspiration on 3/19/10. No risk action plan was developed. Her most current OT/PT Update, dated 7/19/10 for OT and 8/12/10 for PT. A Consultation Report was requested, because Individual #194 had had reduced oral intake with weight loss from 120 to 122 pounds down to a February 2011 weight of 103 putting her below her estimate desired weight range (EDWR) of 112 to 128 pounds. It had been reported that she has been complaining of her throat hurting. The consultation stated: "The team needs to meet to assess the risk vs. benefit of [Individual #194] continuing to eat by mouth. Although she has a long history of pneumonias, it appears that pneumonias have become more frequent in the past three years. Silent trace aspiration on video has been infrequent. Her esophageal dysmotility poses the risk of food stacking up in the esophagus and possible backing up to the level of the pharynx. This would put her at greater risk of aspiration. Although esophageal clearing is shown with liquid during a brief video, this may not be predictive of what happens during a meal." There was no PSPA to discuss the results of the consultation report, no APEN evaluation had been completed, and no referral to the PNMT due to possible placement of a feeding tube. Individual #194 was hospitalized on 5/6/11 with a diagnosis of aspiration pneumonia and UTI. ▪ Individual #433 was observed completing a poorly executed pivot transfer from a wheelchair to a dining chair with staff assistance. Her PNMP, revised 3/28/11, documented that she transferred independently, which the Monitoring Team did not observe. No OT/PT update had been completed to assess this potential change in status. There were no competency check sheets submitted for Individual #433. ▪ The PSP for Individual #244 described the supports for her future physical living environment as: "[Individual #244] needs a home that has few obstacles that pose a fall hazard for her. The furniture should also not be moved much. [Individual #244] has a degenerative condition with her eyes. [Individual #244] will continue to have vision loss." Her PSP listed her completed assessments, but she had not received an Orientation and Mobility assessment. Individuals residing at AUSSLC who are visually impaired should have an assessment completed by a certified Orientation and Mobility specialist to identify needed essential supports. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u> Two of the 11 OT/PT evaluations reviewed (18%) (Individual #389 and Individual #262) addressed medical issues and health risk indicators that would have an impact	

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		on the analysis utilized to establish rationale for recommendations/therapeutic interventions. <u>Evidence of communication and or collaboration is present in the OT/PT assessments.</u> Based on record review, nine of the 11 OT/PT Evaluations (Individual #142, Individual #334, Individual #395, Individual #389, Individual #336, Individual #194, Individual #433, Individual #423, and Individual #81) (82%) included signatures and date by the OT and PT.	
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.	<u>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.</u> Based on a review of two individuals (Individual #43 and Individual #147), who were selected from the submitted list of three individuals receiving direct/indirect OT/PT services, for none of the two (0%) were the wound care and prevention instructions recommended in their OT/PT Evaluation Update and/or Consultation Report, and/or integrated into their PSPs. The following individual example illustrates the absence of a comprehensive plan and/or documentation of integration into the PSP: ▪ Reportedly, Individual #43 was receiving direct PT for wound care. The PT Wounds-Decubiti List, not dated, documented "Stage 2 pressure wound on right lateral malleolus (originally presented as callous with erythema around the borders.) Staff in-serviced on re-positioning every 2 hours in bed. Booties given to wear in bed. She already has a pressure-reducing mattress. Duoderm used to slough off the thick skin." Her OT/PT Evaluation Update, dated 5/13/10 and 5/17/10, documented nine skin tears from 7/09 to 7/10. The PT treated two of these tears, and nursing treated the remaining ones. The recommendation was made to "continue Physical/Nutritional Management Plan (PNMP) to provide mobility and positioning, reduce the risk of skin problems, promote safe and independent dining, and prevent complications from reflux. Report discrepancies or changes in function to OT/PT for consideration of plan." An Interim Staffing, dated 11/13/10, was convened to "discuss [Individual #43's] skin tear that was discovered on her lower left leg on 11/13/10." The PT "noted that her injury was 'L' shaped and 2.5 centimeters high by 2 centimeters in length. After reviewing [Individual #43's] active, record, it was apparent that these skin tears on her lower legs have been documented as far back as July 2010. Her PT suggested using compression socks for protection since they contain anti-bacterial properties and [Individual #43's] skin is particularly thin and fragile. An order for these socks has been placed and she will wear them both during the day and evening." Another Interim Staffing, dated 12/21/10, was held by the PST to "come up with ideas about how to reduce the occurrence of her skin tears." Different strategies were discussed and a follow-up was to be completed by her QMRP. The next	Noncompliance

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		Interim Staffing, dated 3/21/11, was held to "discuss [Individual #43's] recent decrease in weight." She was reported to weigh 95.8 pounds and was significantly below her EDWR of 113-126. The Interim Staffing did not provide a weight history. Individual #43's PT developed wound care instructions for her right upper arm lateral aspect and right lower leg (if needed), dated 10/8/10, with a supply list and seven written instructions. Wound care instructions were developed for her left lower leg (if needed), dated 4/15/11, and included a list of supplies and eight instructional steps. All wound care was to be documented in progress notes. No PT consults had been completed within the past year even though she experienced a change in status with multiple skin tears. The PT and dietitian did not attend her PSPA meeting to assign risk levels, and to formulate an action plan to address her identified risk levels, even though her significant weight loss and poor skin integrity placed her at risk. The objective for skin integrity was: "[Individual #43] will maintain the best possible health by having 3 or fewer episodes of skin impairment during the next 12 months." The action steps were to apply Vitamin E oil to skin twice daily, provide care immediately when in need of brief changes and moisturize skin appropriately, follow PNMP for proper positioning and transfers, and report skin breakdown to nursing/medical staff for treatment. These staff strategies had been in place previously, but Individual #43 continued to experience skin tears. The PST needed the expertise of the PT during the discussion of an assignment of a risk level for skin integrity, as well as providing a more aggressive approach to minimizing her risk related to skin integrity. Direct and indirect therapy interventions should be analyzed, during the assessment and/or update process, as well as in clinical progress notes to determine if progress is being made and/or if changes need to be instituted. Justification for therapy interventions should be outlined in the analysis of findings section to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies. As appropriate, therapy plans should be integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. These supports should be defined in an individual's PSP. Monthly documentation should justify the initiation, continuation or discontinuation of assessment recommendations, and reflect the status of measurable outcomes. Quarterly documentation should be provided for the provision of indirect supports. There should be a formal process for implementing changes in an individual's supports, when progress is made and/or a lack of progress is noted, including a timeframe for re-evaluation. <u>Within 30 days of development of the plan, it is implemented.</u>	

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		As stated above, there were wound care plans developed and implemented for two individuals (Individual #43 and Individual #147), but none of these two (0%) individuals' formal wound care programs were integrated into formal and/or informal current PSP Action Plan objectives and/or skill acquisition programs. 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. Based on documentation provided, none of the two individuals (Individual #43 and Individual #147) (0%) with direct and/or indirect PT services had their plans integrated into the PSP. 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. When individuals' status changed, there was not consistent review and/or modifications to plans. This is discussed in further detail in P1above.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	Staff implements recommendations identified by OT/PT. Multiple examples are provided above with regard to Section O.4 of the Settlement Agreement with regard to staff not following PNMPs, which OTs and PTs had recommended. Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. Based on review of individual records, direct support professionals were identified as competent to implement comprehensive OT/PT interventions and supports as outlined in the PNMPs and other activity plans for none of 11 individuals reviewed (0%). Some examples are provided with regard to Section P.1 in which not all staff had received competency based training and completed competency check sheets for identified PNMP strategies.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and	System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology. No Facility policy was submitted to define a system to routinely evaluate fit, availability, function and condition and effectiveness of all adaptive equipment/assistive technology. The Checklist for PNMP Clinic, not dated, was submitted with the following information: ▪ PNMP - current copy, temporary changes, and copies of revised PNMPs in the past year; ▪ Update - copy of last update; ▪ Wheelchair - copy of last wheelchair evaluation and work orders from past	Noncompliance

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	effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	year; ▪ OT/PT Consults - copy of consults; ▪ OT Data Sheet - data sheet completed and/or copies of request info; ▪ PT Data Sheet - Data sheet completed and/or copies of request info; ▪ Diet card - current copy; ▪ Dining Plan - current copy with picture; ▪ Physician's Orders - current copy; ▪ Medication Sheet – current copy; and ▪ NMT [Nutritional Management Team] – copy of individual report. The Monitoring Team assumed this information was to be present during the PNMP Clinic. The PNMP Clinic Flow sheet, not dated, included the following components: PNMP focus, communication, NMT, skin integrity, pressure mapping, foot assessment, upper extremity/orthotics, handling techniques, transfers, ambulatory status/ambulation devices, gait analysis, seating goals, wheelchair evaluation, mat assessment, circulatory assessment, seating simulation, respiration, and PNMP pictures. No Facility procedures and/or guidelines were presented to address the PNMP Clinic. None of the 14 individual records reviewed (Individual #334, Individual #43, Individual #147, Individual #395, Individual #142, Individual #433, Individual #262, Individual #430, Individual #389, Individual #188, Individual #336, Individual #81, Individual #423, and Individual #194) (0%) documented a comprehensive evaluation/review during the PNMP Clinic to evaluate the fit, availability, function, condition, and effectiveness of all prescribed PNMP adaptive/assistive equipment. Multiple tracking databases were submitted, but no procedures/guidelines were submitted to identify the purpose of the system(s). Moreover, no documentation was submitted to show the completion of an administrative audit of these systems to determine if they were effective, and/or if revisions needed to be implemented. A Blank Assistive Equipment/PNMP Checklist(s) for May 2011 was provided for the Cardinal residence as part of the document request. This document acknowledged: "signed checklist verifies all equipment is present, in good repair, and the PNMP is being carried out as prescribed. Immediately report missing or broken equipment to Hab Therapies X6103. At the end of the month, give completed checklists to PNMP Coordinator." There were no procedures/guidelines provided to explain who completed this form, and what type of support was provided to staff completing this checklist. Two additional databases were submitted for review, including the Wheelchair Quarterly Maintenance, and Wheelchair/Positioner Spreadsheet. These included various fields related to wheelchairs, their condition, and related repairs. However,	

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		without a description of the processes in place, it was difficult to determine how this information was collected, maintained or used. The Facility should develop procedures to ensure individuals' adaptive/assistive equipment will be reviewed annually for the fit, availability, function, condition, and effectiveness. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. Hundreds of Habilitation Therapies PNMP Observation and Training Roster(s) were submitted that were completed during the "last month." No formal analysis had been completed to identify individual-specific and/or systemic issues related to staff compliance and/or non-compliance. 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 Settlement Agreement). Systemic and individual-specific issues related to training staff are discussed above with regard to Section O.5 of the Settlement Agreement. 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 Settlement Agreement). Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. As discussed above, adequate safeguards were not in place to ensure each individual had appropriate adaptive and assistive technology supports. 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 Settlement Agreement).	

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		As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff on individual-specific plans was not being completed. Data collection method is validated by the program's author(s). For none of the two individuals (0%) receiving direct OT/PT services for wound care was the data collection method validated by the program's author.	

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

1. As recommended with regard to Section O.1, therapists should attend state-sponsored continuing education courses. (Section P.1)
2. The following guidance should be integrated into the OT/PT Evaluation template:
    a. Assessment processes should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment;
    b. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;
    c. There should be an analysis of findings to provide a rationale for functional recommendations and intervention strategies;
    d. Recommendations should be integrated into an individual's PSP;
    e. Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and
    f. A process should be delineated for implementing changes in an individual's supports when progress is made or a lack of progress is noted. The lack of progress would identify a re-evaluation timeframe. (Section P.1)
3. The Facility should develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines as outlined in the OT/PT evaluation template. (Section P.1)
4. Individuals residing at AUSSLC who are visually impaired should have an assessment completed by a certified Orientation and Mobility specialist to identify needed essential supports. (Section P.1)
5. With regard to the provision of direct and indirect therapy services:
    a. Direct and indirect therapy interventions should be analyzed, during the assessment and/or update process, as well as in clinical progress notes to determine if progress is being made and/or if changes need to be instituted.
    b. Justification for therapy interventions should be outlined in the analysis of findings section to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies.
    c. Therapy plans should be integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. These supports should be defined in an individual's PSP.
    d. Monthly documentation should justify the initiation, continuation or discontinuation of assessment recommendations, and reflect the status of measurable outcomes.
    e. Quarterly documentation should be provided for the provision of indirect supports.
    f. There should be a formal process for implementing changes in an individual's supports, when progress is made and/or a lack of progress is noted, including a timeframe for re-evaluation. (Section P.2)
6. The Facility should develop procedures to ensure individual's adaptive/assistive equipment will be reviewed annually for the fit, availability, function, condition, and effectiveness. Guidelines should ensure at least the following:
    a. Therapist's signatures document their PNMP Clinic attendance;
    b. All PNMP prescribed assistive equipment is assessed on an annual basis for fit, availability, function, condition and effectiveness; and
    c. A documentation process is established for resolution of problems with fit, availability, function, and condition of prescribed equipment. (Section P.4)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**; o Dental Clinic Annual Assessments October 2010 to March 2011; o Dental Clinic most recent /current Facility oral hygiene; o Individuals receiving suction tooth brushing services; o Oral Hygiene Corrective Action Plans for Residents Examined in the past six months; o Residents with dental x-rays, comment from Dental Director regarding request; o Percentage of individuals utilizing IV anesthesia out of total number of completed appointments, from October 2010 to March 2011; o Percentage of individuals utilizing oral sedation out of total number of completed appointments, from October 2010 to March 2011; o Percentage of individuals utilizing mechanical support out of total number of completed appointments, from October 2010 to March 2011; o Individuals who have not seen the dentist in the past year; o Annual Dental Assessments completed between 3/25/11 and 4/25/11, and 2010 annual dental assessments of same individual for the following: Individual #355, dated 4/6/10, and 3/30/11; Individual #244, dated 5/3/10, and 4/25/11; Individual #21, dated 4/6/10, and 4/5/11; Individual #72, dated 4/29/10, and 4/25/11; Individual #160, dated 4/7/10, and 4/5/11; Individual #204, dated 4/15/10, and 4/4/11; Individual #113, dated 4/20/10, and 4/13/11; Individual #3, dated 4/13/10, and 4/5/11; Individual #248, dated 3/17/10, and 4/7/11; Individual #457, dated 3/30/10, and 3/29/11; Individual #85, dated 4/8/10, and 4/6/11; Individual #65, dated 4/12/10, and 4/6/11; Individual #315, dated 4/20/10, and 4/13/11; Individual #122, dated 4/26/10, and 4/18/11; Individual #22, dated 4/22/10, and 4/20/11; Individual #143, dated 5/20/10, and 4/7/11; Individual #97, dated 3/15/10, and 3/28/11; Individual #16, dated 4/1/10, and 3/31/11; Individual #149, dated 4/22/10, and 4/7/11; Individual #452, dated 4/7/10, and 4/4/11; Individual #8, dated 4/5/10, and 4/4/11; Individual #433, dated 4/5/10, and 4/4/11; Individual #141, dated 4/26/10, and 4/20/11; Individual #340, dated 3/25/10, and 3/29/11; Individual #455, dated 4/15/10, and 3/28/11; Individual #194, dated 5/10/10, and 4/25/11; Individual #323, dated 5/10/10, and 4/25/11; Individual #239, dated 4/20/10, and 4/19/11; Individual #458, dated 4/28/10, and 3/28/11; Individual #265, dated 4/22/10, and 4/13/11; Individual #11, dated 4/15/10, and 4/4/11; Individual #260, dated 3/30/10, and 4/25/11; Individual #19, dated 4/5/10, and 3/31/11; Individual #36, dated 3/9/10, and 3/28/11; Individual #365, dated 4/22/10, and 4/5/11; and Individual #172, dated 4/20/10, and 4/20/11; o Annual Dental Assessments for the following individuals: Individual #315, dated 4/13/11; Individual #113, dated 4/13/11; Individual #265, dated 4/13/11; Individual #122, dated 4/18/11; Individual #239, dated 4/19/11; Individual #141, dated 4/20/11; Individual #22, dated 4/20/11; Individual #172, dated 4/20/11; Individual #149, dated 4/7/11; and Individual #248, dated 4/7/11;

	o Dental records for the following individuals: Individual #94, Individual #273, Individual #146, Individual #357, Individual #42, Individual #267, Individual #115, Individual #103, Individual #340, Individual #350, Individual #170, Individual #425, Individual #189, Individual #172, Individual #327, Individual #361; o For last five individuals to whom pretreatment sedation was administered, all information related to medical/dental pretreatment, for the following: Individual #248, Individual #96, Individual #143, Individual #149, and Individual #36; o Dental records for emergency appointments: Individual #175 on 3/3/11; Individual #29 on 2/22/11, Individual #94 on 12/10/10, Individual #354 on 11/16/10; Individual #119 on 1/13/11; and Individual #74 on 11/19/10; o Dental Clinic: [individuals] admitted to Facility from October 2010 through March 2011; o Dental Clinic: Dental Services other than Annual Exam from October 2010 through March 2011; o Dental Clinic: Refusals from October 2010 through March 2011; o Dental Clinic: Missed Appointments Other than refusals from October 2010 through March 2011; o Dental Clinic: Extractions from October 2010 through March 2011; o Dental Clinic: Dental Emergencies (abscess tooth, complications, etc.) from October 2010 through March 2011; o Dental Clinic: Preventative Care from October 2010 through March 2011 [cleanings fluoride (F12), MI paste (topical bio-available calcium and phosphate), night guard, etc.]; o Dental Clinic: Appointments for individuals who have had restorative dental care from October 2010 through March 2011; o Dental Clinic: Attendance from tracking log from October 2010 through March 2011; o List of no shows/missed appointments per building; o Refused appointments per building; o Dental Clinic: Refusals, Dates and Types of Appointments from October 2010 through March 2011 o Dental Clinic: oral surgery consults; o Dental Clinic: Interventions for Missed Appointments from October 2010 through March 2011; o Emails and Missed Dental Appointment Notices from October 2010 through March 2011; o Dental Clinic: IV anesthesia from October 2010 through March 2011; o Dental Clinic: Restraint and sedation portions of tracking list for completed appointments from October 2010 through March 2011; o For the past six months, a list of individuals who have received pre-treatment sedation medication for medical or dental procedures; o Pretreatment sedation assessments for the following: Individual #251, Individual #128, Individual #384, Individual #356, Individual #369, Individual #151, Individual #263, Individual #168, Individual #347, Individual #144, Individual #435, Individual #379, Individual #64, Individual #381, Individual #96, Individual #234, Individual #399, Individual #174, Individual #253, Individual #100, Individual #408, Individual #422,

	Individual #364, Individual #299, Individual #241, Individual #220, Individual #278, Individual #4, Individual #156, Individual #423, Individual #338, Individual #36, Individual #52, Individual #200, and Individual #363; o Annual dental assessments provided to PST for following: Individual #355, Individual #397, Individual #160, Individual #204, Individual #59, Individual #445, Individual #29, Individual #297, Individual #193, Individual #457, Individual #421, Individual #123, Individual #215, Individual #253, Individual #97, Individual #16, Individual #452, Individual #8, Individual #433, Individual #362, Individual #105, Individual #340, Individual #455, Individual #1, Individual #458, Individual #310, Individual #212, Individual #147, Individual #11, Individual #281, Individual #423, Individual #142, Individual #36, and Individual #52; o For 10 individuals given dental pre-treatment sedation, copies of progress notes from record and dental office from start of sedation to release from monitoring, including: Individual #384, Individual #168, Individual #54, Individual #399, Individual #241, Individual #220, Individual #4, Individual #156, Individual #338, and Individual #52; o Dental abbreviations; o Current list of HRC approved dental medical restraint with sedation; o Email correspondence from Dental Department to other departments, from 11/10 to 3/11 concerning development of oral sedation protocol, daily tooth brushing; o AUSSLC draft policy: Pre-Treatment sedation; o Pre-Treatment Sedation Committee minutes, from 10/25/10, 1/24/11, 3/10/11, and 4/14/11; o Policy/Procedure: San Angelo SSLC: Dental Care – Suction Tooth brushing, dated 5/18/10 o Suction Toothbrush Equipment Instructions, revised 6/21/10; o Meeting notes regarding suction tooth brushing, dated 1/21/11; o Directions and warnings for suction toothbrush; o Sample order for suction tooth brushing; o Meeting notes regarding suction tooth brushing, Phase II, dated 3/25/11; o Oral hygiene at AUSSLC, training PowerPoint by Dental Department for new employee orientation; o Local Dental Policies and procedures: • AUSSLC – Dental Clinic: Annual Dental Assessment Policy, Implementation date 4/1/11; • AUSSLC – Dental Clinic: Comprehensive Dental Care Policy, Implementation date 4/1/11; • AUSSLC – Dental Clinic: Dental Desensitization Policy, Implementation date 4/1/11; • AUSSLC – Dental Clinic: Criteria for Determining Usage of Enteral Sedation or Total Intravenous Anesthesia (TIVA), Implementation date: adopted 8/3/10, revised 3/28/11; and • AUSSLC – Dental Clinic: Missed/Refused Appointments Policy, Implementation date 4/1/11; and

	○ Training roster for above named policies, from Presentation Book Q. ▪ **Interviews with**: ○ Rhonda Stokley, DDS, Dental Director.
	Facility Self-Assessment: The Facility's POI for Section Q provided very limited information about the actions that had been taken to reach compliance, and no data was provided to substantiate the findings. The inclusion of such data obtained through record reviews, as well as other data sources will be an essential component of future POIs. In its POI, the Facility indicated that some steps had been taken address the Settlement Agreement. These areas were basic building blocks for future compliance, including: ▪ A number of dental policies were created, staff trained, and implementation begun. The POI did not indicate specifically which policies these were. However, the Presentation Book included a training roster, and the course title specified the policies on which training was completed. ▪ Suction tooth brushing was piloted on the unit serving individuals with the most medical complexities. ▪ Further steps were implemented in determining the cause of missed appointments. The Facility currently determined it remained noncompliant with the requirements of Section Q. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Dental Department continued to provide quality dental care, and thorough documentation of dental care and follow-up. However, many of the challenges outlined in the Settlement Agreement remained. The development of baseline information concerning oral hygiene ratings across the campus was an important first step. The challenge will be improvement in those rating scores over time. Half the campus had poor or very poor oral rating scores, needing urgent attention. However, dental hygienist training and mentoring in the residences was not part of the current dental services, but it is recommended that such a program be implemented. The need for effective desensitization programs remained, because otherwise the Dental Department was dependent on the use of IV sedation and oral sedation to attain the necessary cooperation to provide dental care. There remained concerns related to monitoring in the residences after oral sedation was administered, and before the dental visit occurred. There was much improved tracking of the missed appointments. However, the challenge will be to reduce the percentage of missed appointments, which will require the collaboration of a number of different departments. A successful suction tooth-brushing program was started and was in the second phase of expansion.

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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 Department indicated all individuals residing at AUSSLC had seen the dentist within the year prior to March 31, 2011. Considering there was only one dentist in the department for a campus the size of AUSSLC and the dental needs of many of the individuals, this was a remarkable accomplishment. There was one dental assistant, and there were two dental hygienists. A sample of annual dental assessments was submitted for 10 individuals. The assessment included sections on level of cooperation, current conditions (oral hygiene, teeth and restorations, periodontal status, and soft tissue exam), appliances, at-risk level, recommendations, and another section, which was used to provide detailed guidance to the PST and residential support staff in improving oral care. Additionally, the dental section of the active record and the integrated progress note section also included a brief progress note summarizing the findings of the annual dental assessment. Where appropriate, these sections were completed for all 10 annual dental assessments (100%). Thirty-four additional annual dental assessments were submitted as examples of the dental summaries provided to the PST as part of the annual team meeting. All 34 (100%) were consistent with the sample of 10 previously mentioned annual dental assessments. The Dental Department submitted a list of annual assessments completed from October 2010 through March 2011, along with the date of the previous annual dental assessment. During this six-month interval of time, 177 annual dental assessments were scheduled. Of these, 126 out of 177 were within 365 days of the prior annual dental assessment, resulting in a compliance rate of 71%. This was a challenge as 38 of these annual assessments had to be rescheduled due to missed appointments. There was one new individual admitted to AUSSLC. The initial exam and x-rays, as well as cleaning were completed within 30 days of admission. More recent data suggested a trend toward improvement. Dental assessments completed in the recent time period between 3/25/11 and 4/25/11 were compared to the dental assessments completed on the same individuals one-year prior. During this more recent time period, 36 annual dental assessments were completed. Of these 31 out of 36 (86%) were completed within 365 days of the prior annual assessment. The Dental Department was asked to submit a list of those individuals who were in need of x-rays according to professional standards. The Dental Director considered this request a "large gray area," and made a best attempt at determining those with outstanding x-ray needs. A total of 214 individuals were identified as having x-rays that met current standards. An additional 91 individuals were identified as not having current x-rays, and 56 individuals were edentulous and did not require x-rays. With a	Noncompliance

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		census of 361, a total of 305 individuals had x-ray requirements. Given that 214 of these 305 individual had current x-rays, a 70% rate of compliance had been achieved. The Dental Director noted several reasons or challenges. For those individuals undergoing TIVA, there were no barriers in obtaining x-rays. However, for the remainder, the ability to obtain x-rays depended on an individual's cooperation. Some would cooperate for bitewings, but not for periapical x-rays, which were associated with more gagging and discomfort. The Dental Director had the difficult task of determining the risk/benefit ratio of whether or not to place an individual under TIVA for x-rays. Additionally, the hours of anesthesia services per month were limited. This entire area was one in which successful desensitization plans could have an impact. The Facility's progress with regard to desensitization plans is discussed in detail with regard to Sections C.4 and J.4 of the Settlement Agreement. Additionally, a rigorous oral hygiene program in the residences would allow improved cooperation over time of a number of these individuals. However, dental hygienist training and mentoring in the residences was not part of the current dental services, but it is recommended that such a program be implemented. As an important aspect of preventive oral health, the oral hygiene rating provides a measure of the individual's oral health. The Dental Department rates the individual's oral health within one of five categories. Since October 2010, the Department had tracked these scores, which allowed for a picture of oral health across the campus. The information submitted provides a baseline for improvement and monitoring of trends. This information indicated that 7% of the individuals were rated as having good oral hygiene, 30% were rated as fair, 12% were rated as fair/poor, 44% were rated as poor, and 7% were rated as very poor. The bottom two categories, poor and very poor represented 51% of the population, suggesting the need for focused improvement efforts in this area. At the time of the review, there were two dental hygienists and one dental assistant in the department, and one dentist. Given the needs of individuals, which often required a dental hygienist to assist the dentist, this did not allow for teaching, mentoring, and monitoring in the residences concerning tooth brushing and oral health care. For the size of the population residing at AUSSLC, additional personnel (i.e., dental assistant, dental hygienist) would be beneficial in assisting to improve the oral hygiene ratings across campus. Focus of these additional staff would be in the residence setting continually monitoring and mentoring good oral hygiene practices. The dental clinic began to provide the dental portion of the training completed as part of New Employee Orientation as a way to provide additional training to the direct support professionals. Additionally, corrective action plans were submitted for the oral hygiene in 86 individuals, which should include many in the 51% that had poor to very poor oral hygiene. It was not determined if all those in these two categories had such corrective	

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		action plans. The Dental Department appeared to provide a full breadth of services. From October 2010 through March 2011, there were 70 restoration appointments scheduled, 408 preventive care appointments scheduled, 177 annual assessments scheduled and completed, nine emergency visits, and 18 extractions scheduled. This was a total of 527 non-annual assessment visits. Total appointments scheduled for all reasons were 682. There were 135 missed appointments for all reasons, with 547 total appointments completed. Some appointments were for more than one indication. There was access to an orthodontist, endodontist, and oral surgeon as needed. Dental records for extractions that occurred in the prior six months were submitted. The following summarizes the review of these records: ▪ Individual #94 had an annual assessment under anesthesia at which time a full set of x-rays were obtained, along with examination, and an additional opinion by the dental anesthesiologist. It was determined that extractions were needed for six teeth (#3, #31, #14, #15, #18, and #19.) On 11/9/10, the individual underwent IV anesthesia and extraction of #3, and #31. On 11/22/10, there was a postoperative note indicating normal healing. On 12/7/10, the individual underwent IV anesthesia with local anesthesia, with extraction of #14, #15, #18, and #19. The individual was seen for follow-up related to discomfort on 12/10/10, with dry socket treatment and additional pain medication. On 12/16/10, a follow-up exam indicated normal healing. There were additional follow-up appointments to ensure healing on 12/22/10 and 1/24/11. ▪ A similar pattern of treatment was recorded for other individuals (Individual #42, Individual #273, Individual #361, Individual #172, Individual #340, Individual #267, Individual #189, Individual #146, Individual #425, Individual #103, Individual #327, and Individual #350). In these records, there was detailed documentation of the procedure, any pre- treatment sedation ordered, the anesthesia (IV and local), the description of the procedure, and the teeth removed, and detailed follow-up visits, with additional procedures documented when necessary to prevent a dry socket. Some individuals were noncompliant with follow-up, and the dentist had to make a visit to the residence for follow-up, but all individuals had documented follow-up until healing. In several cases, there were serial follow-up visits to ensure good healing. Additionally, there were three individuals taking bisphosphonates clearly documented in the dental record, and there was the documented concern of increased risk due to bone necrosis in two of three records. These individuals were Individual #170, Individual #115, and Individual #357. Risks were listed, and in two cases, the attending physician was consulted, and in all cases the attending physician was notified of the condition of	

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		the teeth. The record detailed the findings and rationale for extraction, the medication/anesthesia used, and follow-up visits until healing had occurred. Treatment was considered appropriate, and documentation thorough in all reviews of dental extractions. Dental records were also reviewed for emergency visits. The following provides a summary of these reviews: ▪ Individual #29 was evaluated on 2/22/11 for a fractured tooth sustained from a fall during a seizure. This was treated on 3/22/11 under IV anesthesia. There was a dental progress/treatment record note, as well as an integrated progress note for 2/22/11. ▪ Individual #74 had an emergency visit on 11/19/10 for possible root fracture. A detailed dental note was written in the integrated progress note section of the record with assessment and plans for this complex case. This individual was referred to the orthodontist. There was also concern she needed a root canal treatment. She was prescribed Ibuprofen for discomfort, salt-water rinses, and a soft diet. On 11/24/10, the case was discussed with the orthodontist after x-rays were completed. Impressions of the individual's upper and lower arch were completed on 11/29/11. She was seen in the dental clinic on 12/13/10 for bleeding from the area of the injured tooth, and prescribed Chlorhexidine treatments. The note confirmed the scheduled appointments for both the endodontist and orthodontist. On 1/6/11, the orthodontist saw her, with a recommendation for upper fixed braces for six months, with submitted follow-ups on 3/8/11 and 3/29/11. On 3/31/11, an endodontist consult recommended no root canal treatment. There were dental clinic visits on 3/3/11, 3/22/11, and 3/24/11 due to loose protruding orthodontic wires. On 4/5/11, impressions were made for an occlusal guard, which was successful. ▪ On 11/16/10, Individual #354 was seen as an emergency for a broken tooth and an initial evaluation completed, with a temporary filling placed. On 11/22/10, follow-up treatment was completed for tooth restoration. Notes were written in both the dental progress notes, as well as the integrated progress notes. ▪ Individual #94 underwent IV anesthesia and extraction of four teeth on 12/7/10, and then developed pain on 12/10/10, at which time she was seen as an emergency in the dental clinic. It was noted that healing had not progressed, and debridement was accomplished with application of dry socket paste. She was ordered pain medication for three days. Follows-up occurred on 12/16/10, 12/22/10, and 1/24/11, with no further problems identified. ▪ Other dental records were reviewed for submitted emergency visits (Individual #175, and Individual #119), and these records indicated prompt evaluation and treatment and thorough detailed documentation in both the dental progress notes and the integrated progress notes. Follow-ups were documented until	

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		resolution of the problem, and pain management was documented. The Dental Department submitted a list of nine individuals currently receiving suction tooth brushing. This was piloted in the Cardinal unit/residence, as all but one individual already had his or her own suction machines available. The Dental Department met with the Nurse Educator to develop and implement this procedure. The nurses completed the suction tooth brushing on the individuals. With the moving of individuals to the Castner unit, the next phase of the plan included other individuals in Castner. The suction tooth-brushing program required considerable program research, development, and implementation. A policy/procedure from another SSLC concerning suction tooth brushing was submitted in the Dental Department Presentation Book, presumably as a blueprint for development of the program at AUSSLC. Several steps and guidelines were created for the nursing staff who complete the suction tooth brushing, including: "suction toothbrush equipment instructions," appointing a liaison from the Dental Department to the nursing staff on the unit where the suction toothbrush pilot program was started, and a document providing directions for suction tooth brushing use, as well as warnings. The dentist was to specifically write orders for this procedure. An example submitted provided the following order: "nursing staff to provide oral care using suction toothbrush BID and PRN…" There were also meeting notes from 3/25/11 in which the suction tooth brushing Phase II was discussed. The Frazier free water protocol and success with the Cardinal suction tooth-brushing program (Phase 1) was also discussed. It appeared that the challenges had been overcome, and the suction tooth-brushing program had been successful through Phase I. Dental records were submitted for five individuals to whom pre-treatment sedation was administered. Although consent was obtained for both IV and oral sedation, in three of these individuals, pre-treatment sedation was not administered (despite the title of the submitted document). Four of these required IV anesthesia, including Individual #36 on 3/28/11, Individual #143 on 4/7/11, Individual #248 on 4/7/11, and Individual #149 on 4/7/11; and one required PO sedation only (Individual #96 on 4/6/11). All records had the most recent consent (dated within a year of the procedure), a dental note by both the dentist and dental hygienist, an Infirmary note, an integrated progress note, an Infirmary nursing discharge report, a post anesthesia protocol if appropriate, a post anesthesia vital sign flow sheet, and a PSP with dental service objectives. Additionally, Individual #96 had a completed restraint form, as she had received only oral sedation. Two individuals received pre-treatment sedation Individual #36, and Individual #96, as already mentioned. For those undergoing IV anesthesia, postoperative pain medication was ordered. For the individual with only PO sedation, no post visit pain medication was ordered, but there was no indication this would have been needed. For those undergoing IV anesthesia, there was a Post Anesthesia Care REACT Scoring system form completed, except for Individual #149, for which one was not submitted. Of the five submitted	

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		records, this was the only information lacking in otherwise comprehensive documentation, showing appropriate management. Additionally, dental records were submitted for 10 individuals who had received oral sedation prior to the dental appointment. Copies of progress notes from the records and dental office from start of sedation to release from monitoring were requested. All ten records had vital signs recorded in the dental office, on admission to the Infirmary, as well as on return to the residence. Five records also had vital sign documentation in the residence prior to transfer to the dental office for the appointment. These included records for Individual #168 on 2/1/11, Individual #54 on 2/15/11, Individual #220 on 2/1/11, Individual #338 on 3/10/11, and Individual #52 on 1/25/11. Five records did not have a set of vital signs in a IPN from the residence at the time of sedation administration, or during the period of time prior to transfer to the dental office. These records included those for Individual #384 on 1/5/11, Individual #399 on 1/27/11, Individual #241 on 1/27/11, Individual #4 on 2/10/11, and Individual #156 on 2/9/11. It is suggested the Dental Department continue to meet with the Nursing Department to develop a system to ensure monitoring in the residences after sedation has been administered, and before the individual is transferred to the dental office. A number of emails were reviewed in which the Dental Director continued to collaborate with other departments concerning an oral sedation monitoring policy. The State Office also appeared to be developing a policy for sedation monitoring. However, the status of that policy at the time of the Monitoring Team visit was not discussed, and it did not appear to have been finalized. Additionally, a Facility policy was in draft form entitled: "Pretreatment Sedation." Both this draft policy and the minutes from the Pre-treatment Sedation Committee of 10/25/10, 1/24/11, 3/10/11, and 4/14/11 did not address monitoring/documenting vital signs before transport to the dental office. Dental records also were submitted assessing the effectiveness of the sedation. A total of 35 records were reviewed for this aspect of care. The annual dental assessment recorded the level of cooperation, and the need for oral sedation. There was a description of the uncooperative behavior. In the dental progress/treatment record, there was documentation of the medication prescribed along with an indication of the effectiveness of the sedation in assisting the individual to cooperate. An example of this thorough aspect of recording was for Individual #241. She was described in the annual dental assessment as having "limited cooperation… short attention span… lots of head movement, doesn't stay open on command…" In the dental progress/treatment record, there was the documentation of "Ativan 2mg PO in residence at 1300. Result good. Much improvement over last visit…" This level of thoroughness was found in all 35 records (100%). Although the Facility was often providing good dental care, a number of areas required	

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		focus in order for compliance to be achieved. These included the timeliness of annual assessments, timely completion of x-rays for the individuals who need them, and improvement in individuals' oral health ratings.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	As noted above with regard to Section Q.1, A sample of annual dental assessments was submitted for 10 individuals. The assessment included sections on level of cooperation, current conditions (oral hygiene, teeth and restorations, periodontal status, and soft tissue exam), appliances, at-risk level, recommendations, and another section, which was used to provide detailed guidance to the PST and residential support staff in improving oral care. Additionally, the dental section of the active record and the integrated progress note section also included a brief progress note summarizing the findings of the annual dental assessment. Where appropriate, these sections were completed for all 10 annual dental assessments (100%). Thirty-four additional annual dental assessments were submitted as examples of the dental summaries provided to the PST as part of the annual team meeting. All 34 (100%) were consistent with the sample of 10 previously mentioned annual dental assessments. Missed appointments were tracked through a number of different database systems. In some cases, the data was similar, and in other cases the data was not in agreement. The following is a composite of the different databases and lists of information submitted: ▪ For October 2010, there were eight restorations, 49 preventive care visits, and 30 annual assessments scheduled. This totaled 57 non-annual assessments (a different source indicated 65 non-annual assessments). The total appointments included 57 non-annual assessment and 30 annual assessments, for a total of 87 appointments. Of these, there were three refusals and 11 other missed appointments, for a total of 14 missed appointments out of the 87 total appointments. Total missed appointments represented 16% of the scheduled appointments. A separate tracking system documented a total of 85 scheduled appointments with 14 missed appointments. ▪ For November 2010, there were a total of 109 scheduled appointments (111 appointments according to a separate data system). There were two refusals and 20 other missed appointments, for a total of 22 missed appointments (20% of all scheduled appointments). A separate tracking system listed 111 scheduled appointments, and 22 missed appointments. ▪ For December 2010, there were a total of 114 scheduled appointments (122 by a separate data tracking system). There were eight refusals and 11 other missed appointments, for a total of 19 missed appointments (17% of all scheduled appointments). The separate tracking system indicated there were 22 missed appointments, which was the only month in which there was a discrepancy	Noncompliance

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		between the two data systems for missed appointments. ▪ For January 2011, there were a total of 115 scheduled appointments. There were seven refusals, and 29 other missed appointments for a total of 36 missed appointments (31% of appointments). The separate tracking system indicated there were 138 scheduled appointments. The separate tracking system confirmed there were 36 missed appointments. ▪ For February 2011, there were a total of 114 scheduled appointments. There was one refusal and there were 29 other missed appointments for a total of 30 missed appointments (26% of appointments). The separate tracking system had identical information. ▪ For March 2011, there were a total of 143 scheduled appointments. There were two refusals, and 12 other missed appointments, for a total of 14 missed appointments (10% of appointments). The separate tracking system indicated only 127 scheduled appointments. The reason was not clear. Some of the difficulty and the discrepancy might have been due to the way the scheduled appointments were listed. If the appointment had two purposes, annual and preventive care, for example, the appointment would show up twice, once on the annual list, and once on the preventive care list. In such cases, it would be considered two appointments rather than one. Overall, there appeared to be no trend in direction of the missed appointment percentages. In order to begin to determine the cause of the missed appointments, which would lead to systems changes to reduce the causes of missed appointments, a table was submitted indicating the reason for the missed appointment, as well as the type of appointment. The Dental Department was able to determine reasons for missed appointments in all but five cases. There were 135 missed appointments during this six-month span of time. Reasons were determined for 130 out of 135 missed appointments (96%). There were many copies of emails submitted verifying communication with the QMRP and various PST members concerning missed appointments and rescheduled appointments, which might have assisted in being able to determine reasons for missed appointments. One of the important database domains for tracking refusals and missed appointments was the individual's residence. This could assist in determining any cluster effect. Unfortunately, the Dental Department was not able to provide appointment refusals by residence due to "significant movement of clients amongst residences, particularly in the past 6 months." Additionally, the Dental Department was able to provide the date the missed appointment was rescheduled and actually completed. For missed appointments that were not due to furlough, illness, meetings, etc., 44 out of 48 (92%) were rescheduled and the appointment completed within 30 days. In the remaining four cases, they were	

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		all completed within 60 days. Some of the individuals had serial refused appointments until the appointment was finally completed. The Facility's progress with regard to desensitization plans is discussed in detail with regard to Sections C.4 and J.4 of the Settlement Agreement. As noted in those sections, the desensitization plan development was in its early stages, and plans developed using the new format were not yet available for review. As a baseline by which to measure future impact of desensitization programs, the Dental Department was able to submit the percentage of individuals completing dental appointments that utilized IV anesthesia, oral sedation, and mechanical restraints. In October 2010, 19.7% of individuals completing appointments used IV anesthesia. For the remainder of the months, the following percentages were available: in November 2010, 18% of individuals December 2010, 9% of individuals; in January 2011, 13.7% of individuals, in February 2011, 17.8% of individuals; and March 2011, 12.4% of individuals. A dental anesthesiologist provided IV anesthesia approximately three to four times each month. The number of individuals was submitted for each month: in October 2010, 14 individuals; in November 2010, 16 individuals; in December 2010, 9 individuals; in January 2011, 14 individuals; in February 2011, 15 individuals; and in March 2011, 14 individuals. This totaled 82 cases (there were occasional individuals that had TIVA more than once, although this was a minimal number). Out of a census on 3/30/11 of 362, this represented 82 individuals out of 362 (23%) over six months. On an annual basis that would approach 46% of the population. Given the findings on annual assessments at the time of TIVA, it is likely the restoration and extractions and dental hygiene would not be accomplished without this aggressive approach to sedation. However, it is expected that the rate of TIVA administration would trend downward with successful desensitization, and improved oral hygiene ratings across the campus. Statistics also were available for individuals completing appointments that used oral sedation. This included in October 2010, 21% of individuals; in November 2010, 17%; in December 2010, 20%; in January 2011, 13.7%; in February 2011, 16.7%; and in March 2011, 10.6%. Statistics also were available for individuals completing appointments that used mechanical supports. This included in October 2010, 0% of individuals; in November 2010, 4.5%; in December 2010, 7%; in January 2011, 5.9%; in February 2011, 13%; and in March, 10.6%. These data on sedation and restraints indicated a lack of impact of any desensitization programs, because there was no trend downward, and there might have been an upward	

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		trend in mechanical supports in 2011. A restraint and sedation-tracking list for completed appointments also was submitted for the time period from 10/1/10 through 3/31/11. There were 560 completed appointments. Of these, there were 82 appointments in which IV sedation was used (15%). The number of 82 appointments in which IV sedation was used was identical and confirmed the prior statistics discussed, but the denominator for this statistic was the number of completed appointments, rather than the campus census. There were 89 appointments in which PO sedation was used (16%). There were 39 appointments in which mechanical restraints were used (7%). A separate database for dental pre-treatment sedation was submitted for the time period from 10/1/10 through 4/7/11. It listed 99 doses of PO sedation ordered. Three orders were in the month of April, allowing comparison with the prior tracking list with a total of 96 PO doses given through 3/31/11. There was a discrepancy of seven doses of PO pre- treatment sedation. The inconsistency between the two databases appeared to be small, but the Facility should review the various databases to ensure accurate data entry and data completeness. A number of policies have been created or updated since the Monitoring Team's last visit. These included the following: ▪ AUSSLC – Dental Clinic: Annual Dental Assessment Policy, implemented 4/1/11; ▪ AUSSLC – Dental Clinic: Comprehensive Dental Care Policy, implemented 4/1/11; ▪ AUSSLC – Dental Clinic: Dental Desensitization Policy, implemented 4/1/11; ▪ AUSSLC – Dental Clinic: Criteria for Determining Usage of Enteral Sedation or Total Intravenous Anesthesia (TIVA), adopted 8/3/10, and revised 3/28/11; and ▪ AUSSLC – Dental Clinic: Missed/Refused Appointments Policy, implemented 4/1/11. In addition to continuing to identify and address the issues related to missed appointments, the Facility needs to focus on ensuring adequate monitoring of individuals in the residences between the time pre-treatment sedation was administered and they were transported to the dental office, and developing adequate desensitization plans to prevent the need for restraint and sedation to the extent possible.	

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

1. Training and monitoring of oral hygiene care in the residences by dental hygienists is highly recommended. Other SSLCs have one or more dental hygienists providing dedicated time in the residences training and mentoring tooth brushing with the individuals, as well as direct

support professionals. These programs have been successful. The Dental Department and Facility Administration should review these programs for potential implementation at AUSSLC. (Section Q.1)

2. The Dental Department should review the various databases to determine the reason for the inconsistencies. (Section Q.1)
3. The Dental Department should continue to meet with the Nursing Department and as part of the Pre-Treatment Sedation and Restraint Committee to develop a system to ensure monitoring in the residence during the time period after sedation has been administered and before arrival at the dental office. (Section Q.1)
4. As recommended with regard to Section C.4 of the Settlement Agreement, efforts to improve dental desensitization plans and ensure their consistent implementation should continue. (Sections Q.2, C.4, and J.4)
5. The Dental Department should continue to determine the cause of the missed appointments, with the goal of reducing the missed appointment rate. (Section Q.2)

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section R; o Presentation for Settlement Agreement Monitoring Team Visit for Section R, not dated; o The following documents were requested: SLP Evaluation and Updates, SLP Progress notes, SLP communication program, instructional program for Alternative and Augmentative Communication (AAC) device, PSP and PSPAs for past year, Behavior Support Plan, SLP consultations for the last year, competency-based training, person-specific monitoring, and AAC equipment monitoring for the following 15 individuals: Individual #406, Individual #393, Individual #315, Individual #261, Individual #154, Individual #404, Individual #228, Individual #409, Individual #267, Individual #457, Individual #271, Individual #119, Individual #202, Individual #293, and Individual #41; o Speech Evaluation for Individual #109; o CE Training completed by SLP's, from 7/10 through 3/11; o List of Current SLP and Audiology Staff, revised 2/11/11; o List of Individuals with Alternative and Augmentative Communication Devices, dated 12/1/10; o Communication Assessment Master Plan, revised 4/1/11; o AAC Screening Forms (blank), not dated; o AAC and SLP Assessments, from 12/10 through 3/11; o PSP Addendum Meeting Notes, dated 5/3/11; o PSP Addendum Meeting Notes and Corresponding PSPs, from 1/11 through 4/11; o Speech Assessment Tracking Log, from 10/10 through 3/11; o Monitoring Tools Template for AAC and SLP Programs, not dated; o Completed Monitoring Forms, from 3/11; o AAC-related Spreadsheets, not dated; o List of Individuals with PBSPs, revised 3/16/11; and o Competency-based Training Documents, from 12/10 through 4/11. ▪ **Interviews with**: o Kim Ingram, MEd, CCC/SLP, Habilitation Therapies Director; and o Janice M. Taylor, MS, CCC/SLP. ▪ **Observations of**: o Residence and dining room for 732P; dining rooms for 732D, 732E, 779F, 779H, 779R, Infirmary, and 727C.
	Facility Self-Assessment: The AUSSLC Plan of Improvement, updated 4/27/11, provided comments/status for Section R. Compliance ratings for each of these sections were documented as noncompliance. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance.

	The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: Staffing was potentially one factor that resulted in the inadequate provision of speech and communication supports to individuals at AUSSLC. In sum, therapists were not active members of the PSTs, as evidenced by the SLP's absence from annual PSP meetings [only five of the 15 annual PSPs for individuals in the record review had SLP attendance (33%)], insufficient time to provide direct therapy [only two individuals were receiving direct speech services in the record sample (13%)], lack of development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the insufficient development of informal strategies to reinforce assessment recommendations and measurable outcomes. The Speech Pathologists were to be commended for their focus on competency-based training and completion of staff performance check-offs. The next major initiative should be the incorporation of these communication devices into multiple formal skill acquisition programs, and informal daily activities in multiple environments.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	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 speech language pathologists or other professionals [i.e., Assistive Technology (AT) specialists] with specialized training or experience. Training should include augmentative and assistive communication.</u> There were five budgeted SLP positions, which included an audiologist. The following chart shows the status and caseloads of the SLPs:	Noncompliance

Current SLPs	Current Caseloads and Other Responsibilities effective 5/19/11
SLP #1	PNMT member, and supported individuals in 727-C
SLP #2	Member of the Behavior Committee, and supported individuals in 779H, 779F, 782, 786, 789, 793, 792, 796, and 797
SLP #3	Member of the Behavior Committee, Lead Bilingual Therapist, and supported individuals in 732M, 779R, 781, 729, 791

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SLP #4	Member of the Behavior Committee, and supported individuals in 732D, 732E, 784, 785, 787, 788, 794, and 795
SLP #5	Vacant

Staffing was potentially one factor that resulted in the inadequate provision of speech and communication supports to individuals at AUSSLC. In sum, therapists were not active members of the PSTs, as evidenced by the SLP's absence from annual PSP meetings [only five of the 15 annual PSPs for individuals in the record review had SLP attendance (33%)], insufficient time to provide direct therapy [only two individuals were receiving direct speech services in the record sample (13%)], lack of development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the insufficient development of informal strategies to reinforce assessment recommendations and measurable outcomes.

The SLPs attended a wide variety of continuing education courses and conferences, but the SLPs, except for the SLP who was a dedicated PNMT member, did not consistently attend state-sponsored continuing education courses. Therapists should participate in the state-sponsored seminars to increase their knowledge in providing supports to individuals with significant physical and nutritional support needs.

Communicative Aiders and Speech Generating Devices (SGDs) (simple and complex) are provided to individuals based on need and not staff availability. All individuals in need of AAC receive AAC. SLPs actively participate in all facets of care in which communication is relevant.
Fifteen (15) individual records were reviewed, including: Individual #406, Individual #393, Individual #315, Individual #261, Individual #154, Individual #404, Individual #228, Individual #409, Individual #267, Individual #457, Individual #271, Individual #119, Individual #202, Individual #293, and Individual #41. Two individuals in the sample (Individual #393 and Individual #406) were currently receiving direct speech services. The remaining 13 individuals were not reported to be receiving direct speech therapy services.

The Speech Pathologists were to be commended for their focus on competency-based training and staff performance check-offs. The next major initiative should be the incorporation of these communication devices in multiple formal skill acquisition programs and informal daily activities in multiple environments. Of the 13 individuals reported not to be receiving direct speech therapy, all were in need of formal and/or informal functional communication supports. For example:

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		▪ Individual #154 was identified as Priority 1 in the AUSSLC Communication Assessment Master Plan. Her Speech-Language Evaluation, dated 8/8/10, stated: "Although she speaks to communicate, sometimes she also uses augmentative communication methods to help her when other people do not understand her speech. When she is excited or upset her speech intelligibility declines. When her speech is not understood by others, she will repeat herself, but she becomes very frustrated when she cannot make herself understood." The first evaluation recommendation stated: "speech-language therapy is not indicated as [Individual #154] needs can be best addressed in the context of daily living activities." A SLP completed competency check sheets with a home supervisor for Go Talk 9 and a picture book. No PSP was submitted to support integration of her communication devices into her skill acquisition programs. ▪ Individual #261 was identified as Priority 1 in the AUSSLC Communication Assessment Master Plan. Her first recommendation in her SLP Evaluation stated: "Speech-Language Therapy is not indicated as [Individual #261's] needs can be best addressed in the context of daily living activities." Individual #261 had a Picture Communication Schedule to "provide more structure for transitions in her day." Per report, she did not initiate use of her picture schedule, and required staff to initiate, prompt, and assist her to utilize it through each step. Communication strategies had been developed to support functional communication with Individual #261, which also provided instructions for the set-up and use of her picture schedule. Individual #261 also had a communication dictionary. The Competency-Based Training Tracking Sheet documented a PNMPC had completed a picture schedule competency check sheet administered by the SLP, and additional picture schedule competency check sheets were administered by the PNMPC for five additional staff. Documentation submitted acknowledged: "During the PSP meeting, which the SLP attend, there was discussion regarding [Individual #261's] means of communication, her communication equipment and how to integrate the use of her equipment and communication strategies within her daily activities. Unfortunately, very little of that information was included in the PSP report prepared by the QMRP." Training objectives in her PSP, dated 3/17/11, did not integrate her communication device. ▪ Individual #293 was identified as Priority 1 in the AUSSLC Communication Assessment Master Plan. No direct therapy was recommended in his SLP evaluation dated 9/9/10. "[Individual #293's] primary mode of communication is a few sign approximations like 'bathroom', 'eat', 'water'; pictures, pointing, gestures, making sounds and leading the person to the object. He gains attention by bringing objects to people. He inconsistently answers yes/no questions with a head nod or head shake. He uses a picture schedule and a communication board, by pointing to pictures or using picture symbols from the picture	

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		schedule as a picture exchange system to communicate his preferences and requests. He needs signs or gestures for two-step verbal directions." Training Objectives W4 and W5 in his PSP, dated 9/21/10, addressed the use of his communication board. His SLP did not have any responsibility for the implementation and/or monitoring of these training objectives. Instructions were developed for his picture schedule and picture choice board. A Communication Dictionary had been developed for him. Picture Choice Board, Picture Schedule and Picture Book Competency check sheets had been completed per the Competency-Based Training Tracking Sheet and individual competency check sheets submitted. Per report, three of the 361 individuals residing at AUSSLC (less than 1%) were receiving direct SLP services. Documentation was submitted to support the receipt of direct speech services for one of the two individuals (Individual #393 and Individual #406) (50%) within the record sample receiving direct speech therapy supports. The following observations were made: ▪ Individual #393's documentation of direct therapy was not adequate. Individual #393's Speech Language Therapy Plan, dated 4/1/11, indicated: "[Individual #393] will participate in training in the use of the DynaVox Vmax speech generating device to enable him to master use of the device for general communication in all activities of daily living." He was to be seen a minimum of six times per month for three months. Long-term and short-term goals were presented. The Communication Service Log documented his DynaVox training was initiated on 4/6/10, and continued through 5/10/11, for a total of 57 training sessions. The long-term goal was not a measurable, functional outcome. Monthly documentation was not provided to justify continuation and/or discontinuation of direct communication supports. The progress note should justify the initiation, continuation or discontinuation of speech therapy supports, including an analysis to determine the efficacy of the direct therapy supports provided. If progress was not made, recommendations and/or objectives should have been revised. ▪ Individual #406's documentation of direct therapy was adequate. The long-term goals in Individual #406's Speech Therapy Plan of Care, not dated, were: "[Individual #406] will communicate wants, needs and desires with staff appropriately and effectively with minimal prompting (1 verbal prompt). [Individual #406] will follow directions to complete activities of daily living with minimal prompting (1 verbal prompt)." Seven short-term goals were identified including the trials to be completed. The frequency of intervention was three times weekly. The direct therapy service log documented the number of trails initiated per the short-term objectives and documented progress. A monthly progress note, dated 3/25/11 to 4/25/11, provided compliance percentages	

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		with short-term objectives, status of competency-based training, inconsistencies noted in system use were provided to supervisor, and status of progress noted with picture system.	
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 are identified as being in need of AAC.</u> During the on-site compliance review, the Habilitation Therapies Director was summoned to be an interpreter for Individual #210. This scenario demonstrated that Individual #210 did not have staff within his home who were able to communicate with him. During the last on-site review, concerns were identified related to the absence of resources for individuals who were deaf. Facility administration, in collaboration with the Habilitation Therapies Director and Speech Pathologists, should ensure the provision of essential supports, most importantly related to communication, to individuals on campus who are deaf. None of the 13 records reviewed (Individual #315, Individual #261, Individual #154, Individual #404, Individual #228, Individual #409, Individual #267, Individual #457, Individual #271, Individual #119, Individual #202, Individual #293, and Individual #41) (0%), for individuals identified with severe expressive/receptive language deficits and in need of AAC systems, were provided ongoing direct support by an SLP to facilitate functional communication. Examples of concerns are provided with regard to Section R.1 of the Settlement Agreement. The criteria for Priority Assignment used to schedule Augmentative Communication Assessments was: ▪ Priority 1 = Individuals with a BSP (Behavior Support Plan) and/or Autism who do not speak; ▪ Priority 2 = Individuals with a BSP and/or Autism who speak; ▪ Priority 3 = Individuals without a BSP and/or Autism who do not speak; and ▪ Priority 4 = Individuals without a BSP and/or Autism who speak. Per report, the master plan priority criteria and the master plan priority levels 1 and 2 were for individuals with behavioral issues and coexisting severe language deficit. Eleven individuals in the sample (Individual #406, Individual #315, Individual #261, Individual #154, Individual #409, Individual #267, Individual #271, Individual #119, Individual #202, Individual #293, and Individual #41) were ranked as Priority 1. The remaining four individuals (Individuals #393, 404, 228 and 457) were identified as Priority 2. The AUSSLC Communication Assessment Master Plan identified 79 individuals as Priority 1, 94 individuals as Priority, 66 individuals as Priority 3, and 67 individuals as Priority 4 for a total of 306 individuals. However, at the time of the review, 361	Noncompliance

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		individuals resided at AUSSLC. A review of the AUSSLC Communication Assessment Master Plan revealed that SLP evaluations had been completed for 65 of 79 individuals (82%) identified in the Priority 1 category, 20 of 94 individuals (21%) within Priority 2, 11 of 66 individuals (17%) identified as Priority 3, and seven of 67 individuals (10%) in Priority 4. Five of the seven individuals were identified as new admissions. However, there only had been one recent new admission. Equipment annual review had been completed for 45 of 79 Priority 1 individuals (57%), 15 of 94 Priority 2 individuals (16%), four of 66 Priority 3 individuals (6%), and none of 67 Priority 4 individuals (0%). With regard to the assessment process, the following domains and/or guidance should be incorporated into the SL Evaluation and SL Evaluation Update template: ▪ Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention; ▪ Functional reading skills and literacy; ▪ Assessment process should be sufficiently discreet to identify an individual's functional skills, interests and preferences via observation and clinical assessment; ▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition; ▪ Discussion of efficacy of formal and informal functional communication strategies; ▪ Analysis of findings to provide a rationale for functional recommendations and intervention strategies; and Additional guidelines to ensure: ▪ Integration of recommendations into an individual's PSP; ▪ Documentation to justify initiation, continuation or discontinuation of direct and/or indirect therapy supports; and ▪ Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe. To ensure SLPs use a consistent approach during the evaluation process, additional guidelines should be developed to supplement the format. Also, to ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol. In addition, the development of procedures defining the SL update process when an individual experienced a change in status would be beneficial. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> Since the previous review, one individual (Individual #109) was admitted to AUSSLC.	

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		Individual #109 received a Speech Language (SL) evaluation within 30 days of admission. The admission evaluation was signed and dated by the respective Speech Language Pathologist(s). <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> In one of two records reviewed (Individual #393 and Individual #406) (50%), for individuals reported to be receiving direct speech therapy services, were measurable, functional outcomes developed and documented on a monthly basis. This individual example is provided with regard to Section R.1. As noted above with regard to Section R.1, SLPs were completing evaluations that did not recommend direct supports for individuals who presented with severe communication deficits, but had documented potentials and abilities for functional communication. 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 successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations on a formal (skill acquisition programs) and/or informal basis (integrated into daily activities) within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis. <u>For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP.</u> As reported in the Section R Presentation Book, ongoing collaboration with behavioral services staff included: ▪ Inclusion of behavior considerations within the assessment process and resulting recommendations; ▪ Continued collaboration with the psychologist in the development and revision of Communication Dictionaries for those individuals for whom they were appropriate; and ▪ Speech language pathologists continued to participate in the weekly Behavior Therapy Committee meetings. Behavior Therapy Committee Meeting documentation was submitted for 27 meetings from 10/5/10 to 4/18/11. A Speech Pathologist was represented at 23 of the Behavior Therapy Committee meetings (85%). One (Individual #119) of the three records reviewed for individuals with BSPs (33%) documented collaboration between the psychologist and SLP in the development of the	

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		Behavior Support Plans within the PBSP, SL Evaluation, and/or a SLP consultation. For example: ▪ Individual #315's Positive Behavior Support Plan, dated 2/16/11, acknowledged: "it would be ideal for [Individual #315] to be taught more sign language in order to improve her ability to communicate her wants/needs to others. During her annual meeting (February 2011), [Speech Therapist] verbalized that more sign language would be incorporated into her program (for instance, the sign for 'more'). According to [Therapist], such sign(s) will be incorporated into her Speech-Language program in order for staff members to reinforce the sign(s). The primary outcome of this behavior support plan was to continue to teach and reinforce [Individual #315's] for appropriately communicating that she wants a portable radio. Her PSP, dated 2/18/11, documented the Behavior Objective S4 [Individual #315] will communicate to staff that she wants her radio at least eight time per month for eleven consecutive months." This objective did not mention the use of sign language, nor did not other training objectives integrate the use of sign language. ▪ Individual #404's Speech-Language Evaluation, dated 4/7/10, stated: "[Individual #404] has a positive behavioral support plan which targets: aggression and self-injurious behavior with a replacement behavior of communication via her picture communication board or other adaptive equipment. Reports form her psychologist indicate that her behavior is improving overall." The B1 Training Objective in her PSP, dated 4/1/11, indicated: "[Individual #404] will use a communication device on at least three episodes per month for 9 consecutive months by April 1, 2011. The replacement Behavior in her PBSP, dated 4/1/11, was: "[Individual #404] has a Communication Board of photographs that she is able to carry with her, which also may be stored on the wall in the dining area where it is readily available when needed." The lack of intensity with her behavior objective did not indicate that Individual #404 would have multiple opportunities to be successful. The use of her communication device should be integrated in multiple formal objectives as well as informally in her daily routines. ▪ The Replacement Behavior/Alternative Behavior in Individual #119's PBSP, revised 1/12/11, was "Signing 'stop' or 'stay back': [Individual #119] will use the ASL [American Sign Language] to signal 'stop' when others enter his personal body space." Excerpts from his December 2010 Speech Evaluation were included in his PBSP. <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> The Facility did not have a policy that outlined an assessment schedule and staff responsibilities.	

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R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	The Presentation Book for Section R (R.3) stated: "Under the leadership of the Director of Active Treatment, Speech Language Pathologists collaborated with the Active Treatment staff, the Director of Behavioral Services, the QMRP Coordinator and Music Therapist to develop the current Active Treatment Training Program which included focus on teaching staff how to integrate communication strategies and supports within programming areas as well as during a variety of other activities which occur naturally throughout the day." The Active Treatment training program had been completed for staff. For individuals with intellectual disabilities, the use of AAC devices has the ability to change the way an individual is able to communicate their needs in the classroom, home, work, and leisure environments, through increasing participation, making choices, and enhancing functional communication skills. Most importantly, when an individual has learned how to use an AAC device to communicate successfully, the perceptions and stereotypes of a familiar and/or unfamiliar communication partner changes from not believing the individual would be able to communicate to exploring multiple strategies to communicate with an individual. Speech language pathologists were to be commended for the development of multiple task analyses, which should lead to staff competence in the utilization of communication devices. These learned skills should provide staff with foundational skills and stated competencies to support individuals in the utilization and implementation of individual-specific and generic functional communication devices in multiple natural environments. The provision of competency based training and check sheets had been initiated, but there continued to be significant numbers of individuals whose staff will require competency-based training on their communication devices. <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> Communication interventions were not integrated into individuals' daily schedules. <u>AAC devices are portable and functional in a variety of settings.</u> Fifteen of the 15 PNMPs reviewed (Individual #406, Individual #393, Individual #315, Individual #261, Individual #154, Individual #404, Individual #228, Individual #409, Individual #267, Individual #457, Individual #271, Individual #119, Individual #202, Individual #293, and Individual #41) (100%) 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). Per report, assessment-based PNMPs were in place for individuals with identified needs for augmentative/alternative communication. The PNMP Section of I-Book included as appropriate: ▪ Communication strategies-newly developed and implemented for individuals	Noncompliance

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		recently assessed per the master plan evaluation schedule and for annual review. The future plan was to increase Communication Strategies for those previously assessed at the time of their annual review. ▪ Communication device instructions with clearly identified equipment photographs; and ▪ Communication Dictionaries. The following examples illustrated PNMP staff strategies for AAC devices to be utilized in a variety of environments: ▪ Individual #409's PNMP, revised 2/25/11, stated: "use picture schedule daily when changing from one activity to another; use speech generating device during all activities; and make picture exchange wallet available during all outings, social activities and at workshop." ▪ Individual #202's PNMP, reviewed 12/2/10, stated: "provide choices throughout the day using the Picture Choice Board." <u>AAC devices are individualized and meaningful to the individual.</u> For the one individual receiving direct speech services (Individual #393), the record did not indicate how the direct speech language services would be individualized, and did not encourage the use of speech generating devices beyond the direct speech services sessions to ensure these devices were meaningful and functional for the individual. There were no formal communication programs developed with individualized strategies to be implemented by staff to reinforce what was being learned in direct speech therapy related to the individual's AAC device. 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, and/or provide multiple opportunities to practice the use of their AAC device. For the second individual within the sample (Individual #406), the record did indicate how the direct speech services would be individualized and instructions for how staff were to reinforce these supports. <u>Staff are trained in the use of the AAC device.</u> The Speech Department was to be commended for the development of the 33 competency-based training check sheets related to specific alternative and augmentative communication devices, as well as earplugs. Competency-based training was being implemented. Documentation of the presence of competency-based training check sheets was presented in individual examples throughout Section R. A Competency-Based Training Tracking Sheet had been developed and tracking had been implemented.	

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		Presentation Book for Section R (R.3) presented the plans for the 788 and 789 Autism Homes: ▪ Completion of comprehensive communication assessment ▪ Implementation of competency-based training for staff Competency-based training rechecks for staff regarding use of AAC systems with individuals was planned. ▪ Monitoring and modeling care and use of AAC systems with individuals by PNMPC was ongoing. ▪ System to formally track home-specific collaboration planned, but not yet developed and. ▪ SLP to monitor, train and model to increase functional communication utilizing AAC system was ongoing. The Monitoring Team supports this initiative. However, most importantly, individuals must have formal skill acquisition programs developed and integrated into their PSPs, as well as informal activities woven into their daily activities. Three (3) individuals (Individual #406, Individual #41, and Individual #202 who resided in Home 789, and an additional three individuals (Individual #409, Individual #267 and Individual #271) who resided in Home 788 were reviewed by the Monitoring Team. The following provide some examples of observations that were made: ▪ Individual #409 Speech Language Evaluation Update Equipment Review, dated 2/16/11, identified: "[Individual #409] is at risk for communication breakdown." No direct speech therapy was recommended, as his "needs can be best addressed in the context of daily living activities." Individual #409 was not receiving direct speech services, but the following supports had been developed: communication strategies for staff; instructions for how to use his Go Talk 9+ device, picture schedule, and picture exchange system with photographs; and a communication dictionary. A PSPA Meeting, dated 3/25/11, put the following in place: o Continued use of his picture schedule was recommended following the guidelines noted in the PNMP; o A wallet sized portable picture exchange system was to be released after the meeting; o A nine-message portable speech generating device was to be released after the meeting; and o Communication strategies/active treatment instructions were presented. Competency-Based Training Tracking Sheet documented multiple staff were trained by the SLP and/or PNMPC in April 2011 for: o Go Talk 9 Competencies;	

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		o Picture Exchange System Competencies; o Picture Schedule Competencies; and o Picture Book. Training objective T2 in his PSP, dated 2/25/11, stated: "With 3 verbal prompts [Individual #409] will use his go talk to make chooses (sic) when communicating with staff 6 of 8 assessment trials for eight months." The responsible person for this objective was a direct support professional. It was to be monitored by the Active Treatment Coordinator, direct support professional, and supervisor. There were no other training objectives, which integrated his communication devices. Within the body of the PSP, the PNMP section stated: "integration of plan into daily schedule: DCS have be in serviced on this plan and it is in cooperated (sic) with [Individual #409's] daily schedule." There was no evidence to support this integration of the PNMP. ▪ Individual #267 had written communication strategies, picture schedule instruction and picture choice board instructions with photographs, and a communication dictionary. A QMRP, Home Supervisor, PNMPCs, and direct support professional had completed competency check sheets for the picture choice board and picture schedule. A PSPA, dated 3/25/11, was held to "discuss the findings of the speech-language evaluation and recommendations for communication." His PSP did not contain any training objectives related to communication. ▪ Individual #202's PSP, dated 12/2/10, integrated his communication devices into three training objectives (T10, T11, and T12). ▪ Individual #41 had a picture communication book. Instructions had been completed for this device with a photograph. His PSP, 11/19/10, did not incorporate his communication device into his skill acquisition programs.	
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	<u>Monitoring system is in place that tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.</u> AUSSLC Communication Equipment Log, revised 5/6/11, presented the following fields to track individual's communication equipment: unit, home, last name, first name, date distributed, fields for device one through five, which included device description, location, instruction page location, comments, and count of equipment pieces shared and individual. The Monitoring Team supported the content of the communication equipment log, but the development and implementation of a tracking system that would be able to run multiple queries for reports would be significantly helpful. List of Communication Dictionaries, revised 5/6/11, identified that 144 individuals had communication dictionaries.	Noncompliance

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	and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	The Facility developed instructions for the completion of the Individual/Shared Communication Equipment Monitoring form. The instructions provided were comprehensive, and should support consistency in the completion of the form. According to the Presentation Book for Section R.4, a Communication Equipment Monitoring Spreadsheet was "recently developed and is still being refined to track and trend data collected form the communication equipment monitoring sheets." Fifteen of the 15 individual records reviewed (Individual #406, Individual #393, Individual #315, Individual #261, Individual #154, Individual #404, Individual #228, Individual #409, Individual #267, Individual #457, Individual #271, Individual #119, Individual #202, Individual #293, and Individual #41) (100%) documented monitoring of communication devices. Although the monitoring forms had been completed, consistent follow-up to address problems was not documented. The following observations were noted: ▪ Individual #271's multiple Individual/Shared Communication Equipment Monitoring forms over the past two months consistently documented his device was not in use. The completed monitoring forms were reviewed by an SLP, but there was no discussion related to Individual #271 not using his device. ▪ Individual #267's multiple monitoring forms documented his communication devices were not in use. The SLP documented "modeled for staff on how to use picture schedule and choice board with PNMPC." Subsequent monitoring forms continued to reveal his communication devices(s) were not in use. ▪ Multiple monitoring forms for Individual #41 acknowledged his communication device was not in use. A SLP reviewed these forms, but there was no discussion and/or resolution related to the non-use of Individual #41's communication device. As stated in the previous report, there was no Facility policy developed for communication devices and AAC devices to define the frequency of monitoring to provide a systematic and routine review of the components of communication equipment and hearing aides/ear plugs. The Facility Speech Language monitoring policy should incorporate the following: ▪ Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual; ▪ Monitoring forms that include instructions for individual monitoring indicators to support consistency and inter-rater reliability; ▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability; ▪ Formal schedule for monitoring to occur;	

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		▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; ▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and ▪ Establishment of thresholds for staff re-training. <u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u> The individual record sample documented that equipment monitoring occurred in the individual's residence, but not in all aspects of the individual's daily life. <u>Validation checks are built into the monitoring process and conducted by the plan's author.</u> There was no evidence that validation checks were built into the monitoring process and conducted by the plan's author.	

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

1. As recommended with regard in Section O.1, therapists should attend state-sponsored continuing education courses. (Section R.1)
2. Progress notes should be completed for individuals receiving direct speech services, and should justify the initiation, continuation or discontinuation of speech therapy supports, including an analysis to determine the efficacy of the direct therapy supports provided. If progress was not made, recommendations and/or objectives should be revised. (Section R.1)
3. Facility Administration, in collaboration with the Habilitation Therapies Director and Speech Pathologists, should ensure essential supports, most importantly related to communication, to individuals on campus who are deaf. (Section R.2)
4. The following domains and/or guidance should be incorporated into the SL Evaluation and SL Evaluation Update template:
    a. Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention;
    b. Functional reading skills and literacy;
    c. Assessment process should be sufficiently discreet to identity an individual's functional skills, interests, and preferences via observation and clinical assessment;
    d. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;
    e. Discussion of efficacy of formal and informal functional communication strategies;
    f. Analysis of findings to provide a rationale for functional recommendations and intervention strategies; and

    Additional guidelines to ensure:
    a. Integration of recommendations into an individual's PSP;
    b. Documentation to justify initiation, continuation or discontinuation of direct and/or indirect therapy supports; and
    c. Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe. (Section R.2)
5. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as their BSPs to ensure the AAC device is meaningful to the individual and they have a voice in multiple environments. (Section R.2)

6. To ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol. (Section R.2)
7. The Speech Department should continue their competency training and competency check sheet initiative. (Section R.3)
8. The Facility Speech Language monitoring policy should be modified to incorporate the following:
    a. Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual;
    b. Monitoring forms that include instructions for individual monitoring indicators to support consistency and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    f. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
    g. Establishment of thresholds for staff re-training. (Section R.4)

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Section S Presentation Book, including: Monitoring Team Report from 11/10; AUSSLC Plan of Improvement, dated 4/27/11; Settlement Agreement cross referenced with ICF-MR standards; Active Treatment Monitoring Tool, dated 10/26/10; overview, PowerPoint presentation, and related materials for staff training on Writing Measurable Objectives; New Employee Orientation (Active Treatment training for new staff – PowerPoint presentation; Young Adults Institute (YAI) staff workbook for training – How to Teach People with Profound Developmental Disabilities; YAI Facilitator's Guide for Effective Teaching Within Community Settings; Specific Active Treatment training for new staff – PowerPoint presentation; YAI Facilitator's Guide for How to Improve Thinking Strategies for People with Developmental Disabilities: Ten Techniques for Staff); list of and sample training materials from YAI National Institute for People with Disabilities; Daily Hygiene and Appearance Checklist; organizational charts for Active Treatment, Day Programming, and Vocational Services departments; Pre-Treatment Sedation Committee meeting minutes from 7/1/10 through 4/28/11; Community Activity Policy, dated 4/15/11; Active Treatment Department On-the Job Training (O.J.T.) Packet, dated 4/1/11; Sample Activity Totes; o Completed Active Treatment Monitoring Tools; o Active Treatment Monitoring Results, from 3/11 and 4/11; o Active Treatment Quarterly Review – Q2FY2011; o Policy: Personal Support Plan Process, dated 4/14/11; o Personal Support Plans for: Individual #273, Individual #210, Individual #342, Individual #333, Individual #160, Individual #108, Individual #168, Individual #406, Individual #428, Individual #179, Individual #304, Individual #261, Individual #84, Individual #403, Individual #181, Individual #394, Individual #293, Individual #101, Individual #10, Individual #140, Individual #80, Individual #412, Individual #323, Individual #167, Individual #158, Individual #186, Individual #117, Individual #389, Individual #11, Individual #260, Individual #202, Individual #19, Individual #74, Individual #142, Individual #360, Individual #177, Individual #425, Individual #161, Individual #219, Individual #98, Individual #382, and Individual #73; o Specific Program Objectives and accompanying Data Sheets for: Individual #355, Individual #53, Individual #424, Individual #406, Individual #158, Individual #320, Individual #117, Individual #212, Individual #74, Individual #161, Individual #98, and Individual #73; o Specific Program Objectives for: Individual #210, and Individual #335; o Personal Support Plan Meeting/Documentation Monitoring Checklist for: Individual #307, Individual #53, Individual #34, Individual #206, Individual #87, Individual #302,

	Individual #41, Individual #380, Individual #158, and Individual #280; o Registration of Blind Students, dated 11/22/10; o Positive Assessment of Living Skills (PALS) for: Individual #160, Individual #84, Individual #284, Individual #30, Individual #335, Individual #247, Individual #185, Individual #241, Individual #141, Individual #412, Individual #323, Individual #186, Individual #320, and Individual #212; and o Vocational Comprehensive Assessment Program Planning System (CAPPS) Summary for: Individual #355, Individual #12, Individual #210, Individual #160, Individual #29, Individual #424, Individual #406, Individual #180, Individual #457, Individual #335, Individual #247, Individual #61, Individual #141, and Individual #320. ▪ **Interviews with**: o Tom Cochran, QMRP Coordinator; and o Sarah Knowles, Director of Active Treatment. ▪ **Observations of**: o Residence 729, Residence 732, 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; o Workshop 527, Workshop 532, Workshop 544, and Workshop 775; o Day Program 510, Day Program 512, and Day Program 533; o Personal Focus Assessment Meeting for Individual #332, held on 5/9/11; and o Unit Meeting, held on 5/10/11.
	Facility Self-Assessment: The Facility's Plan of Improvement 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. As evidenced during the introductory meeting held with administrative and supervisory staff of the Facility, and reinforced in a separate meeting with the Director of Active Treatment and QMRP Coordinator, changes had occurred since the last visit. Generic training in active treatment had been developed, introduced to New Employee Orientation, and expanded to already existing staff. As of 4/26/11, a total of 935 staff members had been trained. Additional training in working with individuals with developmental disabilities had been provided to Active Treatment Staff and PNMP Coordinators. An associate psychologist had been recruited to train QMRP and Active Treatment Staff in writing behavioral objectives. Lastly, the QMRP Coordinator had been trained as a Facilitator in the Supported Visions and PSP Process. A monitoring tool had been developed to help ensure that the PSP process was comprehensive and in compliance with the established guidelines. It was in its early stages of implementation. The checklist originally designed to assess engagement had been greatly expanded, and was being used by members of the QA department. The checklist to evaluate an individual's hygiene and appearance had been revised, staff had been trained, and it was being implemented in the residences. Other steps taken to ensure

	improved opportunities for leisure, work, and community-based activities had also been implemented. Materials had been purchased for use in the residences, although it was recognized that the scope and quantity of materials remained limited. Equipment and materials to offer ceramics work had been purchased, and implementation was expected once the kiln was installed. New day treatment programs had been identified and begun. Lastly, the policy for community trips had been amended, making it easier to travel greater distances without specialized staff (i.e., nursing). Data was also initiated to track opportunities for training in the community. The POI included a brief narrative description of many of these activities, and included additional information about initiatives underway in the attached action plans. No data was provided, however, to substantiate findings of substantial compliance or noncompliance. As the Facility expands its self-assessment activities, it will be important to include data from audits, as well as other sources.
	Summary of Monitor's Assessment: As noted in the previous report, many of the changes presented in the POI and during the visit held promise of continued improvement in the future. The staff are commended for their efforts to improve training, to expand opportunities for the individuals served, and to develop monitoring tools that will allow for objective assessment of progress. The challenge will be to ensure that these efforts result in improvement in the quality of life, development of skills, and access to a variety of environments by the individuals who reside at the Facility. While the PSP process had expanded and improved in recognizing individual preferences and identifying risks, the objectives identified remained quite limited and inadequate in their scope. Teaching opportunities remained infrequent, methodologies were compromised by a lack of clarity and consistency, and data used to assess progress was below standard. Comprehensive assessment of an individual's strengths, needs, and preferences remained an area that required improvement. Adaptive behavior across skill domains was not consistently assessed, resulting in training programs that were severely limited. Further, preference assessments were not routinely completed. The activities available to the individuals served at AUSSLC were also quite limited. Work presented was often repetitive and non-functional, with very little variety offered. Opportunities for engagement in the residences were compromised by the lack of age-appropriate, and individualized activities and materials.

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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	An updated Personal Support Plan Process policy, dated 4/14/11, was reviewed. A broad overview of the PSP was described as: "Each PSP will include integrated protections, services, treatments, and supports that are based on an individual's preferences, strengths, and needs in order to improve independence, safety, and opportunity for community integration" (p. 2). Several documents were reviewed	Noncompliance

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	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.	related to the PSP process. First, a total of 42 PSPs were reviewed. Each began with a brief description of the individual's preferences and interests. Next, assessments were identified that were used to guide the PSP process. Specific measures of adaptive behavior [either the Positive Assessment of Living Skills (PALS) or the Inventory of Client and Agency Planning (ICAP)] were identified in only 21 of these 42 plans (50%). The date of completion of the assessment was identified in only two of these 21 plans (10%). As the PSP is the principle guiding document in developing and implementing the individual's program of services, it is recommended that assessments be clearly identified and dated to ensure that information regarding the individual's strengths and needs is current. Thirteen plans, or 31% of the sample, included a completed risk assessment in table format. This allowed for a quick review of areas of concern and need. Staff should carefully review this section, because on least three occasions the information provided in the text of the PSP did not correspond to the information provided in the table. ▪ Individual #273: Falls were noted as low risk in the table, yet falls were identified as an area of concern on pages 1 and 7 of the plan. ▪ Individual #140: The risk of falls was not noted in the table (although a comment indicated no problems), yet on page 5 of the plan, there was a note that this individual "has a history of falls resulting in serious injury." ▪ Individual #219: Challenging behavior was identified as low risk, however, this individual had a behavior support plan that targeted pica, picking of skin, tearing of clothing, and intentional vomiting. This would suggest that challenging behavior should be noted at a minimum of a medium risk. ▪ Although the risk assessment for Individual #382 was not provided in table format, the first page of her plan indicated that she did not need sedation or restraint for dental appointments. Later in the text of the plan, the need for both was noted. Training objectives were included in every plan reviewed. A total of 498 training objectives were identified, with a range of four (Individual #219 and Individual #98) to 25 (Individual #342). The following findings were made with regard to these objectives: ▪ Of these, 301, or 60% were scheduled to be addressed at a minimum of five days per week. The schedule for training on the other 197 objectives was identified from two to three times each week to once per month. Unless training is provided on a rich schedule, it is unlikely that skill acquisition will occur. ▪ In all but five plans, individual training objectives were often similar with only a minor change in prompting, duration of the activity, or materials involved. ▪ When the objectives were reviewed to identify the domain addressed, the following was determined: 32 of the 42 PSPs (76%) included at least one	

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		objective addressing leisure skills, most often in the form of shopping or making a purchase; 30 plans (71%) included at least one objective addressing personal hygiene; 27 plans (64%) included at least one objective addressing work skills; and 15 plans (36%) included at least one objective addressing domestic skills. ▪ Clearly identified community training objectives were included in only four of the plans reviewed (10%). Twenty-two additional plans (52%) noted that training could take place in the community setting, but not all of these objectives were appropriate for the community. For example, Individual #428 had an objective to gather his bathing items; Individual #80 had two objectives to grasp her toothbrush; and Individual #425 had two objectives to wash his body. Clearly, these are not activities that take place in the community. Comprehensive plans should be developed that will ensure the individual is learning skills across a range of domains, including social, communication, self-care, academic, vocational, leisure, domestic, and community living. Specific concerns were raised after reviewing the PSPs for some individuals. These are addressed below. ▪ Individual #342 had a service objective to address pedestrian safety skills, yet this was scheduled to occur only four times per month. It is doubtful that this very important safety skill could be learned with such limited exposure to teaching trials. ▪ Individual #160 had training objectives to do the laundry, wash her upper body, wash her hands after toileting, and count out 70 cents, yet each was scheduled to occur three times per month. Again opportunities for learning were severely limited. ▪ Individual #108 had reported to his team that he did not like working in the on-campus workshop, because he found it boring, yet his plan included six objectives related to the workshop. Consideration should have been given to exploring other opportunities for meaningful and interesting work. ▪ Individual #168 was blind. An identified obstacle to an alternative living environment was the need for the services of an orientation and mobility specialist, yet AUSSLC did not employ one. Therefore if this truly was an obstacle when considering living options, it would appear that AUSSLC was not an appropriate environment for this individual. ▪ Individual #428 required sedation and restraint for dental and medical procedures, yet he will be given the opportunity to visit these clinics only once per month to help reduce his anxiety. Similarly, Individual #140 required sedation for dental and medical work. He too was going to visit these clinics once monthly. Such infrequent exposure was unlikely to result in the desired effect.	

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		▪ Individual #179 had seven training objectives, all of which were scheduled to occur once monthly. This did not provide for an enriched environment designed to provide habilitative services. Although not a substantive matter, staff should carefully proof all documents, because throughout the PSP three different ages were identified for this individual. ▪ Individual #323 had two objectives related to feeding himself pudding mixed with his medications. The schedule was identified as "zero falls per month for 12 months." He also had an objective to brush his teeth daily. The schedule was identified as "no more than one suppository monthly." The QMRP Coordinator provided copies of the monitoring checklist used to assess adherence to the PSP guidelines for 10 individuals. This tool provided a structured method for ensuring that PSP meetings were conducted as intended with all relevant areas addressed. One recommendation would be to provide the QMRP with a summary of positive meeting components and areas in need of improvement. The latter should include specific recommendations to improve the function and quality of the PSP process. A total of 51 Specific Program Objectives, representing 14 individuals (Individual #355, Individual #53, Individual #424, Individual #406, Individual #158, Individual #320, Individual #117, Individual #212, Individual #74, Individual #161, Individual #98, Individual #73, Individual #210, and Individual #335), were reviewed. Corresponding data sheets also were reviewed for all but two of these individuals (Individual #210, and Individual #335). Each was analyzed with regard to specifications outlined in the Settlement Agreement monitoring tool. Findings are summarized below. ▪ Where appropriate, a task analysis was present in 25% of the objectives. As noted previously, a clear outline of the steps or component parts of a complex skill allow staff to identify the specific behavior expected of the individual. It also allows for a more accurate assessment of the individual's ability to perform the skill. It is important to note that task analyses should be created that are specific to the individual. Some individuals may require a greater number of smaller teaching steps to master a complex skill. Others may learn the same skill when it is broken into fewer, but larger steps. ▪ Nine of the 51 objectives (18%) were noted to include an operational definition, oftentimes due to the observable behavior described with the task analysis. Examples where the behavior was not defined in observable and measurable terms included: Individual #355 was to save 20% of his paycheck, but how he saved his paycheck was not clear; Individual #424 was to accept criticism, but it was unclear how her acceptance was manifested; and Individual #158 was to assist his co-workers, but the form of assistance was not clear. Unless a behavior is operationally defined, there is a risk of different interpretations by different	

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		staff members. ▪ All of the objectives (100%) noted a schedule for training and for data collection. Forty-two (82%) of the objectives indicated that training would take place daily or five days per week. The remaining nine objectives included the following schedules: Monday through Thursday, weekends, Saturday, Friday or occurrence, occurrence, or monthly. None of the objectives (0%) noted the number of trials to be conducted during each day of training. Without sufficient opportunities to practice a skill or repeated exposure to teaching, mastery of new behaviors will be very slow or significantly impeded. ▪ Only six of the 51 objectives (12%) provided a clear description of teaching conditions. Without this information, it is very likely that staff members will employ a variety of teaching strategies thereby compromising the individual's mastery of the identified skill. ▪ Sixteen of the 51 objectives (31%) identified a discriminative stimulus related to the skill. The others provided no clear stimulus that would cue the individual to engage in the response. ▪ Twenty-three of the 51 objectives (45%) were written to indicate that the individual would perform the skill in response to multiple prompts. A prompt is an added stimulus that should occasion or result in the correct response (Cooper, Heron, & Heward, 2007). If a person is told repeatedly to demonstrate a response, he/she is effectively learning not to respond to the discriminative stimulus and the staff person who is trying to teach the skill is essentially engaging in nagging behavior. Prompts are often necessary, yet the prompt chosen should result in the desired behavior. There should be a plan for fading prompts whenever these are employed. ▪ The identified reinforcer for correct performance of a skill was praise in 40 of the 51 objectives (78%). While praise from particular staff members might serve as a reinforcer for some individuals, it is unlikely that this will effect behavior change across all individuals in all areas of learning. Four objectives identified access to an item purchased as the reinforcer, one objective noted that the person would enjoy the salad she had made, and one objective noted the person would access a sensory item. Individual #212 was to be praised and provided a massage if she exchanged a dollar for a sensory item. This objective was confusing on many levels, including the function of teaching this person to pay for sensory items that she would then be prompted to hold onto. ▪ Consequences for incorrect responding were not identified. In some plans, staff were advised to cease interacting if the person showed a lack of interest by engaging in behavior problems. This could effectively strengthen the problem behavior, if it served an escape from demands function. ▪ None of the objectives included instructions for ensuring that maintenance and generalization of newly acquired skills occurred.	

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		Some individual objectives raised specific concerns. ▪ Individual #355 was going to learn to save his paycheck. Training was scheduled for every day, yet paychecks are not distributed on a daily basis. ▪ While data sheets had been provided for Individual #168, a note was attached that the Specific Program Objective sheet was missing for all eight objectives. Similarly, notes were provided indicating that four Specific Program Objective sheets were missing for Individual #103, and all Specific Program Objective sheets and accompanying data sheets for March and April were missing for Individual #202. It is concerning that instructions for staff as found on the Specific Program Objective sheets were not present, and it did not appear that anyone had recognized this as a problem to be addressed. ▪ Individual #158 had an objective to purchase an art kit, yet in the special note section staff were advised to discuss different types of low calorie snack foods. ▪ Individual #74 had five objectives, yet a note indicated that no objectives had been completed for the months of March and April. ▪ Individual #98 had two work objectives, but these had not been addressed for the months of March and April, because he was in school. It is unclear why his PSP included objectives that clearly could not be implemented due to a known scheduling conflict. ▪ Individual #161 had met the established criterion on 100% of the trials for two months, yet the plan was to continue for another month. It is important to continue to build on and expand a person's repertoire of adaptive behavior. ▪ Individual #73 had one objective indicating he would "…defer from striking himself," and a second objective indicating he would "…defer from hitting or pushing staff during a lotion rub." Neither of these objectives addressed the development of an adaptive behavior. In order to ensure that identified skills are taught in a systematic and effective manner, it will be necessary for staff to develop plans that offer clear and comprehensive guidelines to staff. As staff become more proficient in implementing specific training objectives, it would be helpful if direct support professionals also were trained in incidental teaching strategies. There are multiple opportunities throughout the day to involve an individual in activities of daily living, including domestic skills. For example, meals offer a great opportunity to teach individuals to set the table, to serve themselves, and to clean up afterwards. Multiple opportunities to expand an individual's communication skill also present themselves throughout the day. For example, the individual could be encouraged to choose which music he/she would like to listen to, which television show he/she would like to watch, or even which magazine he/she would like to glance through. There are	

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		many teaching moments that arise daily. Training staff to engage the individuals in these moments would contribute to the ongoing effort to provide appropriate habilitation services. During this visit, Planned Activity Checks (PLACHECKS), a measure of engagement, were conducted while touring the Facility. PLACHECKS (Cooper, Heron, & Heward, 2007; 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. The data collected is reported below. ▪ A total of 35 PLACHECKS were collected in the residential environments. Engagement ranged between 0% and 100%, with a mean of 31%. ▪ Seven PLACHECKS were collected in the workshop areas. Engagement ranged between 0% and 100%, with a mean of 59%. ▪ A total of seven PLACHECKS were conducted in the Life Skills setting. Engagement ranged between 25% and 100%, with a mean of 76%. Whenever the staff-to-individual ratio was one-to-one, engagement was 100%. ▪ Lastly, in the day habilitation settings, a total of six PLACHECKS were conducted. Engagement ranged between 0% and 100%, with a mean of 52%. As noted in the first two reports, several concerns were raised: ▪ The materials used were often in poor condition. Individuals were observed in workshop areas bundling worn pamphlets, manipulating broken notebook binders, or using jigs that were poorly designed for the task (e.g., plastic cups to hold items that were too large for the size of the cup). ▪ When efforts to teach were observed, teaching strategies were often applied inconsistently. For example, when trying to teach an individual to fill parts of a jig with materials, rather than teaching the individual to complete the task systematically by moving from left to right and top to bottom, the staff member often guided random placement of materials. Without a consistent method of teaching a skill, it is unlikely that the individual will learn to complete the routine independently. Further, there appeared to be little use of reinforcement to ensure that the individual was appropriately motivated and rewarded for engaging in the activity. During one observation in a residence, Individual #234 was repeatedly told to stand up to complete her exercises. Again, there appeared to be no method to teaching this skill, and as a result, the person spent most of her time sitting on the floor. ▪ Activities were often not appropriate for the individual's age and were the same across environments, showing a lack of consideration for individual preferences and interests. Throughout several residences, the materials available to individuals included games of Connect Four, children's puzzles, blocks, or	

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		bubbles. While occasionally staff were observed engaging an individual in a game of cards (Individual #424), riding bikes with an individual (Individual #283), or encouraging individuals to assist with household chores (Individual #119 and Individual #281), oftentimes, the interaction was limited with very little available to maintain the individual's interest or participation. Individuals were often observed sitting idly, while the television and/or radio played. Some individuals were consistently observed walking back and forth (Individual #293), around areas of the residence (Individual #249), or sitting and staring out the window (Individual #425). To ensure the provision of adequate habilitation services to each of the individuals served at AUSSLC, it will be essential to assess and identify activities that are age-appropriate, functional, and of interest to the individual. It will also be necessary to develop teaching methodologies that result in skill acquisition, greater independence, and improved quality of life. As noted in the last report, the Director of Active Treatment had developed a tool to monitor the engagement levels of the individuals served at AUSSLC. Since the last visit, the Active Treatment Monitoring Tool had been revised and expanded. Part I consisted of a Planned Activity Check (PLACHECK). Engagement was briefly defined, with examples provided. This strengthened the tool, because it helps to provide all staff with a better understanding of what constitutes active engagement. During training, examples of non-engagement also should be reviewed. In addition to engagement, staff were expected to note the number of individuals who required intervention for problem behavior. Other changes to the tool included a review of four areas to be completed by a staff member from the Active Treatment and Quality Assurance departments (Part II). *Environment and Individual Hygiene a*ssessed the cleanliness, décor, and quality of furnishings in the area; the presence of rights posters and hotline information; and the appropriateness of individuals' dress and grooming. *Staff Interactions and Knowledge* assessed the quality of the staff interactions with the individuals served (including acknowledgement of needs, preferences, and positive behaviors), staff response to problem behaviors, ongoing supervision throughout the environment, and knowledge of job responsibilities. *Individual Participation p*rovided a review of engagement, as well as comments regarding the use of adaptive equipment. Lastly, *Formal Programming a*ddressed the presence of I-Books and appropriate training materials, data recording, and staff knowledge regarding individual goals and objectives. The tool ended with a section for comments and instructions for completion. The information gleaned from this monitoring tool should prove very helpful in assessing the quality of habilitation services provided to the individuals served. To help understand the usefulness of this tool, the Monitoring Team requested copies of	

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		completed forms. A total of 204 monitoring tools completed by five quality enhancement staff were reviewed. Monitoring had been conducted in residences, workshops, and day habilitation settings. Forms were considered to be complete if all of Parts I and II were scored, and if comments were added. While Part I was completed consistently (100%), Part II and the Comments sections were not always completed. In only 64 of the 204 forms (31%) was the section related to Formal Programming completed. Although comments were provided on 180 or 88% of the completed forms, this section proved to be the part of the form with the greatest degree of variation depending upon the staff member completing the form. One staff member consistently provided feedback, often referring to the materials provided, the adequacy of active treatment, or appropriate "redirection" of problem behavior. This same staff member noted problems with comments such as: "I've seen it better," "Not much happening," or "A few guys lined up in front of the television – not very appropriate." Another observer consistently described what she observed. A third observer did not provide comments in the majority of her reports. When comments were provided, observed problems were noted including an individual who was experiencing difficulty moving his wheelchair without any staff providing assistance. A fourth observer also commented infrequently, but when she provided positive feedback, it was without the benefit of descriptive praise. The last observer consistently provided comments. These often noted the presence of adaptive equipment, ongoing formal training, regular or pulled staff, or appropriate display of rights and hotline information. On at least four occasions, problems were noted including one situation in which an individual had taken off her clothing and was seated on the floor. While the staff are commended for their efforts to gather information regarding individual engagement and the overall quality of the environments in which the individuals live, learn, and recreate, these tools should be adapted to ensure maximum benefit. First, it would be helpful to focus on active engagement and environmental quality as two separate (albeit related) issues. The purpose of Planned Activity Checks (PLACHECKS) is to not only gather information on current levels of engagement, but more importantly to help staff develop their skills to improve opportunities for engagement. Positive descriptive feedback should be provided where appropriate activities, interactions, and engagement are observed. Equally important staff should be provided constructive suggestions for areas of improvement. Direct support professionals cannot be expected to create and expand opportunities for engagement and training on their own. Supervisory and support personnel should work collaboratively to advise and instruct the staff who work directly with the individuals. Immediate feedback, both verbal and written, should be provided so that staff are praised for their efforts and given suggestions for improvement in that specific situation. Feedback regarding materials, furniture, program books, data collection, and even individual attire might be something that is not directly related to the direct support	

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		professionals who are working at the time of the observation. Environmental quality might be a supervisory or administrative responsibility, program books and data collection might be the responsibility of professional staff, and individual attire might be related to the individual's resources or issues that residential supervisors need to address. These are all important elements that require ongoing attention, but they might be better addressed through other avenues. Regardless of the manner in which this information is gathered, it will only be useful if it results in an improved and enriched quality of life for the individuals served. During one visit to a residence, a member of the Monitoring Team was reviewing I-Books when the residential supervisor sat down to complete her paperwork. This staff member then filled in two hygiene and appearance checklists, although she was not observing either of the individuals. She then recorded data for four training objectives. Lastly, information was recorded on the behavior observation notes for one individual. Although it was approximately 3:20 pm, the time recorded in the notes was 1:35 pm. Clearly, this staff member did not understand the importance of recording data as, or immediately after instruction was provided, or the need for direct observation. It is essential that staff understand the purpose and the need for accuracy in all data collection. Once a system for collecting measures of inter-observer agreement is developed, this will help clinical and support staff to provide ongoing training and feedback in data systems. With regard to ensuring that all individuals are supported to have good hygiene and appropriate clothing, it might prove more helpful if administrative and support staff used the checklist to conduct random observations of individuals throughout the Facility. This remained an important matter, and one that was directly tied to basic rights and quality of life. Three observations made during the on-site visit deserved review. More specifically: ▪ During a visit to her residence, Individual #86 was observed sitting in her wheelchair in urine soaked pants. Although she was moving about the dining room with several staff present, it was not until the Monitoring Team member pointed this out to a staff member that the woman was changed. ▪ While visiting a day program, Individual #151 was observed with a colored drawing of a fish taped to his shirt. Although this was clearly not intended to be disrespectful to the individual, this was neither age-appropriate nor culturally acceptable. ▪ During a visit to a workshop area, Individual #195 was resting on a mat after having had his blood drawn. It would have been more appropriate for him to have been given the opportunity to recover on a couch or at home in his bed. As he was lying on his back, it was noted that this man's last name was written in marker near the front pocket of his pants. This is clearly contraindicated when	

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		one considers the principle of normalization or social role valorization. During the onsite review of the Facility, a number of individuals were observed who had visual impairments. The list of "Registration of Blind Students" indicated that a total of 65 individuals with significant visual impairment were residing at AUSSLC in November of 2010. In only one instance was an individual observed using a cane to navigate his environment. In no other case was there evidence of instruction in orientation and mobility skills. Without appropriate supports and specialized training provided to the staff who work directly with these individuals, the habilitation services provided to these individuals will be compromised. A review of I-Books across four residences revealed that in many cases, the books contained dated information, lacked data sheets for recording progress on program objectives, or reflected an absence of data for the current month. Of the 16 books reviewed, all but one contained the PSP. In 10 of 15 (67%), the PSP was over one year old. Eight of these 10 dated plans (80%) were from 2009. Similarly, where PBSPs were included and dated, six out of 13 (46%) were over one year old, with two from 2009 and one from 2008. In one residence, none of the books included data sheets for recording performance on program objectives. As the I-Books are intended to serve as guides for staff, it is essential that required documents are current and complete. It remained that data collected on skill acquisition programs were not presented in graphic format. Therefore, concerns addressed in the last report are repeated. 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 of activity, or something similar. Data also should be collected to evaluate the success or failure of maintenance and generalization of newly acquired skills. As noted previously, it also will be necessary to develop a system for collecting measures of inter-observer agreement to ensure that data is accurate and reliable. New staff orientation was expanded to include more in-depth information on active treatment. Particularly noteworthy was the description of the core components of active treatment, including: a) purposeful; b) age-appropriate; c) functional; d) offers choices; e) encourages independence; f) promotes skills; and g) provides opportunities to practice new and existing skills. The challenge will be to ensure that this sound	

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		philosophical approach to active treatment is put into practice. Additional training had been provided to Active Treatment Department staff and QMRP staff regarding effective objective writing. A board certified Associate Psychologist had developed an in-service training program and presented this to identified staff. She and another member of the psychology department developed a rubric for determining whether written objectives met the criteria outlined in her training. Written objectives were chosen and scored using this rubric resulting in pre- and post-training measures. An analysis of the data reflected an 11% improvement in written objectives. This collaboration between active treatment and psychology is most commendable. One area to include in future training is to plan for not only skill acquisition, but also maintenance and generalization of all behavior change. A review of the AUSSLC Policy regarding Personal Support Plan Process, dated 4/14/11, was completed. The policy clearly described competency-based training as a "…person's demonstration that he or she can use such knowledge and skills effectively in the circumstances for which they are required" (p. 2). This policy further indicated that such training would take place at initial employment, as needed, and every 12 months thereafter (p.17). The first step in this process will be to develop checklists that outline the essential steps a staff member should demonstrate when working with an individual. Once a staff member is familiar with these critical components of his/her job, supervisory or support personnel should schedule a time to observe the staff member as he/she performs the identified task. Components of the checklist on which the staff member displayed competence should be noted, areas of needed change should be addressed, and immediate feedback should be provided. While this is a lengthy process, it will ensure that the Facility is meeting the requirements of the Settlement Agreement, and result in improvement in the quality of habilitation services provided to the individuals.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	The Positive Assessment of Living Skills was reviewed for 14 individuals. This assessment addressed 41 skill areas across 16 broad categories including self-determination, self-care, adaptive equipment, communication, sensory characteristics relationships, home living skills, meal management, time management, leisure, campus living, money management, conceptual skills, telephone skills, mobility skills, and community living. The assessment also allowed for a summary of the individual's skills and needs. In none of the plans reviewed was there an indication that a formal preference assessment had been completed. Below is a table that outlines the number of areas assessed, essential areas excluded, and summary information provided for each of the 14 individuals.	Noncompliance

#	Provision	Assessment of Status			Compliance
		Individual	**Categories assessed**	**Summary**	
		Individual #160	10 areas across eight categories – no self-care, communication, or community living	Summary comments referred to the level of assistance/prompts needed; no skill training recommended.	
		Individual #84	26 areas across 13 categories	Summarized person's abilities and suggested areas to be trained.	
		Individual #284	18 areas across nine categories – did not include communication	Summary comments referred to the level of assistance/prompts needed; no skill training recommended.	
		Individual #30	Three areas across two categories – no self-care, communication, relationships, home living, meal management, or leisure	No summary provided, no suggestions for training.	
		Individual #335	11 areas across five categories – no communication, relationships, or leisure	No summary provided, no suggestions for training.	
		Individual #247	Four areas across four categories – no self-care, communication, relationships, home living, meal management, leisure, or community living	No summary provided, no suggestions for training.	
		Individual #185	21 areas across 11 categories – although this individual was visually impaired, mobility was not assessed	Summarized person's abilities and suggested some areas to be trained.	
		Individual #241	16 areas across 10 categories – no communication	In all but one area, summary comments referred to the level of assistance/prompts needed; one	

#	Provision	Assessment of Status	Compliance

		recommendation for training under money management.
Individual #141	12 areas across nine categories – no communication or community living	In all but one area, summary comments referred to the level of assistance/prompts needed; no skill training recommended.
Individual #412	Nine areas across eight categories – no self-care, communication, or community living	In all but one area, summary comments referred to the level of assistance/prompts needed; no skill training recommended.
Individual #323	33 areas across 15 categories	Summarized person's abilities and suggested areas to be trained.
Individual #186	22 areas across 11 categories – although this individual was visually impaired, mobility was not assessed	Summarized person's abilities and suggested areas to be trained.
Individual #320	14 areas across six categories – included assessment of shaving ability (face and neck) although this is a female – no communication, relationships, meal management, leisure, or community living	Summarized abilities and suggested areas to be trained.
Individual #212	15 areas across nine categories – no home living or community living	Summarized abilities and suggested areas to be trained.

As illustrated above, there was considerable variability in the quality of the assessment completed, with 12 of the 14 assessments (86%) lacking information in areas that were pertinent to the individual. When used appropriately, this tool would help provide a comprehensive assessment of an individual's adaptive behavior. The information

#	Provision	Assessment of Status	Compliance
		gleaned could then guide the development of training objectives to ensure that daily living skills, including skills related to work and leisure activities, are addressed. Barriers to community integration also should be identified. A total of 14 vocational assessments were also reviewed. Selected portions of the Comprehensive Assessment Program Planning System were completed. In five of the assessments (36%), additional information was provided under "Notes." This provided a better understanding of the individual's strengths and needs. Work-related objectives were included in 11 of the assessments (79%). General categories related to initiating work, sustaining work, and obtaining additional materials were addressed. A few assessments included objectives to improve overall behavior when at work. Where noted, prognosis for more independence was better than 50% positive in nine of 13 assessments (69%). Only two of the assessments (14%) included a brief reference to the individual's interest in a specific type of work. While the objectives were somewhat improved and the prognosis for greater independence was more positive, this assessment did not result in a vocational profile based on objective data, situational assessments, work history, or interest inventory.	
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 with regard to Sections S.1 and S.2, comprehensive assessment of an individual's needs is essential to designing a program of services that will promote growth and independence. At the time of the review, the Facility was not completing the assessment process as required by the Settlement Agreement. Further, skill acquisition programs were limited in their scope and did not address an adequate array of adaptive behavior. Programs were not written clearly, effective teaching interventions were not provided, and schedules did not allow for sufficient opportunities to master the identified skill. Programs were not individualized, nor did they consider an individual's preferences and interests. The AUSSLC Policy on Personal Support Plan Process clearly indicated that: "… training objectives will occur in the most integrated setting" (p.14). However, of the 361 individuals residing at AUSSLC, only one was employed in an integrated, community-based setting at the time of the visit. Clearly, there were vast opportunities for work and	Noncompliance

#	Provision	Assessment of Status	Compliance
		leisure activities within the greater Austin area. It will be important to explore training opportunities beyond the boundaries of the campus. One area of concern raised during the visit was an understanding of the need to balance an individual's right to freedom of choice with the Facility's responsibility to provide services and supports that meet the individual's needs (see Risley, 1996). There were several individuals who had been reportedly were refusing to attend work or leave their residences. Individual #332 was reported by his vocational instructor to have gone to work only five times in March. The staffing reports for Individual #395 reflected an increasing pattern of work refusal and extended time in bed. When Individual #168 was observed disrobed on her bare mattress, a staff member explained that she does not like sheets. When Individual #190 was observed poorly positioned in a recliner in his residence, a staff member reported that he did not sleep well at night, and therefore, he had the right to sit in the recliner anyway he chose. Without appropriate support and habilitation services, life will not improve for these individuals. The level of expectation must be raised for each individual to live as enriched and independent a life as is possible.	
	(b) Include to the degree practicable training opportunities in community settings.	Although the above-mentioned policy indicates that at least one community-based objective would be included in the individual's PSP, but this policy was not consistently followed. As noted with regard to Section S.1, only four of the 42 PSPs reviewed (10%) clearly identified community training objectives. While the policy indicates that justification must be provided when community-based objectives are not included, this was not addressed in the PSPs. Opportunities to access the community were not sufficient. Training in work and leisure skills in the community should be a component of most, if not all, PSPs.	Noncompliance

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

1. Comprehensive plans should be developed that will ensure the individual is learning skills across a range of domains, including social, communication, self-care, academic, vocational, leisure, domestic, and community living. (Section S.1)
2. 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. In addition, it will be essential to assess and identify activities that are age-appropriate, functional, and of interest to the individual. (Section S.1)
3. Ongoing staff training and supervision will be necessary to ensure that staff are provided the support necessary to promote learning among the individuals served. This will include not only a better understanding of the goals of habilitation provided through didactic instruction, but will also require competency-based training to ensure that staff are implementing teaching strategies and supports in the most effective manner possible. (Section S.1)
4. 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. (Section S.1 and S.2)

5. 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, ensuring 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. (Section S.1)
6. An area that should be included in future training on the development of skill acquisition programs is to plan for not only skill acquisition, but also maintenance and generalization of all behavior change. (Section S.1)
7. 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. (Section S.1)
8. With regard to the tool being used to measure engagement, as well as to collect additional information related to active treatment, the following changes should be considered:
    a. Active engagement and environmental quality should be separated as two separate (albeit related) issues.
    b. Positive descriptive feedback should be provided where appropriate activities, interactions, and engagement are observed.
    c. Staff should be provided constructive suggestions for areas of improvement. Supervisory and support personnel should work collaboratively to advise and instruct the staff who work directly with the individuals. Immediate feedback, both verbal and written, should be provided so that staff are praised for their efforts and given suggestions for improvement in that specific situation.
    d. Feedback regarding materials, furniture, program books, data collection, and even individual attire might be something that is not directly related to the direct support professionals who are working at the time of the observation. These are all important elements that require ongoing attention, but they might be better addressed through other avenues.
    e. With regard to ensuring that all individuals are supported to have good hygiene and appropriate clothing, it might prove more helpful if administrative and support staff used the checklist to conduct random observations of individuals throughout the Facility. (Section S.1)
9. I-Books should be checked to ensure all necessary material is included and current. (Section S.1)
10. A plan should be developed to ensure inter-observer agreement measures are collected on skill acquisition programs. (Section S.1)
11. 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. (Section S.1)
12. 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. (Section S.2)
13. 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. (Section S.3)

14. Preference assessments are recommended to ensure that potentially effective reinforcers are incorporated into all training objectives.
15. Staff should provide assistance and training to individuals who are refusing efforts to further develop their skills or expand their access to a variety of environments. Efforts should be made to ensure that individual preference is assessed and addressed to the extent possible. (Section S.3)

References:

Cooper, J.O, Heron, T.E., & Heward, W.L. (2007). *Applied behavior analysis (second edition).* Upper Saddle River, NJ: Pearson.

Doke, L.A., & Risley, T.R. (1972). The organization of day-care environments: Required vs. optional activities. *Journal of Applied Behavior Analysis, 5*, 405-420.

Risley, T.R. (1996). Get a Life! Positive behavioral intervention for challenging behavior through life arrangement and life coaching. In L.K. Koegel, R.L. Koegel, and G. Dunlap (Eds.), *Positive behavioral support: Including people with difficult behavior in the community.* Baltimore, MD: Paul H. Brookes Publishing Company.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of individuals referred for placement, since the last onsite review, undated; o List of individuals who have requested community placement, but have not been referred, undated; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed, since 10/11/10; o List of individuals who transferred to the community (excluding alternative placements), since the last review; o In response to request for list of alternate discharges, the response: "None"; o Community Placement Report, dated 4/14/11; o Community Placement Obstacles, from 5/12/10 to 5/12/11; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o Educational Opportunities Regarding Community Alternatives: Client Alpha List – Community Exposure, from 2/20/08 through 4/15/11; o Agenda and handouts for Austin SSLC Training on Living Options, Community Referral Process, and Community Placement, dated 3/28/11; o List of Training and Educational Opportunities for Staff that Address Community Living, from 10/19/10 through 3/28/11; o DADS "Explanation of Mental retardation services and supports," dated February 2010; o In response to request for: "For the last 12 months, a list of individuals who have been assessed for placement, date of assessment, and resulting recommendations," a statement that: "AuSSLC does not assess individuals for placement; there is no assessment tool. Living option (sic) are considered during annual meetings and documented in the PSP"; o In response to request for: "A description of how the facility assesses an individual for placement," a statement that: "AuSSLC does not use a formal assessment tool to assess an individual for community placement. This is because anyone can be served in the community with the right supports in place; an individual does not have to be ready or meet a certain criteria to be referred and placed"; o Tool used to ensure all relevant assessments are submitted within 45 days of the individual's move date, undated; o In response to request for: "Any facility-wide needs assessments related to the provision of community services to people with developmental disabilities," the response: "None"; o In response to request for: "A printout of the database/report summarizing the obstacles identified for individuals' movement to the most integrated setting appropriate," a statement that: "Database is not yet operational"; o In response to request for: "Most recent report of the facility's analysis of the major

	obstacles to the individuals' movement to community living as identified by the SSLC," the statement that: "Database in not yet operational"; o In response to request for: "A list of all people returned from a community residential placement, the response: "None"; o In response to the request for: "A list of all deaths that occurred following transitions to the community, the response: "None"; o PSPs and related assessments for the following individuals: Individual #272, Individual #19, Individual #74, Individual #350, Individual #244, Individual #339, Individual #301, Individual #434, Individual #227, Individual #195, Individual #109, Individual #168, Individual #323, Individual #199, and Individual #365; o Community Living Discharge Plans, PSPs, and related assessments for: Individual #285, Individual #192, Individual #384, and Individual #167 (in draft form); o List of all Post-Move Monitoring, since the last review; o As available, pre-move monitoring documentation and Post-Move Monitoring Checklists for: Individual #285, Individual #170, Individual #401, Individual #125, Individual #192, Individual #384, and Individual #446; o PSPAs in response to post-move monitoring results for Individual #446, and Individual #170; o Monitoring/review tools, including: ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options, revised February 2011; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options Guidelines, revised February 2011; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 and 4 – Planning for Movement, Transition, and Discharge and Alternative Discharges – Review of Community Living Discharge Plan (CLDP), revised February 2011; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 1 and 4 – Planning for Movement, Transition, and Discharge and Alternative Discharges – Review of CLDP Guidelines, revised February 2011; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post Move Monitoring, revised February 2011; ▪ Settlement Agreement Cross Referenced with ICF/MR Standards, Section T – Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post Move Monitoring Guidelines, revised February 2011; o Plan of Implementation for Section T; 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 #107; o Post-Move Monitoring Visits for Individual #285; o Visits to various residences and day programs on campus; and o CLDP meeting for Individual #167.
	Facility Self-Assessment: The Facility's POI provided a very helpful narrative description of the activities the Facility had undertaken since the last review to reach compliance with the Settlement Agreement. The Facility's Presentation Book for Section T also included a significant amount of information, which was valuable to the Monitoring Team as it attempted to learn about the progress that had been made. The Facility generally found that it remained out of compliance with the most of the provisions of Section T, which was consistent with the findings of the Monitoring Team. However, as noted in the POI, much progress was being made. The provisions for which the Facility found it was in compliance included: ▪ Section T.1.c.3, which required the Facility to review the CLDP with the individual and his/her guardian, as appropriate. The Monitoring Team agreed with the Facility's assessment. ▪ Section T.1.e, which requires the Facility to verify through the MRA, or otherwise, that the essential supports are in place prior to the individual's departure from the Facility. The Monitoring Team did not agree with this assessment. Although progress had been made in defining essential and non-essential supports, none of the CLDPs included a comprehensive set of supports. The process for verifying such supports had improved with the involvement of the Post-Move Monitor. However, documentation provided did not support that this had happened consistently. ▪ Section T.1.h, which requires the Facility to submit a community placement report to the Monitor and DOJ every six months. Unfortunately, due to what appears to have been an oversight, the report provided to the Monitor did not cover the six-month reporting period. As a result, the Monitoring Team found the Facility out of compliance on this provision. It should be noted that the POI included no monitoring data. It was unclear how the Facility had reached its conclusions related to compliance without such data. As the Facility's self-assessment process expands, it will be important to include such data in the POI to substantiate compliance findings.
	Summary of Monitor's Assessment: 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. 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. AUSSLC held a community provider fair in March 2011. Due to extensive outreach efforts, attendance of individuals and staff was very good. Family and guardian involvement was minimal, but the Facility was following up with a survey to determine if another day and time, or format would be more appealing to this group. Individuals were assisted to ask questions about community options that were available, which increased the educational value of the event. PSTs had made little progress in identifying obstacles to community placement, and/or developing plans to overcome them. The Facility was not yet aggregating or analyzing information related to obstacles/barriers to community transition. The CLDPs reviewed included essential and non-essential supports, and significant progress had been made in better defining more of the protections, supports, and services individuals need. However, teams still 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. Each of the items on the checklists had been addressed. Efforts clearly were being made to add information regarding the interviews conducted, the documents reviewed, and the observations made. This assisted in justifying the Post-Move Monitor's findings with regard to whether or not protections, supports, and services were adequately in place. As noted in the previous report, the biggest difficulty the Monitoring Team noted was with regard to the standards used to monitor. During this most recent review, questions arose with regard to the stringency of monitoring standards being used to evaluate community providers.

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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	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	Noncompliance

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	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.	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 once individuals' teams made referrals to the community, 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. For example: ▪ For Individual #301, the professionals on the team did not appear to provide any independent assessment or recommendation regarding community transition. The narrative of the PSP indicated that his guardian's preference was Individual #301's continued placement at AUSSLC. It later stated: "The PST determined the most integrated setting at the current time is: to remain living at Austin State Supported Living Center…" ▪ No evidence was found that the professionals on Individual #244's team had made an independent assessment or recommendation regarding community transition. Individual #244's team identified no obstacles for transition to the community. With regard to the most integrated setting, the team concluded: "The team has agreed with her guardian, [name of guardian], that AuSSLC is the most integrated setting for [Individual #244]. The team feels [Individual #244] is fine to remain at [number of residence] however, the team is aware that [Individual #244] may benefit from being around more people who [use] sign [language to communicate]. It is felt that if there is a female home on campus where there is more communication in this mode then [Individual #244] should move there…" Concerns related to the team's lack of action related to Individual #244's need for communication supports are discussed in further detail with regard to Section F of the Settlement Agreement. 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	

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		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. Based on discussions with the Admissions Placement Coordinator and Post-Move Monitor, the Facility recognized the need to increase referrals to the community. Efforts were planned to meet with the various PSTs on campus to review community options, and the referral and transition processes. It should be noted that at the time of the review, eight individuals had been referred for transition to the community. A number of these individuals had complex needs, particularly behavioral needs. Based on discussion with the Admissions Placement Coordinator and Post-Move Monitor, Facility staff were working closely with community provider staff to develop configurations of services that would meet their needs. This was positive, and showed a commitment on the part of the Facility, as well as community providers to address the needs of individuals with complex needs in the most integrated setting appropriate.	
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. It was anticipated that DADS would issue a revised policy on Most Integrated Setting soon. In its POI, AUSSLC indicated that once the policy was issued, it would adopt and modify it, as needed. The three Monitoring Teams recently had submitted comments on the DADS draft policy for the State's consideration. In addition, the Facility remained out of compliance with the implementation of the policy. This is discussed below with regard to each of the subsections of provision T.1.b of the Settlement Agreement. As a result, an overall finding of noncompliance has been made for Section T.1.b.	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	Requirement T.1.b.a of the Settlement Agreement 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, minimal improvement was seen in these areas. The two major requirements of this section of the Settlement Agreement 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 Settlement Agreement, as well as throughout other sections of the report, PSPs generally did not	Noncompliance

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	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.	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 three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals served by AUSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the 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, and non-essential supports are provided in a timely and complete manner. 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>: Teams continued to be struggling with the identification of obstacles and strategies to overcome them. The new format for the PSP included a section on obstacles identified by the PST. In reviewing a sample of six PSPs (for Individual #301, Individual #227, Individual #301, Individual #365, Individual #195, and Individual #244) that utilized the new format, often some obstacles were identified. It often was unclear if: 1) the lists of obstacles were based on the team's knowledge of what was or was not available in the community, because often they were written in terms of the needs of the individual as opposed to lack of availability of such supports in the community, or the lists included items that were not actually obstacles; and 2) if the lists were complete. Of the six PSPs reviewed, three had	

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		some obstacles defined (50%) (i.e., Individual #301, Individual #227, and Individual #301). Individual #365, Individual #195, and Individual #244 did not. Moreover, action plans to overcome the obstacles identified generally were not present. Of the six PSPs, one (17%) included an action plan to address educational opportunities for the individual and/or family/guardian (i.e., Individual #227). None (0%) included plans to address other identified barriers. The following provide examples of PSPs that did not adequately define obstacles, and/or the plans to overcome them were inadequate: ▪ Individual #227's team indicated that her "needs could be met adequately in a community setting." However, her guardian was reluctant to have her move due to Individual #227's familiarity with AUSSLC, and her dislike for change. In the narrative section of the report, the team documented that the guardian "did express an interest in going with [Individual #227] on a community exposure tour…" An action plan was developed, but it did not indicate that the guardian would be involved in the community tour. It also provided no indication of what follow-up the team would complete to determine Individual #227's and/or her guardian's reaction to the visit. The timeframe for completion was 12 months, which seemed to be an excessive amount of time to complete this objective. It should be noted that a PSPA was held approximately a month after the annual PSP meeting, at which time the team discussed a new housemate who had pushed Individual #227 to the ground twice within a the span of a couple of weeks, placing her at risk due to instability in her neck. The guardian was not involved in this meeting. The team considered having Individual #227 move somewhere else on campus, but it did not appear that the team considered recommending to the guardian that a smaller community home be considered. ▪ Although Individual #301's guardian was reluctant to consider transition to the community, based on the documentation in the PSP, it was not clear whether or not the PST had explored the specific reasons for this reluctance. In addition, although the team had identified some obstacles, it was unclear whether or not they actually all were obstacles. For example, under the obstacles section, the team had listed that Individual #301 "will need 24 hour nursing." In neither this section nor the action plan section of the PSP had the team had defined the specific nursing supports he required. Likewise, the team documented in the section on obstacles that Individual #301 "is unable to be exposed to the outdoors if temperature drops below 40 degrees." This was not mentioned anywhere else in the PSP, but it also was not clear why the team viewed this as an obstacle to transition to the community. Likewise, the team had identified wheelchair accessible transportation as an obstacle, which should not be an obstacle. The remaining obstacle the team identified related to his need for	

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		habilitation therapy supports, which the team believed would best be provided through a centralized location. The team concluded that: "in general, it is challenging to find such centralized services outside of a large facility." No plan was developed to research whether such supports existed in a community setting. ▪ Although Individual #244's team did not identify any obstacles to her transition to a community setting, in the narrative section of the document, the team documented some of her guardian/mother's concerns. These included that the guardian believed AUSSLC was "the best place for her," and that Individual #244 was happy where she was. The PSP also stated: "[Individual #244] likes to be able to walk freely around her neighborhood and can do that at AuSSLC but may not be able to do that in a different home." No action plans were developed to explore other options, including those that might allow Individual #244 access to safe places to walk, such as local parks, or could provide equivalents to this, such as a job that would give her the opportunity to walk from place to place. Based on AUSSLC's POI, the Facility recognized that the Living Options Discussion portion of the PSP meetings needed to improve. According to the POI, on 5/1/11, the Post-Move Monitor would be monitoring at least 10 percent of the PSPs on a monthly basis, using the new monitoring tools. The new tools are discussed in further detail with regard to Section T.1.f of the Settlement Agreement. The POI also indicated that the State had hired a consultant "to conduct independent reviews of the living options discussions." AUSSLC remained at the beginning stages of identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition to PSPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Consistent with the previous review, AUSSLC, in conjunction with the Intellectual Developmental Disability (IDD) Local Authority, previously known as 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 March 4, 2011, a provider fair was held. This event was planned in conjunction with the IDD Local Authorities with whom the Facility regularly works, as well as a number of community providers. In response to a Monitoring Team recommendation, the Facility set goals for itself to measure success more objectively, as well as action steps to achieve these outcomes. The desired outcomes included: 1) increasing attendance by all parties, particularly	Noncompliance

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		individuals and staff; 2) having comprehensive representation of community providers from all fields of service and geographic areas AUSSLC served; 3) obtain feedback though evaluations and surveys to improve the event; and 4) log all steps taken to create a template for future events. The following provides a summary of the Facility's success with the event: o According to the information collected, 23 provider and several other community resources staffed booths, where information was available and those who attended could ask questions. According to staff, day habilitation programs had minimal representation. Increasing their participation had become a goal for the next provider fair. o Based on interview and the documentation provided, attendance by individuals and staff was very good. Over 300 staff, and approximately 150 individuals attended the fair. Several QMRPs had committed to ensuring that all of the individuals in the residences they supported would have the opportunity to participate. This required close coordination with Residential Services to ensure adequate staffing coverage at the residence, as well as for individuals as they went to the provider fair. On another positive note, many of the individuals, some with assistance from staff, developed and asked relevant questions about the community providers and the services they offer. o The Facility reported less success with regard to family/guardian involvement. In response to this, the Facility planned to conduct a survey with families and guardians. It was thought that holding the provider fair on a weekend or evening might increase attendance of families and guardians, but the survey was expected to assist the Facility in determining if this was the case. The Facility planned to hold another fair within approximately six months. o The Self-Advocacy Group assisted in handing out a survey to allow the Facility to obtain feedback on the event. This feedback was being reviewed to determine any changes that might be necessary for future events. ▪ 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 live or work. The IDD Local Authorities 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. Based on the list provided, between 5/1/10 and 4/15/11, almost a year's time, only 22 individuals had had the opportunity to visit homes and/or day programs in the community. AUSSLC is encouraged to continue and expand	

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		upon these opportunities for visits to community homes and/or day programs. From the listing provided, it was unclear if some of these visits were pre-placement visits, after individuals had been referred to the community. ▪ 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. Similar to the outcomes developed for the provider fair, outcomes should be developed and measured with regard to the CLOIP process. ▪ The minutes from the monthly Self-Advocacy Committee meetings showed that they had been actively involved in the planning of their involvement with the provider fair. The most challenging area with regard to education of individuals, families, and guardians is individualizing this process, and documenting that individuals and their guardians are making informed decisions. Of the six PSPs reviewed for individuals who were not referred for transition to the community, one (17%) identified a need for further education (i.e., Individual #227). 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 Settlement Agreement.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each	The Monitoring Team requested for the last 12 months, a list of individuals who had been assessed for placement. In response to this request, AUSSLC submitted the following statement: "AuSSLC does not assess individuals for placement; there is no assessment tool. Living option (sic) are considered during annual meetings and documented in the PSP." In response to request for: "A description of how the facility assesses an individual for placement," a statement was submitted that read: "AuSSLC does not use a formal assessment tool to assess an individual for community placement. This is because anyone can be served in the community with the right supports in place; an individual does not have to be ready or meet a certain criteria to be referred and placed." Moreover, in its POI, the Facility indicated that: "All individual are assessed for	Noncompliance

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	Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	community placement during their annual PSPs. However, the quality and depth of the living options discussion is not currently in alignment with policies and best practice. It was positive that AUSSLC recognized this as a need, and had asked the State Office Continuity of Services Coordinator to come to AUSSLC to provide training to all team members regarding Living Options/Most Integrated Setting. This training occurred on 3/28/11, and was mandatory for all PST members. All but three of the current QMRPs, and 163 PST members attended the training. A make-up session was scheduled in May for those team members who were unable to attend. Based on the agenda and handouts for the training, it provided information about available community services, the transition planning process, and the methodology for identifying, and documenting obstacles to transition. As is discussed above with regard to Section T.1.a of the Settlement Agreement, 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. Professionals on individuals teams should formulate such recommendations, and they 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.	
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.b of the Settlement Agreement, 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. AUSSLC was in the initial stages of implementing the new Community Living Discharge Plan process. Many of the changes to the CLDP format were in response to discussions that Monitoring Teams had with Facility and State staff during onsite monitoring visits, as well as in response to findings noted in baseline monitoring reports. The Monitoring Teams appreciate and acknowledge the Facility and State's responsiveness. Additional comments regarding the specific CLDPs reviewed are offered later in this section. The following comments are based upon a review of the 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	Noncompliance

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		has moved by reviewing the results of each post-move monitoring visit. ▪ The form included a section for documentation of key events, such as dates referral packages were sent to the IDD Local Authority, dates potential provider lists were sent to the PST, dates the PST met to decide upon providers for pre-selection visits, information related to pre-selection visits, and results/deliberations of such visits. Because the CLDP is a document that would need to be updated at many stages of the process, it is recommended that dates be included each time the document is revised. For example, such dates could be added to the first page, or placed in the footer. ▪ A list of standard items to be completed and in place prior to every individual's move now appeared on page six (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 non-essential supports that were truly based upon individual needs and preferences. ▪ The list of summaries and recommendations on page nine was also an improvement. It was designed to help the PST remain focused on its primary 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 non-essential supports. ▪ If the PNMT has conducted specific assessments, and/or made recommendations, these should be included. ▪ 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 non-essential 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. ▪ Many of the person directed planning questions included on pages 13 and 14 should assist teams in planning for individuals' transition to the community. It will be essential, as the process is implemented, to ensure that the information gathered from this component of the new process is incorporated into the essential and non-essential supports. ▪ It was also good to see that the CLDP required a description of the evidence to indicate whether or not an essential or non-essential support was in place. This	

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		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 six. This could be added to the list on page 23. Community Living Discharge Plans were reviewed for three individuals (i.e., for Individual #192, Individual #384, and Individual #285), and an additional draft plan was reviewed (i.e., for Individual #167). This sample was drawn from the list of six individuals who had had CLDPs developed 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. Since the previous reviews, significant progress had been made in including a more complete list of measurable action steps, and/or essential supports and services in the CLDPs. However, the process needs continued refinement 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 Settlement Agreement, and some examples are provided. With regard to timeliness of the Community Living Discharge Plans, according to the dates on the plans, none of the three reviewed (0%) were developed more than a few weeks prior to the individual's 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. However, this might be a function of documentation versus the actual planning process. All of the plans reviewed used the new CLDP template. The CLDPs documented the many efforts of the team from the time of the referral, until the time of transition. This often spanned approximately six months. According to the documentation, the teams began discussing essential and non-essential supports during the meeting at which the decision was made to make a referral to the community. Given that the CLDP is meant to be a living document that grows each time the team meets, a way of documenting the various team meeting dates, such as in the footer of the document is recommended.	
	1. Specify the actions that need to be taken by the Facility,	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	Noncompliance

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	including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	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 Settlement Agreement, 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 three CLDPs (0%) adequately defined the Facility staff's role in assisting community provider staff to learn about these plans and their implementation. When such training was referenced, the CLDP did not define what the training would consist of, what the AUSSLC's role would be in the training, or specifically what the expectations were with regard to the competency of the community provider staff in implementing the programs. None of the three plans described the need for collaboration between staff that AUSSLC and staff, consultants, or clinicians in the community. For example, it would be expected that clinical staff at AUSSLC would be responsible for sharing information and answering questions through face-to-face or telephone contact with their counterparts in the community. In none of the plans reviewed was this included as a requirement. Likewise, in none of the plans reviewed were expectations included for community provider staff or consultants to spend time at AUSSLC to get to know the individual, and/or to work with their counterparts to learn about the individual's routine and/or program. Again, for some individuals, this would be appropriate and expected. 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 Settlement Agreement, 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. This was not written into CLDPs as an essential support. The monitoring activities were identified in the CLDPs, including the role of the IDD Local	

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		Authority, 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: ▪ Although training was required on Individual #192's BSP, CLDP, and Special Considerations, the person responsible for this training was the Program Coordinator for the community provider agency. Various staff at AUSSLC, including the Psychologist, QMRP, nurse, etc., would have more appropriately provided this training. If the Program Coordinator was to provide the training, he/she should have been required to demonstrate competence in implementing the various plans. This might also have been an appropriate role for the community provider agency's psychologist, in consultation with the AUSSLC psychologist.	
	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 three of the plans reviewed (100%).	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	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 three of the three plans reviewed (100%), sign-in sheets were provided that confirmed the presence of the individual and his/her guardian. The Monitoring Team also observed a CLDP planning meeting, at which the individual was present and participated. Her family, who were not her guardians, also were present, and offered input into the planning process.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	Based on the documented dates of assessments reviewed at the CLDP meetings, in none of the three individuals' CLDPs assessments (0%) had been updated within 45 days. Timely assessments were not available for: ▪ Many of Individual #192's assessments or assessment updates were more than 45 days old, including the medical, vision, dental, OT/PT, psychological, vocational, and psychiatric assessments. ▪ Similarly, a number of Individual #384's assessments were older than 45 days, including the psychology, OT/PT, hearing, and psychiatry assessments. In addition, it appeared that the RN Case Manager had completed the "medical evaluation," and a full nursing assessment had not been completed. It was unclear why the physician had not updated the medical assessment, and made	Noncompliance

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		recommendations. ▪ Individual #285's psychiatric assessment was older than 45 days. He had a number of psychiatric issues, necessitating an up-to-date psychiatric assessment. The Facility was using the new CLDP format, on which the assessments would be listed, including whether or not an update was required, the person responsible, and the date of completion/review/update. This should be a helpful tool in ensuring that all assessments are updated, available for use by the team in the finalizing the CLDP, and available to the community provider(s).	
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 three CLDPs reviewed included essential and non-essential supports. Although substantial progress had been made in identifying a larger array of supports, as well as ensuring that the supports were more measurable, 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 three 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 both positive aspects of, as well issues identified with regard to the identification of measurable essential and non-essential supports: ▪ Individual #192's CLDP set forth a number of essential and non-essential supports, and identified the evidence that the Post-Move Monitor would use to confirm their existence. For example, the CLDP required the community provider to have a psychiatrist, neurologist, and psychologist or behavior analyst on contract or staff at the time that Individual #192 moved to the community. The plan also required implementation of the AUSSLC PBSP, including data collection, until a community-based plan was developed. It further required that a community-based plan be developed and in use within 90 days. Likewise, it required his AUSSLC diet to be maintained, and that a community nutritionist conduct an assessment within 90 days. However, there were some areas in which the plan did not specify or did not specify in sufficient detail the essential and non-essential protections, supports, and services that Individual #192 required. The following provide a few examples: o As noted above, although training was required on Individual #192's	Noncompliance

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		BSP, CLDP, and Special Considerations, the person responsible for this training was the Program Coordinator for the community provider agency. Various staff at AUSSLC, including the Psychologist, QMRP, nurse, etc., would have more appropriately provided this training. If the Program Coordinator to provide the training, he/she should have been required to demonstrate competence in implementing the various plans. This might also have been an appropriate role for the community provider agency's psychologist, in consultation with the AUSSLC psychologist. o No requirements were included in the plan with regard to staffing ratios, or supervision levels. For example, none of the essential supports identified whether Individual #192 required one-to-one supervision, or if he could be left alone for unlimited periods of time. o Likewise, staff qualifications were not clear. For example, although it appeared from Individual #192's BSP that physical holds had been used with him, and he required de-escalation techniques, at times, no requirements for staff to be certified in psychological and physical management techniques were included in the CLDP. Likewise, he used some sign language to communication, but no requirements were included for staff to have sign language skills. o Although the plan required the provider agency to have a psychologist or behavior analyst on staff or under contract, the CLDP did not define the role of such staff or consultants. For example, no requirements were included for them to train staff, review data, make observations of staff's implementation of the plan, or make adjustments to the plan in the interim until a new community plan was developed. o Individual #192 appeared to have dental and nursing needs, but these were not carried forward in the CLDP. 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 previous reports, the MRA/IDD Local Authority 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 IDD Local Authority 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. For the seven individuals included in the sample of pre- and post-move monitoring (i.e.,	

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		Individual #285, Individual #170, Individual #401, Individual #125, Individual #192, Individual #384, and Individual #446), four (57%) had pre-move monitoring forms completed by the Post-Move Monitor (i.e., Individual #446, Individual #125, Individual #285, and Individual #192). For those that were provided, it appeared that appropriate steps had been taken to confirm that essential supports were in place, and this had been done in a timely manner (i.e., at least a few days to a week before the planned transition date). In at least one instance, a support was not present, but the pre-move visit occurred sufficiently prior to the transition date to allow correction of the problem. Specifically, for Individual #125, an essential support was alarms on his bedroom door to protect him and his housemates. It was not in place at the time of the pre-move site visit by the Post-Move Monitor, but was brought the community provider's attention, and corrected prior to the individual's move.	
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.	AUSSLC had begun to use revised monitoring tools to evaluate its compliance with Section T of the Settlement Agreement. The revised monitoring tools that the State Office provided included guidelines. They also were divided into three different review tools. The three tools addressed: 1) Planning for Movement, Transition, and Discharge/Review of Living Options; 2) Planning for Movement, Transition, and Discharge/Review of CLDP; and 3) Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs/Review of Post-Move Monitoring. This allowed the reviewer(s) to draw samples of individuals who remained at the Facility, as well as individuals who already had transitioned to the community. Having these various samples was necessary to review the various provisions of the Settlement Agreement that address planning activities, transition activities, pre- and post-move monitoring, and alternate discharges. The Facility had developed a grid that identified the samples that would be drawn for each review tool, and each auditor responsible for their completion (i.e., QA staff and departmental staff). The development of guidelines to supplement the review tools was a positive step. The Monitoring Team will not comment here on the full set of guidelines. However, it is important to note that some of the interpretations included in the guidelines were inconsistent with those of the Monitoring Teams. This likely will result in differences in the Monitoring Team's compliance determinations and the Facility's self-assessment of its compliance with the Settlement Agreement. The following provide a couple of examples of this: ▪ With regard to Section T.1.a of the Settlement Agreement, one of the State's guidelines read: "Is there documentation that the PST members were individually in consensus with the placement decision? Refer to the living options discussion." As is discussed above with regard to this section of the Settlement Agreement, the Monitoring Teams expect to see an independent recommendation(s) from the professionals on the team.	Noncompliance

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		▪ Question #4 on the Review of Post Move Monitoring tool addressed: "If any of the noted deficiencies appear to be in areas essential to health and safety, these were addressed in (however are not limited to) the manner below: immediate manner, effective manner, recommendations were made, and actions taken to remedy all deficiencies noted." The guidelines read: "This is referring to deficiencies that the facility is accountable for. For example, if it is discovered through a PMM visit that we did not provide a piece of assistive equipment, actions were taken to correct the issue as soon as possible." This is not an accurate interpretation. The Monitoring Teams would expect to see that the Facility took appropriate action to address any deficiencies related to health and safety regardless of whether or not the Facility was identified in the CLDP as responsible. ▪ Some of the guidelines provided incomplete direction. For example, for Section T.2.a, it is important for the reviewers to ensure that post-move monitoring visits included visits to each site at which protections, services, and supports are provided (e.g., home and day/vocational sites). However, clear instructions to this effect were not found in the guidelines. The guidelines read: "Check PMM documentation to ensure that all of the required timeframes were met, that they were thoroughly completed, and that the documentation is reflective of the specifics of the visit." Without additional guidance regarding specifically what is expected, there likely will be discrepancies between reviewers. At the time of the review, this monitoring process was fairly new. A relatively small sample had been reviewed. Based on the documentation provided, the data had not yet been aggregated and/or analyzed. In addition to establishing inter-rater reliability, the analysis of data will be an important next step, which should be facilitated by a database State Office was finalizing for use by all of the SSLCs.	
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	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. In addition, in response to request for: "A printout of the database/report summarizing the obstacles identified for individuals' movement to the most integrated setting appropriate," the Facility submitted a statement that read: "Database is not yet operational." In response to request for the: "Most recent report of the facility's analysis of the major obstacles to the individuals' movement to community living as identified by the SSLC," AUSSLC also submitted a statement that: "Database in not yet operational." In discussing this with staff, the Facility was collecting data on "barriers," which appeared to be defined as issues preventing teams from referring individuals, but not "obstacles," which appeared to be defined as issues related to actually transitioning the individual to the community. It remained unclear how or why this distinction was made. However, the Facility was able to produce a listing of aggregate numbers of "barriers" to individuals being referred.	Noncompliance

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	assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	A list was produced in response to a request for: "For the past year, report/list of barriers to transition to the community, including the individual, date of staffing and barriers identified." The document stated: "The data below reflects individuals that had a preference of Community Placement, but were not recommended for placement to the community by the IDT [Interdisciplinary Team]." This resulted in a list of only 14 individuals. The data for this small group of individuals was as follows: ▪ LAR Choice – 71.4%; ▪ Behavior/Psychiatric – 14.3%; ▪ Medical – 0%; ▪ Citizenship/Funding – 0%; ▪ Prefers Family/Not Available – 0%; ▪ MRA Not Present – 14.3%; ▪ Exploring Community Options – 0%; ▪ Legal Issues – 0%; ▪ Pending Community Risk Assessment – 0%; ▪ Intra-State Transfer – 0%; and ▪ Other – 0%. Although this data provided some valuable information, no analysis had yet been completed. The Monitoring Team looks forward to reviewing reports on obstacles, including analyses of the data during future reviews. Based on interviews with staff, as well as record reviews and visits to community programs, anecdotally, a number of potential obstacles to individuals receiving the supports they needed in the community were identified. In addition, the Monitoring Team discussed with Facility staff the patterns regarding recent admissions and referrals to the Facility, which were also indicative of concerns in the community system that result in individuals requiring placement in more restrictive settings. Obstacles and concerns included: ▪ Since the last review, only one individual had been admitted to AUSSLC. However, a number of referrals also had been made, some of which were in the process of being considered. The primary reason for these individuals being admitted was behavioral concerns that did not allow them to be supported safely in the community. ▪ Many individuals who worked in the work center on campus might not have the same opportunity in the community. Although reportedly there were some work centers and other vocational opportunities in the community, these were limited, and many did not offer behavioral supports. As a result, when an individual engaged in a behavior considered to be inappropriate, they often would be discharged from the community work center or vocational program.	

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		▪ Based on the review of a sample of PSPs, teams had the perception, whether it was true or not, that individuals with complex medical needs could not effectively be supported in the community. For example, "24 hour nursing," and the need for centralized medical and therapeutic services frequently were cited as obstacles to individuals transitioning to the community. It will be important as teams discuss potential community transition that if such obstacles impact individuals that these are clearly identified to provide the State with the information it needs to take appropriate steps to overcome such obstacles. As indicated in the Settlement Agreement, the State would need to take such steps subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report, dated 4/14/11. However, the report did not appear to cover a six-month period, as the Settlement Agreement requires. Unfortunately, this issue was not identified until after the onsite review was completed. It likely was an error in the printing of the report. The report listed individuals who had been referred by their teams for community placement between 11/2/10 and 3/15/10, including the individual's name, the date of referral, and, if applicable, the date the referral had been rescinded. The list included eight names of individuals referred, none of whom had had their referrals rescinded. The list of individuals for whom community placements had occurred, only included one individual (i.e., Individual #384). However, according to other lists, at least five additional individuals had transitioned to the community during the previous six-month period. During December 2010, the Monitoring Panel requested some information regarding transition be added to the reports in order to capture categories of individuals who had either requested community transition, or whose teams had determined they could be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses. For meetings occurring between 9/1/10 and 4/14/11, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the name of two individuals with the date of the meeting at which the decision not to refer was made. The data included was not consistent with the list provided related to barriers to community transition, which indicated that there were five individuals, within this time period, who preferred community placement, but the reason for the team not making a referral was the LAR's choice. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included two individuals, including the date of the meeting and a brief description of the	Noncompliance

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	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.	reason for the referral not being made. For one individual, the reason was noted as "behavior/ psychiatric." For the other (i.e., Individual #283), the reason was listed as "MRA Not Present." Given that the meeting date listed for Individual #283 was 9/10/10, it was unclear why another meeting had not been held with the IDD Local Authority present. In addition, the data included was not consistent with the list provided related to barriers to community transition, which indicated that there were three individuals, within this time period, who preferred community placement, but there were "other" reason for the team not making a referral. ▪ LAR Prefers Community, Not Referred: No individuals were listed in this category. The Monitoring Panel asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State indicated that at this time, its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested. The Monitoring Team looks forward to reviewing this information in the future. According to State Office staff, this report also had been provided to the United States Department of Justice. However, due to what appeared to be inaccuracies with this report provided, a finding of non-compliance has been made.	
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	Timeliness of Checklists: Post-move monitoring documentation was reviewed for seven individuals, including Individual #285, Individual #170, Individual #401, Individual #125, Individual #192, Individual #384, and Individual #446. Of the 18 required visits, 15 (83%) had been documented as having been completed on time. For three individuals, complete documentation was not provided. For Individual #384, this appeared to be due to a copying issue, because every other page was missing. Although it appeared that the seven-day monitoring had been completed in a timely manner, this individual's documentation could not be reviewed to determine the quality	Noncompliance

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	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.	of the content of the monitoring, or follow-up activities. For Individual #170 and Individual #401, monitoring reports were missing for the seven and 45-day, and seven-day monitoring visits, respectively Content of Checklists: With regard to the content of the checklists, the checklists all utilized the format attached to the Settlement Agreement as Appendix C, with some improvements. These improvements included the addition of a column for a description of the evidence that the Post-Move Monitor would review to determine if supports or services were in place, as well as a specific column for comments to be entered. The AUSSLC Post-Move Monitor had chosen to leave information from previous monitoring visits on the subsequent forms, but to highlight it, so that the new information could easily be identified. This allowed the reader to quickly see the progression of activities. Each of the items on the checklists completed had been addressed. As noted in the Monitoring Team's previous reports, efforts clearly were being made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. This assisted in justifying the Post-Move Monitor's findings with regard to whether or not protections, supports, and services were adequately in place. As noted in the previous report, the biggest difficulty the Monitoring Team noted was with regard to the standards used to monitor. During this most recent review, questions arose with regard to the stringency of monitoring standards being used to evaluate community providers. Standards similar to those being applied to the SSLCs should be used in evaluating the protections, supports, and services provided to individuals who transition to the community. In some instances, a lesser standard appeared to be used. Examples of these concerns included: ▪ At the time of the review, Individual #192 was at a State mental health hospital, where he had been brought after an incident in the community involving the police. Five days after his transition to the community from AUSSLC, Individual #192's behavior escalated, eventually resulting in his entering a neighbor's home and destroying their property. Community provider staff were unable to get him to leave the home, and the police were called. The police escorted him back to the group home, where he engaged in additional aggressive behavior, which community provider staff was unable to manage. The police eventually removed him. Of concern, the CLDP required that staff have "competency-based" training on his PBSP from AUSSLC. The Post-Move Monitor made a finding that this had been completed. The related documentation included a very brief outline of a number of topics including a brief list of psychological supports, and a note that stated: "All staff were able to answer questions correctly after inservice was completed." Answering questions would not be considered competency-based training at AUSSLC in relation to a PBSP or	

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		PNMP, and should not have been considered adequate for the community provider. As the incident reports related to the incident that resulted in Individual #192's placement in a mental health hospital showed, the community provider staff were not competent in the implementation of the PBSP. As is discussed above with regard to the quality of CLDPs, a number of protections, supports, and services were not adequately defined in the CLDP. As has been recommended in the past, a review should be conducted of Individual #192's transition planning and implementation process as a process improvement exercise. ▪ Similarly, for Individual #285, his CLDP included as an essential support "competency-based" training on his PNMP, which included diet texture. In the post-move monitoring reports, the Post-move Monitor indicated that she had reviewed the training rosters and materials used for training. However, it was unclear if the training met the standard of being competency-based. The Settlement Agreement defines competency-based training as "the provision of knowledge and skills sufficient to enable the trained person to meet specified standards of performance as validated through that person's demonstration that he or she can use such knowledge of skills effectively in the circumstances for which they are required." It did not appear that, for example, a competency-based checklist had been used to ensure that all staff responsible for preparing Individual #285's food had successfully demonstrated the skills necessary to prepare the proper texture. As is noted below with regard to Section T.2.b of the Settlement Agreement, the Post-Move Monitor identified issues with regard to staff's competency in preparing the proper food texture during Individual #285's 90-day post-move monitoring visit. This was positive. However, it is essential that the initial training is reviewed, and a determination made with regard to whether or not it meets the requirements of being competency-based. 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. Examples of this were found with Individual #285, and Individual #401. This illustrated a strong commitment to ensuring that individuals receive the protections, supports, and services that they need. This is commendable, and should continue. AUSSLC had begun to have the PSTs of individuals who transitioned to the community review the post-move monitoring reports, determine if any further action was necessary, and document the results of their review in a PSP Addendum. A sample of four to six	

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		PSPAs was requested, but only two were provided. These two PSPAs showed vastly different approaches to addressing the post-move monitoring reports. One appeared adequate, while the other did not. More specifically: ▪ The PST for Individual #446 documented on the PSPA form that: "The team met and reviewed the 7 day Post Move Monitoring form for [Individual #446] unanimously (sic) agreed with the information provided on the Post-Move Monitoring checklist information (sic)." No other substantive information was provided. Given that the Post-Move Monitor had identified a number of issues during the visits, this was particularly concerning. In fact, an incident occurred on the day of the post-move monitoring visit in which Individual #446 alleged he had been restrained and verbally abused. This had been called in to the abuse hotline. In discussing Individual #446's PBSP with day program staff, where the incident had occurred, the Post-Move Monitor was unable to confirm that staff had a good working knowledge of the PBSP. As a result, she stated in her report: "… it is probable that the staff [at the day program] need to be retrained on positive techniques to avoid [Individual #446] getting to that level of agitation. AuSSLC staff may be able to help with this." The PSPA did not include any action steps, or plan to ensure that the community provider staff were adequately trained, and that Individual #446 was provided with adequate protections and supports. ▪ On the other hand, Individual #170's team had met after her 90-day monitoring visit, and discussed the results of the review, and documented their deliberations thoroughly. The team concluded that any of the concerns or changes the Post-Move Monitor identified had been properly addressed, so their involvement was not needed. For example, Individual #170 had experienced a seizure. The team reviewed the actions the community provider had taken, including a transfer to the ER by ambulance, and the scheduling of an appointment with a neurologist. The team concluded that this was sufficient, and no further recommendations or actions were needed. The team highlighted in the PSPA a number of positive outcomes that Individual #170 had achieved since moving to the community as well. Overall the PSPA showed the team had conducted a thorough and thoughtful review of the post-move monitoring report. It should be noted that through its post-move monitoring activities, the Facility had identified a number of positive outcomes of individuals who had transitioned to the community. For example: ▪ Although Individual #446 indicated he was homesick during the first couple of monitoring visits, by the 90-day visit, it appeared he had adjusted to his new home, and listed a number of positive aspects of living in a home in the community. AUSSLC had assisted in the transition by bringing some of	

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		Individual #446's friends to visit him at his new home. This was very positive, and it is hoped that efforts such as this will continue, not only for Individual #446, but for others who transition as well. As appropriate, it would be important to include such activities in individuals' transition plans. From a normalization perspective, when people move, often one of the hardest aspects is leaving friends behind, and typically plans would be made to help stay in touch with important colleagues or friends. ▪ During the last onsite review, members of the Monitoring Team attended Individual #170's CLDP. As evidenced in the meeting, Individual #170 spent good portions of her days hiding under a blanket in her wheelchair, refusing contact with others, and refusing to eat meals, despite an ability to eat. The following is the Post-Move Monitor's description of Individual #170 at her 90-day monitoring: "[Individual #170] has changed in many positive ways: Her blanket was off for a majority of time I was there. She happily ate a full pureed dinner of steak and vegetables. There was a lightheartedness in her interactions with staff, especially [staff's name]… She stays in the common areas without complaint, often without her blanket on. She has demonstrated zero incidents of maladaptive behavior… And [Individual #170] is attending dayhab M-F almost 6 hours per day." The Facility continued to make progress in this area. 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.	
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 #285's day program and home. Similar to the observations during the Monitoring Team's last review, the Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. 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 #285 in comparison with his CLDP, it appeared that the Post-Move Monitor reviewed relevant documentation, and conducted appropriate observations and interviews. For example, Individual #285 required a specialized diet, due to choking risks. In addition to interviewing staff about his diet texture, the Post-Move Monitor observed a snack time. Based on both of these methodologies of review, the Post-Move Monitor identified that Individual #285 was receiving the incorrect diet texture, which placed him at risk for choking. In addition to	Substantial Compliance

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		talking with staff onsite, including a supervisory level staff person, she also called the community provider's management staff, expressed significant concern, and requested that immediate action be taken to ensure all staff were trained on the correct diet texture. Subsequently, the Post-Move Monitor provided the Monitoring Team with documentation from the community provider showing that all staff had been retrained within a 24-hour period. Based on a thorough review of the documentation onsite, the Post-Move Monitor identified inconsistencies with documentation related to use of Individual #285's psychiatric symptoms, hearing aids, community integration, and participation in a music group. The Post-Move Monitor discussed these with the supervisory staff person present for the review. As was noted in the Monitoring Team's previous report, as the CLDPs improve in depth and quality, the level of post-move monitoring also will increase. As is noted above, efforts need to continue to ensure CLDPs 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 Settlement Agreement will be dependent on post-move monitoring 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 -**		

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	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	At a parties' meeting on December 2 and 3, 2010, it was agreed that in addition to the categories listed in the Settlement Agreement, other circumstances of an individual moving from a SSLC might fall under the category of "alternate discharges." For example, reasons such as a LAR choosing to discharge an individual from the Facility without formal transition planning occurring, or an individual transferring to another SSLC would be considered alternate discharges. These would be situations in which the Facility would be expected to follow the Centers for Medicare and Medicaid (CMS) discharge procedures. However, since the previous review, there had been no alternate discharges of individuals served by the Facility. As a result of no alternate discharges having occurred, this provision of the Settlement Agreement was not rated.	Not Rated

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. (Section T.1.a)
2. When the absence of an IDD Local Authority is the reason for a PST potentially not making a referral to the community, the team should reconvene quickly (e.g., within two weeks) with the IDD Local Authority present. (Section T.1.a)
3. Once the State policy is revised, the Facility should develop Facility-specific policies and/or procedures to customize the policy to AUSSLC and

ensure its implementation. (Section T1.b)

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. (Section T.1.b.1)
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. (Section T.1.b.1)
6. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based. (Section T.1.b.1)
7. 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. More specifically:
    a. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible, and timeframes for completion.
    b. Increased efforts should be made to encourage individuals to visit community residential and day/vocational options.
    c. Outcomes should be developed and measured with regard to the CLOIP process.
    d. It is particularly important for individualized activities to be identified in individuals' PSPs, as appropriate, and implemented. (Section T.1.b.2)
8. With regard to the revised Community Living Discharge Plan template and process:
    a. Because the CLDP is a document that would need to be updated at many stages of the process, dates should be included each time the document is revised. For example, such dates could be added to the first page, or placed in the footer.
    b. Given that the new process requires the teams to meet multiple times, sign-in sheets should be maintained with the CLDP document that show the attendance at the various meetings held.
    c. 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.
    d. 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. (Section T.1.c)
9. 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. (Section T.1.c)
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. (Section T.1.e)
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. (Section T.1.e)
12. With regard to monitoring activities related to the Facility's performance with regard to this section of the Settlement Agreement, 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 T.1.f)

13. 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. (Section T.2)
14. 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. (Section T.2)

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

1. Given that from a normalization perspective, when people move, often one of the hardest aspects is leaving friends behind, and typically plans would be made to help stay in touch with important colleagues or friends, as appropriate, it would be important to include such activities in individuals' transition plans. (Section T.1.e)

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Individual without LAR (Legally Authorized Representative), printed on 4/15/11; o Statement: "There has not been one individual removed either from the waiting list for Family Eldercare or the Guardianship Assistance Program in the past six months; o Social Work Contact Notes regarding guardianship for 14 individuals, various dates; o AUSSLC Guardianship Status list, undated; o Statement: "Instrument to determine Functional Capacity regarding consent has not yet been approved by the state office. When it is approved, curricula for training of select staff will be written"; o Statement: "State policy regarding Consent remains in draft form"; o Presentation Book for Section U; o Draft State Supported Living Centers Statewide Policy and Procedures: Guardianship, undated; o Draft Guardianship Priority Rating Tool, undated; o AUSSLC Plan of Improvement for Section U: Consent; o "A Texas Guide to Adult Guardianship," undated; o Settlement Agreement Cross Referenced with ICF/MR Standards: Section U – Consent; and o Settlement Agreement Cross Referenced with ICF/MR Standards: Section U – Consent Guidelines. ▪ **Interviews with**: o Leslie Banks, Social Worker.
	Facility Self-Assessment: The Facility self-assessment showed that it continued to be in noncompliance with the two provisions of Section U of the SA. This was consistent with the findings of the Monitoring Team. The Facility had begun to monitor its compliance with Section U of the Settlement Agreement. It was using a monitoring tool based on the Monitoring Teams' review protocol to which guidelines had been added. Appropriately, the tool also had been redesigned to identify only the indicators that could be assessed through the conduct of an individual record review. This made the tool more functional. The narrative section of the POI did not include any results from the monitoring activities. As the Facility's self-assessment process continues to grow, it will be important to use the monitoring data to substantiate compliance or noncompliance with the Settlement Agreement.
	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 Settlement Agreement requirements. AUSSLC did not have a specific guardianship policy, but had some policies related to the informed consent decision-making

process.

AUSSLC indicated in a written statement that the "Instrument to determine Functional Capacity regarding consent has not yet been approved by the state office. When it is approved, curricula for training of select staff will be written." It was anticipated that the State Office policy would provide guidance with regard to the instrument/processes to be used in determining functional capacity. However, at the time of the review, 123 of the 361 individuals the Facility served did not have guardians.

AUSSLC continued to use its valuable resources to assist teams 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. However, since the previous review, no additional individuals had obtained guardians.
- 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. A total of 30 individuals were on the waiting list for a guardian with this agency. With new grant funding, it was anticipated that seven individuals would be removed from the waiting list soon, and be provided with guardianship services.
- 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. According to the Facility's list, a total of 28 individuals were in the referral process at the time of the review.
- An additional private guardianship was being processed.

AUSSLC had developed a draft document entitled: "Guardianship Priority Rating Tool." The draft tool appeared to provide a structured mechanism to identify the factors that might prioritize one individual over another for guardianship. It used some objective measures, such as the number of high risk areas the individual had been assessed as having through the at-risk screening process, use of a PBSP and/or SPCI, and a past history of a need for frequent medical concerns, fractures, or surgical interventions. The Facility's effort to draft a tool for this purpose was commendable.

DADS recently had issued a new guardianship booklet, entitled "A Texas Guide to Adult Guardianship," which the Facilities could use as an educational resource. Review of the booklet showed that it provided a basic overview of guardianship, as well as alternatives to guardianship. It was designed as a resource for families and other people interested in learning more about guardianship of individuals with intellectual/developmental disabilities, as well as elderly people. It answered a number of common questions about guardianship, and the guardianship process, and used case examples to illustrate the resolution of specific issues.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	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 Settlement Agreement requirements. As reported previously, 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 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/ Guardians. In response to the Monitoring Team's document request, AUSSLC indicated in a written statement that the "Instrument to determine Functional Capacity regarding consent has not yet been approved by the state office. When it is approved, curricula for training of select staff will be written." It was anticipated that the State Office policy would provide guidance with regard to the instrument/processes to be used in determining functional capacity. Of the 361 individuals residing at AUSSLC at the time of the review, 123 were on the list of Individuals without an LAR. As noted above, no formal assessment process was yet in place to determine functional capacity. The Facility's social workers had reviewed the 123 individuals, and for some a rating had been assigned based on the following, the individual had: 1) health/behavioral issues, and minimal to no family involvement; 2) health/behavioral issues, and some family involvement; 3) support through a family member or advocate, and little need for decision-making; and 4) involved family and	Noncompliance

#	Provision	Assessment of Status	Compliance
		little need for decision-making. The list was not complete, though, because ratings had not been assigned to each individual. AUSSLC had developed a draft document entitled: "Guardianship Priority Rating Tool." At the time of the review, the State Office reportedly was in the process of reviewing it. If it was approved, the Facility intended to have teams use this form to assist in determining each applicable individual's priority rating on the list of individuals requiring guardians. The draft tool appeared to provide a structured mechanism to identify the factors that might prioritize one individual over another for guardianship. It used some objective measures, such as the number of high risk areas the individual had been assessed as having through the at-risk screening process, use of a PBSP and/or SPCI, and a past history of a need for frequent medical concerns, fractures, or surgical interventions. The Facility's effort to draft a tool for this purpose was commendable.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The Facility's status on this requirement generally remained as it had during the previous reviews. 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. Since the previous compliance review, no additional individuals had obtained guardians. As the Monitoring Team reported in previous reports, 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 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. At the time of the review, 30 individuals on the list of Individuals without LARs had been referred to Family Eldercare. The waiting list for services with this agency was fairly long. Staff estimated that the wait time was approximately two years. However, since the previous review, Family Eldercare had obtained a grant, which allowed them to hire another staff member. The grant specifically allowed the agency to provide guardianship services to individuals over the age of 55. AUSSLC had identified the seven oldest people on the list of individuals needing guardians, and it was anticipated that that Family Eldercare would serve these seven individuals.	Noncompliance

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		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. At the time of the review, a total of 28 individuals were 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. A delay had been experienced in setting up such a day, due to changes in staffing at the Court. However, at the time of the review, it was anticipated that two such days would be scheduled soon to accommodate the close to 30 individuals who were eligible for the process. An additional private guardianship was being processed. This involved individual #93, whose mother had been her guardian, but died in 2007. Her bother was in the process of petitioning the Court for guardianship. 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. DADS recently had issued a new guardianship booklet, entitled "A Texas Guide to Adult Guardianship," which the Facilities could use as an educational resource. Review of the booklet showed that it provided a basic overview of guardianship, as well as alternatives to guardianship. It was designed as a resource for families and other people interested in learning more about guardianship of individuals with intellectual/developmental disabilities, as well as elderly people. It answered a number of common questions about guardianship, and the guardianship process, and used case examples to illustrate the resolution of specific issues. As stated in previous reports, the Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the	

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		need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators may be appointed to assist the court in evaluating the need for guardianship, as well as the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings included family members, as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs, and preferences, teams could potentially provide valuable information, both in terms of written reports, as well as verbal information, regarding individuals who become the subject of guardianship proceedings. 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. (Section U.1 and U.2)
2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation. (Section U.1 and U.2)
3. Once the State policy is finalized, AUSSLC should develop a policy on guardianship to reflect the State policy. (Section U.1 and U.2)
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. (Section U.1)
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. (Section U.2)
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 U.2)

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 4/15/11; o Presentation Book for Section V; o Active Record Order and Guidelines, revised 3/15/11; o Index for Master Record, revised 3/15/11; o AUSSLC Policy and Procedure for Master Record Filing, dated 3/15/11; o AUSSLC Master Record Order, Volume I, II, and III, revised 3/15/11; o Individual Notebook and Guidelines; revised 3/15/11; o Active Record Order Guidelines Audit Tool, dated 3/15/11; o Settlement Agreement Cross Referenced with ICF/MR Standards – Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4, revised 12/2/10; o Settlement Agreement Provision V.4 – Interview Tool for Use of the Record, dated 4/25/11; o Completed quality assurance checklists for last 10 records reviewed; o Draft Procedure for Individual Notebook (I-Book), dated 3/22/11; and o AUSSLC Table of Contents for Policy and Procedure Manual. ▪ **Interviews with**: o Gail Tigue, Client Records Coordinator; o Sherry Weir, Unified Records Coordinator; o Kimberly Quarry, Unified 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. The POI provided a narrative description of a number of actions that had been taken to move towards compliance, including a shift in the unit clerk's supervision from the units to the Records Department. The Facility also reported on a number of meetings that had been held to discuss the many issues related to the records. Section V.2 of the Settlement Agreement addresses policy development for all of the requirements of the Part II of the Settlement Agreement. However, the POI only included information about policies related to Section V. In the future, the POI should provide an analysis of the Facility's overall policy development. The POI indicated that record audits had been completed, but none of the data from these audits were included in the POI to substantiate findings of noncompliance, or to highlight areas in need of improvement. Further refinement of the auditing process, including analysis of information, and

	development and implementation of corrective action plans, is necessary to ensure that the Facility is able to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: As indicated in the last report, 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 this most recent review, all 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. However, the quality of the records was significantly lacking. The Facility had just begun the process of identifying the underlying issues that were resulting in documents not being filed in a timely and accurate manner. As noted in other sections of this report, the Facility continued to develop and/or revise policies to address the various components of the Settlement Agreement. Policy development was in different stages, both at the State and Facility-level, and, in some cases, the Facility was awaiting new or revised policies from the State before revising or developing its own policies. 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.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Since September 2010, AUSSLC had completed the conversion of all the medical records at the Facility to the new Table of Contents required by the State Office. However, consistent with the past two reviews, in reviewing records onsite, it was noted that a number of documents were not in the medical records and had to be obtained from the units. For example, as noted with regard to Section M.1, several Nursing Quarterly Assessments, Nursing Annual Assessments, and Nursing Health Management Plans were not found in the records. From a review of ten QE record audits, these findings were consistent with the Facility's findings. Although the Facility had finalized the Recordkeeping Policy in April 2011, finalized the Individual Notebook policy/procedure in March 2011, and the Client Records Coordinator had assumed supervision of the Unit Clerks, the Facility continued to be dependent on the use of the "green files." These "green files" contained copies of lab work, consultations, and other types of medical documentation specific to each individual, which had been created due to the number of missing medical documents from the records. From discussion with the QE Director, there was no tracking system in place to ensure that all laboratory results, consultations, or other medical documents were received and timely filed in the medical records. The Facility should develop and implement a tracking system to ensure that documents are filed in a timely manner in	Noncompliance

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		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. It appeared that there were potentially many reasons for the deficits with the records, including a lack of clarity of the flow of records from the departments to the clerks, issues related to the timely completion or submission of documentation, as well as resources for filing. This latter issue recently had begun to be addressed. The unit clerks had come under the supervision of the Client Records Coordinator, and had office space assigned in the Records Department. Although six positions existed for unit clerks, only four were filled, and one of these staff members was frequently out on leave. At the time of the review, efforts were being made to recruit for the open positions. Two Unified Records Coordinators were in place. In addition to efforts to fill vacant unit clerk positions, the Facility should conduct a full analysis to determine the issues negatively impacting the quality of the records, and develop an action plan(s) to address these issues. This will require the coordination with and cooperation of most, if not all, of the various clinical and programmatic departments on campus. As noted with regard to Section S.1, a review of I-Books across four residences revealed that in many cases, the books contained dated information, lacked data sheets for recording progress on program objectives, or reflected an absence of data for the current month. Of the 16 books reviewed, all but one contained the PSP. However, in 10 of 15 (67%), the PSP was over one year old. Eight of these 10 dated plans (80%) were from 2009. Similarly, where PBSPs were included and dated, six out of 13 (46%) were over one year old, with two from 2009 and one from 2008. In one residence, none of the books included data sheets for recording performance on program objectives. As the I-Books are intended to serve as guides for staff, it is essential that required documents are current and complete. The Facility had held meetings to discuss the I-Books, because a number of disciplines were concerned about critical information, such as seizure protocols and behavioral data, being lost and/or not available, when treatment decisions were made. This information was only being pulled and filed once a month. Although the Facility had made some efforts to ensure that data was available, such as providing training to QMRPs and Home Supervisors, and developing a cover sheet that indicated at what types of activities the I-Books needed to be present, this issue did not appear to have been resolved. The Facility should collaborate with other Facilities, which are successfully using the I-Book, to identify and implement practices that effectively make use of the I-Book system, while maintaining the integrity and security of individuals' protected health information. It should be noted that the Facility had completed a survey that State Office sent, which was designed to seek ideas about improving the I-Book process.	

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		In addition, one of the requirements included in Appendix D is for records to be maintained securely. Consistent with the previous 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. 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 Settlement Agreement were in various stages of development. Specifically for this provision of the Settlement Agreement, the pre-review document request included a request for a list of all new and revised policies implemented since the last onsite review, as well as any communication to staff to inform them of the new policy, a description of any training, and/or any related competency evaluation tools. In response, the Facility submitted a note stating that while the Monitoring Team was on site, information would be shared about the new recordkeeping policy. It appeared there was a misunderstanding about the breadth of this Settlement Agreement requirement, which addresses all policies related to Part II of the Settlement Agreement (i.e., Sections C through V). As a result, no summary was submitted of overall policy development, and no information was provided with regard to how staff were informed of policy changes, or trained on new or revised policies. As reported previously, AUSLC had developed a process 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
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	Both the Unified Records Coordinators and staff from the Quality Enhancement Department were conducting record reviews. Based on the documentation provided, it appeared that at least five reviews had been conducted in a month. Since the last review, the Facility had begun using the monitoring tool entitled "Settlement Agreement Cross Referenced with ICF/MR Standards – Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4," revised	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	12/2/10. This was in addition to the Active Record Order Guidelines Audit Tool, dated 3/15/11. In the last report, the Monitoring Team noted that the Active Record Order tool was not capturing all of the components of the Settlement Agreement, including some of the quality indicators, such as legibility, and completeness. The addition of this new tool resolved this issue. As noted above, these reviews identified a number of issues related to the records, including missing, out-of-date, or misfiled documents. With the addition of the new monitoring tool, issues such as those related to legibility, completeness, use of appropriate dating and signature conventions, gaps between entries, and accurate record-keeping practices also had been identified. It appeared that the Unified Records Coordinators were sharing the results of the individual record reviews with the assigned unit clerks, and requesting corrections be made on a case-by-case basis. However, no evidence was presented to show that this data had 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.	
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: ▪ The filing of medical information into the records remained a concern. Reportedly, in gathering documents to respond to the Monitoring Team's requests for information, much of the information was not in the records, and there was reliance on saved computer copies. ▪ Staff also reported that there was greater difficulty in accessing the actual medical records than there had been previously. In the past, a campus driver would bring records from the buildings to the PCPs for review and documentation. In recent months, the driver was assigned other duties, and for a period of time, there was no one to bring the records to the medical offices. More recently, the administrative assistants were assigned the task of bringing over records. This process was just beginning at the time of the Monitoring Team's visit. ▪ From the last Monitoring Team visit, the I-Book had been identified as an area needing improvement. There was a lack of timely filing of data from the I-Book into the active record. On 3/22/11, a "Procedure for Individual Notebook (I-Book)" was drafted to ensure timely placement of information in the active record. This remained an ongoing project, but it appeared work was progressing toward resolution of areas of concern. As part of the procedural draft, a detailed "individual notebook-purging schedule" was created. It is	Noncompliance

#	Provision	Assessment of Status	Compliance
		recommended that finalization of the procedure for the I-Book occurs, as well as implementation of the process to ensure timely filing of I-Book data in the active record. ▪ Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. In reviewing the collection of data for Positive Behavioral Support Plans and skill acquisition goals, it was determined that staff might not have been consistently and timely documenting data, and processes were not in place to ensure data reliability. ▪ 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 legibility of information in the records, and the accuracy of such information. The Facility just recently had received guidance from State Office on methodologies for monitoring this component of the Settlement Agreement. The monitoring tool included interviewing staff (e.g., clinical staff, QMRPs, etc.) about the usefulness of the records in conducting their job responsibilities. However, evaluating this provision will require a number of different methodologies, including, for example, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, PSP meetings, etc.), and reviewing documents such as medical consultations to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinators, but might be distributed in other monitoring tools.	

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

1. In addition to efforts to fill vacant unit clerk positions, the Facility should conduct a full analysis to determine the issues negatively impacting the quality of the records, and develop an action plan(s) to address these issues. This will require the coordination with and cooperation of most, if not all, of the various clinical and programmatic departments on campus. (Sections V.1 and V.4)
2. The Facility should develop and implement a tracking system to 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. (Sections V.1 and V.4)
3. I-Books should be checked to ensure all necessary material is included and current. (Sections V.1 and V.4)
4. The Facility should collaborate with other Facilities, which are successfully using the I-Book, to identify and implement practices that effectively make use of the I-Book system, while maintaining the integrity and security of individuals' protected health information. (Section V.1)
5. 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. (Section V.1)
6. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures. (Section V.2)
7. 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. (Section V.3)

8. The Facility's POI should provide an analysis of the Facility's overall policy development. (Facility Self-Assessment, and Section V.2)
9. As the Facility expands its self-assessment processes, for Section V.4, a number of different methodologies, including, for example, interviewing staff, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, PSP meetings, etc.), and reviewing documents such as medical consultations to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinators, but might be distributed in other monitoring tools. (Facility Self-Assessment, and Sections V.3, and V.4)

List of Acronyms

Acronym/ Symbol	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Automatic Defibrillator
AED	Antiepileptic drug
AFO	Ankle Foot Orthoses
APC	Admissions/Placement Coordinator
APEN	Aspiration Pneumonia/Enteral Nutrition
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ASH	Austin State Hospital
ASL	American Sign Language
AT	Assistive Technology
AUSSLC	Austin State Supported Living Center
BCBA	Board Certified Behavior Analyst
BID	Twice a Day
BiPAP	Bilevel Positive Airway Pressure
BM	Bowel Movement
BMI	Body Mass Index
BSP	Behavior Support Plan
CAP	Corrective Action Plan
CAPPS	Comprehensive Assessment Program Planning System
CBT	Competency-based Training
cc	Cubic Centimeter
CDC	Centers for Disease Control
C-Diff	Clostridium difficile
CE	Continuing Education
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid
CNE	Chief Nursing Executive
COTA	Certified Occupational Therapy Assistant
CPAP	Continuous Positive Airway Pressure
CPE	Comprehensive Psychiatric Evaluation
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
DCS	Direct Care Staff
DD	Developmental Disabilities
DEXA	Dual-energy x-ray absorptiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
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
EEG	Electroencephalogram
EDWR	Estimated Desired Weight Range
EGDs	Esophagogaastroduodenoscopies
EKG	Electrocardiogram
EMS	Emergency Medical Services
ENT	Ear, Nose, and Throat
EPS	Extrapyramidal Motor Side Effects
ER	Emergency Room
F12	Fluoride
FBA	Functional Behavior Analysis
FNP	Family Nurse Practitioner
FTE	Full-time Equivalent
GE	Gastroesophageal
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
gm	Grams
G-tube	Gastrostomy Tube
HCG	Health Care Guidelines
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
HT	Habilitation Therapy
I-Book	Individual Notebook

IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICD	International Statistical Classification of Diseases and Related Health Problems
ICF/MR	Intermediate Care Facilities for Persons with Mental Retardation
ID/DD	Intellectual Disability/Developmental Disability
IDT	Interdisciplinary Team
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IPN	Integrated Progress Notes
IV	Intravenous
J-tube	Jejunostomy Tube
L	Liters
LAR	Legally Authorized Representative
LBSSLC	Lubbock State Supported Living Center
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
ml	Milliliters
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MRA	Mental Retardation Assistant
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
NEO	New Employee Orientation
NG	Nasogastric
NM	Nutritional Management
NMT	Nutritional Management Team
NOO	Nursing Operations Officer
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OIG	Office of Inspector General
OJT	On-the-Job Training
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Assessment of Living Skills

PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEG	Percutaneous Endoscopic Gastrostomy
PFA	Personal Focus Assessment
PLACHECK	Planned Activity Check
PMAB	Prevention and Management of Aggressive Behavior
PNM	Physical and Nutritional Management
PNMT	Physical Nutritional Management Team
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PO	By mouth
POI	Plan of Implementation
PP	Patient Population
PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)
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
q	Every
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QID	Four times a day
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
R/O	Rule Out
ROM	Range of Motion
RT	Respiratory Therapist
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAMS	Self-Administration of Medications
SFAR	Structural and Functional Assessment Report
SFBA	Structural and Functional Behavior Assessment
SGD	Speech Generating Device
SIB	Self-Injurious Behavior
SL	Speech Language
SLP	Speech and Language Pathologist

SO	State Office
SOAP	Subjective, Objective, Assessment and Plan
S/P	Status Post
SPO	Specific Program Objective
SSLC	State Supported Living Center
STD	Sexually-transmitted disease
TB	Tuberculosis
TF	Trust Fund
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UA	Urinalysis
UGI	Upper Gastrointestinal
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulators
VRI	Viral Respiratory Infection
VS	Vital Signs
YAI	Young Adults Institute