United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

Dates of Review: November 14 through 18, 2011

Date of Report: February 20, 2012

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I. Background

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

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

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

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

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

II. Methodology

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

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

III. Organization of Report

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

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

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

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

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

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

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

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

IV. Executive Summary

Since the baseline review, the Monitoring Team consistently has identified a number of significant issues related to the protections, supports, and services that Austin State Supported Living Center (AUSSLC) has offered to the individuals it serves. Given that this most recent review represented the conclusion of the second year of reviews, it was surprising and concerning that, as a whole, AUSSLC was not further along. Little progress had been made in some of the areas that are key to providing individuals with safe, meaningful lives with opportunities for growth and development, as well as complying with the Settlement Agreement.

As the Monitoring Team shared at the exit meeting, AUSSLC is fortunate to have a number of talented staff, many of whom are committed to making change. However, everyone needs to be part of making change happen, and this only can be achieved through teamwork. As is illustrated in a number of different sections of this report, staff were not

consistently working together to identify areas needing improvement, and developing creative and workable solutions to improve outcomes for the individuals served.

As noted in previous reports, 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 continued to view it as a priority.

Even with all of the concerns noted, in a number of areas, efforts were underway to make improvements. As promised at the exit conference, the progress that the Monitoring Team noted has been detailed in this report. However, it is important to note that many of these initiatives cannot be fully achieved through the efforts of only one department or a small group of staff. If full compliance with the Settlement Agreement is to be achieved and outcomes for individuals improved, then interdisciplinary collaboration and cooperation must become a priority.

Staff at the Facility are encouraged to work together over the next six months to set clear priorities, develop comprehensive action plans, and implement activities that will firmly establish strong foundations for compliance with the Settlement Agreement. Throughout all of these activities, improving the supports and protections offered to individuals should be the driving force. As in all reports, the Monitoring Team has offered recommendations that it hopes will assist in this process. The Monitoring Team is hopeful that upon its return, staff will have successfully implemented significant improvements.

The following is a brief summary of AUSSLC's status with regard to relevant the sections of the Settlement Agreement:

<u>Restraints</u>

- During the previous 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. As a result, it was not possible to fully evaluate the Facility's use of restraint with any degree of confidence at that time. The Director of Quality Assurance was urged to work with the Director of Behavioral Services to establish a timely, comprehensive and reliable system for reporting the use of restraint. Regrettably, during this recent site visit, there was no evidence of improved outcomes. Troubling concerns about the integrity of the restraint data again were documented, and there was a disturbing lack of urgency in implementing appropriate remedial actions. Again, as previously reported, at the time of the recent 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. It also was not clear that the issue of restraint use was a priority for the Facility

as a whole. Based on the evidence reviewed, 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.

- Restraint documentation remained inconsistently complete. A complete description of events necessitating restraint and steps taken to avoid restraint was not consistently evident in restraint reports. Similarly, debriefing information or administrative consult for chemical restraint was not always provided.
- Efforts to reduce the use of restraint and/or sedation for dental procedures remained a very slow process. No dental desensitization plans had been developed and implemented at the Facility.
- Although the Facility had developed a format for Personal Support Plan addenda to address application of more than three restraints in 30 days, a review of documentation revealed this was not consistently implemented. Further, staff response to frequent restraint was often limited. Required assessments were not identified or completed, changes to the individual's habilitation and/or behavior support plan were not implemented, and in-service training often was identified as the strategy of choice to ensure improved implementation of positive behavior supports. Although in-service training could be beneficial, it should not have been the only response.

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

- The Facility indicated that the findings of Immediate Jeopardy that the State survey and certification issued in the months just prior to the site visit had detracted from its efforts to achieve substantial compliance with Section D. It is critical that the Facility as a whole demonstrate a greater sense of urgency about compliance with the Settlement Agreement, particularly with regard to protection from harm.
- Throughout the site visit, repeated examples were seen of the failure to develop and implement strategies to correct environmental and other deficiencies that contributed to increased levels of risk for the individuals living at AUSSLC. Despite routinely scheduled meetings to review serious incidents, including allegations of abuse and neglect, there was a disturbing lack of activity in addressing well-documented problems or areas of vulnerability. The lack of aggressiveness in responding to the support needs of individuals with potentially problematic behavioral issues, and the lack of reliability in implementing Corrective Action Plans was deeply troubling. This very failure to address recurrent problems was reflected in the investigation reports reviewed for this report. These investigations confirmed physical abuse, neglect, ineffective supervision, and the lack of adherence to interventions and initiatives prescribed in the Personal Support Plans. As a result, the vulnerable individuals entrusted to AUSSLC were not only not protected from harm, but they were subjected to increased risk.
- With the appointment of an experienced Incident Management Coordinator, the Facility expected to develop more sophisticated analysis of serious reportable incidents, to establish tracking and trending processes, and to improve its coordination with other key areas of management performance.

Quality Assurance

- Since the Monitoring Team's review, there had been a lack of significant progress in the implementation of strategies that contributed to the development of a comprehensive quality assurance system, as well as to compliance with the requirements of the Settlement Agreement.
- The QA Department had continued or revised certain initiatives implemented previously, including the 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. On 8/31/11, a Facility-wide in-service on revised procedures for abuse and neglect reporting was completed, and on 9/1/11, a revised quiz on these reporting procedures was implemented.
- As discussed with regard to Section D, the newly appointed Incident Management Coordinator had begun to refine the collection of data regarding allegations of abuse, neglect, and exploitation. The availability and analysis of reliable data will be essential to the formulation of corrective action strategies to reduce risk.
- As previously reported, the QA 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 still was not evident that this information was being used in a comprehensive and continuous manner for improvement across the Facility.
- Although a mechanism for the tracking of Corrective Action Plans (CAPs) was initiated on 9/1/11, actual implementation of the tracking system appeared to be inconsistent. Although timely completion of the CAPs was essential for improved performance at the Facility, delays were noted throughout the site visit. A sense of urgency appeared to be lacking throughout the Facility, thus contributing to the lack of progress towards compliance with the provisions of the Settlement Agreement.

Integrated Protections, Services, Treatments and Supports

- Although some progress had been made in this area, which should not be diminished, Section F requires everyone's cooperation and involvement. A number of factors stymied teams' abilities to develop adequate plans, including but not limited to late assessments, inadequate assessments, team members' lack of meaningful participation in team meetings, and the development of plans without adequate information being sought from relevant team members, particularly direct support professionals. If team members continue to work in isolation or with no regard for how their lack of meaningful participation impacts the rest of the team, success will not be achieved.
- Since the last review, steps had been taken to increase Qualified Developmental Disabilities Professionals' (QDDPs') skills with regard to the facilitation of meetings, as well as teams' overall knowledge of the team process and their roles in it. In addition to providing classroom training, the State consultants had begun to provide technical assistance to teams at AUSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to QDDPs' facilitation skills. More limited changes were noted with regard to teams' ability to integrate

supports, develop comprehensive action plans, and include all team members in the process. As would be expected, significant changes had not yet occurred in the ISP documents themselves.

- 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' ISPs.
- 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.
- It was clear that teams were trying to expand action plans to include more of the protections, supports, and services individuals required. However, ISPs still did not adequately integrate protections, supports and services. This remained a work in progress.
- Continuing problems were noted with regard to the timeliness of ISP meetings, as well as the completion of the final documents to allow implementation to occur. The Facility had developed a corrective action plan to address these issues, and was in the process of implementing it. It appeared to be an appropriate plan, and, hopefully, will result in improved outcomes.
- AUSSLC continued to be at the initial stages of developing and implementing quality assurance mechanisms to ensure compliance with Section F of the Settlement Agreement. Due to other priorities, the QDDP management team had not yet begun to conduct auditing. Although it was reported that the QA Department was conducting monitoring, the Facility did not submit adequate documentation for the Monitoring Team to substantiate this assertion. No information was submitted to show that the Facility was aggregating monitoring data, and using it to identify issues, and develop plans to correct them.

<u>Integrated Clinical Services</u>

- The Facility remained out of compliance with this section, and no noticeable progress had been made. A number of committees had potential for developing, implementing, and monitoring integrated care. The morning medical meeting had the potential to provide a forum for integrated care, but struggled with implementation and follow-through to closure. The Clinical Care Committee was newly developed. It appeared to be an administrative committee overseeing several subcommittees, each of which had an interdisciplinary composition and was assigned selected goals. However, as these were all new subcommittees, no reports had been returned to the Clinical Care Committee.
- Important policies remained in draft form. The consultation management policy was implemented recently. However, no database or method to track any progress had been developed.
- None of the committees appeared to have a monitoring component to measure efficiency or effectiveness. In addition, there was no method to determine accountability in completing tasks assigned to the various committees.

Minimum Common Elements of Clinical Care

- There had been no progress made in this area. The lack of any attempts to address this section for over two years was striking. A vacuum of leadership and vision held the Facility back in this area. The Facility had not defined the goals for this section in the context of its campus, developed clinical and administrative tools to measure progress, developed information management systems that would be helpful in creating the evidence needed for compliance, or developed a system and schedule for data analysis. The Medical Department was unable to provide complete, accurate, and reliable assessment data.
- However, the Dental Department was able to submit complete and accurate information for tracking of a number of dental concerns. It also has data on one important clinical indicator: oral hygiene rating scores across the campus. The Dental Department should develop other clinical indicators using its current database systems.
- The role of the Pharmacy Department in assisting with clinical indicators of efficacy of treatment remained important. The development of the "patient intervention" documentation needed follow-through, and the QDRR process had regressed, but appeared to be back on track with improved staffing in the department. The Pharmacy Department should review Section H to determine its role and how the current tools could be utilized to assist in compliance.

At-Risk Individuals

- Since the Monitoring Team's last review, the teams appeared to have made improvements in assessing risk. However, wide variation was noted in the quality of the risk rating documentation. Some included a considerable amount of precise documentation, and others had none. At times, the State Office guidelines were not followed, and no rationale was submitted for the variation. There remained considerable need for the clinical/medical staff to participate in the risk-rating portion of the PSP or PSP addendum to provide valuable guidance in the clinical ratings.
- An ongoing need also existed for aggressive pursuit of treatment or interventions to address individuals' ongoing needs. Tests, including the results and interpretation of results, should be part of the risk rating rationale, and, if further testing is needed, this should be part of the risk action plan steps. When gaps in clinical information exist, teams cannot decide on accurate risk ratings, or develop and implement appropriate plans.
- Although some progress was noted in all areas of this section, significant challenges continued to exist.

Psychiatric Care and Services

- The Psychiatry Department had made progress in a number of areas. The primary initiatives had been the formulation and completion of the Comprehensive Psychiatric Evaluations (CPEs) that complied with the content and quality specifications set forth in the Settlement Agreement. This process had begun at the time of the prior review. As noted at that time, the quality of the new CPEs that were reviewed was uniformly consistent, and met the standards set forth in the Settlement Agreement. The completion of these documents was very labor intensive, and the progress in completing these for all of the individuals who received

psychotropic medication had been incremental. Currently, these CPEs had been completed for 37 (23%) of the 160 individuals who receive psychotropic medication.

- A complimentary process had been the development of new documentation for the Quarterly Psychiatric Reviews. This format was designed to correspond with the provisions of the Settlement Agreement that are specific to the appropriate use of psychotropic medication. These documents were also labor intensive. At the time of the review, the newly formatted Quarterly Psychiatric Review Forms had been completed for 81 of the 160 individuals (51%) who receive psychotropic medication. Collectively, the information contained in the CPEs and the revised Quarterly Psychiatric Review Forms directly related to ten of the 15 provisions in Section J of the Settlement Agreement. Thus, these were extremely important documents, and their completion for all individuals receiving psychotropic medication should be a priority for the Psychiatry Department.
- The planning for the Desensitization Plans for dental and medical procedures had proceeded, but as of yet, no actual plans had been implemented.
- The Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) monitoring for the side effects of psychotropic medications had been carried out, as specified, for a relatively high percentage of the sample of individuals who receive psychotropic medication. However, the monitoring of the individuals who receive Reglan (which has side effects similar to those of antipsychotic agents) was significantly deficient.
- The Psychiatry Department had been actively addressing the issue of adequate risk versus benefit analysis related to the use of psychotropic medication, as well as the implication of this analysis for obtaining consent that was truly "informed." A specific multidisciplinary "Consent Committee" also had been developed to further refine this process, and progress in this area will be monitored in future reviews.

<u>Psychological Care and Services</u>

- In addition to the Director of Behavioral Services, three associate psychologists were Board Certified Behavior Analysts. With the exception of one associate psychologist, all other master- and doctoral-level staff had completed at least one course in pursuit of certification.
- The Facility had made significant gains in developing both internal and external systems of peer review. Internal peer review continued through the weekly meetings of the Behavior Therapy Committee. Through affiliation with Lubbock and El Paso State Supported Living Centers, monthly external peer review had been established.
- The Facility had begun completing updated assessments of cognitive abilities and adaptive behavior skills.
- Other areas remained seriously out of compliance with the provisions of the Settlement Agreement. Data collection remained an area with significant problems. In spite of efforts to train home supervisors who would then train direct support professionals, analysis of data reflected errors, missing data, and poor compliance with data collection guidelines. As noted following each visit, this is particularly concerning, because clinical decisions are made based upon this inaccurate and unreliable data.

- Very few functional behavior assessments had been completed since the last visit. This assessment provides the foundation for a strong behavior support plan, and should be a priority for any individual who displays problem behavior. This is particularly true for individuals whose behavior has worsened or for those who have displayed a poor response to treatment.
- As noted in the past, behavior support plans continued to lack comprehensive preventative and antecedent strategies, reflected ineffective teaching strategies to develop functionally equivalent replacement behaviors, and identified poorly designed reinforcement systems.
- When new behavior support plans were developed or revisions were made to current plans, the timeline for necessary consents was inefficient and resulted in delays to plan implementation.
- Lastly, limited progress had been made with regard to competency-based training of staff on all components of individual behavior support plans. Changes had been made to New Employee Orientation. Additionally, psychology staff had met several times to address the development of a competency-based training model. A revised template for providing on-the-job feedback was created. However, this had been an exceptionally slow development process.

<u>Medical Care</u>

- Overall, the Facility had made very little progress with regard to Section L. It was not clear that the Facility had a clear understanding of the intent or the urgency of compliance with the provisions in this section of the Settlement Agreement. The Facility remained out of compliance with all sub-sections of Section L.
- One of the few areas in which limited progress had been made was in the development and role of the morning report. Attendance was interdisciplinary, and an efficient format for minutes had been developed. The group was beginning to ask critical questions, but there was little evidence of closure, and the breadth of critical questions and follow-up was inadequate to ensure quality care across the campus. Although in the weeks immediately preceding the Monitoring Team's review, the minutes reflected the need to develop a system for closure of issues raised in the meetings, several months of these meetings had occurred without the resolution of this necessary step. This reflected the lack of administrative action/leadership, and a significant delay in responding to this essential area of clinical administrative oversight.
- There appeared to be no review of databases created for preventive tests, such as colonoscopies, mammograms, pap smears, etc. There was no evidence of data tracking, analysis, and meeting with PCPs to review findings and develop action steps to address issues related to appropriate care and treatment. The Monitoring Team identified a number of problems with the completion of these essential tests. In addition, insufficient data was available to determine the adequacy of treatment for osteoporosis. Given the large numbers of individuals at AUSSLC with this serious condition, it was concerning that the Facility did not have a rigorous system to allow internal review.
- The external review process should include review of 20 percent of the records per year for compliance, and this had not yet occurred. Concerns related to the reviews included the lack of establishment of inter-rater

reliability, and the lack of formal documentation for each review. However, results of the peer reviews had had a positive impact on clinical practice.

- No initiatives were in place for internal review. To date, the Medical Department had had two years to develop internal tracking systems. The Medical Department appeared to consider Section L.3 an option rather than a requirement. If lack of knowledge on medical QI/QA systems was a problem, the Medical Department did not appear to have made any attempt to gain outside assistance or consultation in developing an internal program. At this point in time, none of the necessary infrastructure existed. This should have included providing guidance and collaborating with the Information Technology Department in creating systems that would be helpful to the Medical Department by providing information for trend analysis and ongoing QA monitoring. The current databases appeared to have been developed only for the purposes of providing information for the Monitoring Team's visits. The Medical Department was not using them for self-monitoring and improvement.

Nursing Care

- Since the last review, AUSSLC had made a number of changes regarding the Nursing Department and nursing positions, some which included filling the positions for the Nursing Operations Officer (NOO), the Hospital Liaison, the Nurse Manager positions for Castner Estates and the Infirmary, and the Quality Enhancement Nurse position. In addition, since May 2011, AUSSLC had not used the services of any agency nurses, and had established a Licensed Vocational Nurse 16-hour work schedule pool to cover weekends and other staffing issues. At the time of the review, the Nursing Department had a total of 143.6 allotted positions for Nursing, including 80.1 RN positions and 63.5 LVN positions. Overall, the total nursing vacancies included 12 RN positions, and eight LVN positions. These positive staffing advancements should assist the Facility in moving forward in achieving positive clinical outcomes for the individuals residing at AUSSLC.
- Similar to the last review, at the time of this review, the restructuring process of the Nursing Department was still underway with other interventions yet to be implemented. The Nursing Department and the Program Compliance Nurse had implemented few Heath Monitoring Tools due to a variety of staffing issues. However, a review of the Nursing Department's limited audits and data for some of the Nursing Health Monitoring tools found that with better consistency, there was promising potential to be able generate relevant data regarding nursing practices. However, due to the problematic issues regarding the lack of clear and specific instructions for the monitoring tools, lack of establishment of the clinical competence of the auditors in the areas they were are reviewing, and the lack of inter-rater reliability established for the monitoring tools, the current data generated were unreliable.
- Some of the Facility's positive steps forward included initiating the attendance of the Chief Nurse Executive, the Nursing Operations Officer, the Infection Control Nurse, the Hospital Liaison, the Infirmary Nurse Manager, and the Nurse Educator at the daily morning medical meetings. This was a positive step forward in facilitating communication between disciplines regarding acute events, and updates on individuals who were in the hospital. In addition, a procedure had been developed to address data reliability for Infection Control, which

was a crucial element in being able to accurately identify the Facility's trends related to infectious and communicable issues. Also, a very promising database was developed and implemented to track, analyze, and trend infectious diseases. The Facility also established the Medical Emergency Response Committee to review the Facility systems related to emergencies.

- However, consistent with the findings from the past reviews, there was no appreciable progress made in the critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, the quality and timeliness of the quarterly and annual nursing assessments, issues related to the Medical Emergency Response System, and/or nursing medication practices and the medication variance system. The Facility's inability to address these issues directly related to inadequate care provided to individuals, and, in some cases, placed individuals at increased risk of harm.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department was aware of its many areas of noncompliance. Regression in compliance appeared to be due to staff shortages in critical areas. However, the Facility appeared to be resolving the shortages. A clinical pharmacist position recently was filled, and the Facility continued to recruit for another pharmacist position.
- The Facility continued to make progress with regard to Section N.1, and incorporating lab monitoring into the order entry system. Documentation of follow-through with the patient interventions was needed. For example, when the primary care practitioner (PCP) was contacted, documentation was necessary to show the impact of that communication (e.g., new orders, etc.). Internal monitoring was needed to ensure all the steps of the new order review were completed.
- The Quarterly Drug Regimen Review (QDRR) process had been put on hold due to loss of the clinical pharmacist. With refilling this position, these sections should improve. The addition of pre-treatment sedation information to the QDRR was a positive contribution. However, additional focus was needed on the sections involving justification of polypharmacy and justification of anticholinergic medications. Reconciliation of chemical restraint use with behavioral services information was ongoing.
- The adverse drug reaction (ADR) interim protocol provided a short-term system, but further work was needed to complete the adverse drug reaction policy. Once this was finalized, a major task will be the education of the many staff that would need to implement the policy.
- Since the Monitoring Team's last visit until August, the Pharmacy Department was unable to initiate a Drug Utilization Evaluation (DUE). At the time of the most recent review, a calendar of future DUEs had been created.
- The department developed a process and database for internal medication variances. However, the Facility had made little progress in researching the reasons for the medication errors and medication variance reports.

Physical and Nutritional Supports

- The AUSSLC Physical and Nutritional Management Team (PNMT) continued to make progress in implementing the PNMT process. However, it was significantly impacted by the Facility not embracing the mission of the

PNMT. This was evidenced by staff's noncompliance with PNMT action plans and PNMPs, as well as the PNMT and IDT members not working collaboratively together. To achieve compliance with Section O, the Facility should create a culture in which the implementation of PNMPs and dining plans are non-negotiable, and an environment where all team members work collaboratively to achieve success in implementing outcomes for individuals at highest risk. To do its part, the PNMT should improve its collaboration with all team members supporting individuals on its caseload. This should involve increasing all team members' input in developing plans, improving team members' understanding of the importance of implementing the plans, and increasing capacity related to physical and nutritional management (PNM) supports.

- Positive developments for the PNMT included the development of transition plans for individuals returning from the hospital, PNMT members visiting individuals on their caseload in the hospital, completion of a retroactive record review to look at events prior to an individual's hospitalization, the tracking of monitoring results and graphing intervention results to determine the efficacy of their interventions, as well as the initial development of integrated care plans for two individuals.
- The Facility should critically review the PNMT's Levels of Involvement, including the definitions for Level I and II. These levels might be appropriate in the future. However, AUSSLC IDTs did not currently have the skills to complete comprehensive assessments and develop effective action plans for individuals at highest risk.
- State and Facility policy had been revised to require additional components in Physical and Nutritional Management Plans (PNMPs). The Facility should prioritize individuals at highest risk to incorporate these revisions into their PNMPs as soon as possible. PNMPs for individuals at high risk should be audited to ensure that they include adequate staff strategies for wheelchair and alternate positioning throughout the 24-hour day, mealtimes, oral care, medication administration, bathing, personal care, and transfers.
- The Facility had implemented a pilot program for mealtime management, which was a positive initiative. The plan was to expand this initiative to all residential units by the end of the year. A draft protocol had been developed that identified mealtime management participants, training requirements, and responsibilities.
- Habilitation Therapies had revised and piloted a universal tool that would monitor all PNMP activities. The new tool will allow for tracking and trending of monitoring results to assist in resolving staff non-compliance and systemic issues.
- The Facility did not have a system that provided data to track and trend the progress of individuals with PNM concerns. IDTs that support individuals with high-risk physical and nutritional management difficulties should track and analyze the efficacy of their interventions to minimize and/or reduce identified risk indicators, and make changes when appropriate.
- Individuals who received enteral nutrition were to receive an Aspiration Pneumonia/Enteral Nutrition (APEN) evaluation. The purpose 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. APEN evaluations were not consistently adequate to address the Settlement Agreement requirements.

Physical and Occupational Therapy

- Based on interview, therapy staff were divided into teams and assigned to specific units. This was done to support integration and collaboration between therapists and unit staff, as well to have consistent therapy presence at unit meetings, PSPs, and PSPAs. The Monitoring Team viewed this as a positive restructuring of the Habilitation Therapy (HT) Department.
- OT/PT assessment and assessment update formats had been revised to instruct therapists to address medium and high risks indicators that required therapy services. This was a constructive addition.
- Unfortunately, individual Occupational Therapy/Physical Therapy (OT/PT) assessment recommendations were primarily focused on service recommendations to support health and safety, and did not include recommendation that would assist individuals to improve their functional capacities, and/or expand their inclusion and involvement in various settings. Although improved health and wellness are important, therapy supports also should lead to individuals having greater access to activities, including potentially new environments for social interaction, learning, and work.
- Seven of the 351 individuals (2%) living at AUSSLC received direct PT services. No individuals received direct OT services. Direct therapy plans were not reinforced through formal skill acquisition programs or informally during daily activities.

Dental Services

- The Facility remained in noncompliance with both subsections of Section Q, but continued to make progress in all areas. Review of dental records indicated complete and comprehensive care. An electronic annual dental assessment had been established. The dental assessment form was adapted to meet the needs of the direct support professionals by including clear oral hygiene recommendations.
- A number of initiatives were in place for improving oral hygiene. Attempts were made at home instruction, but with staffing shortages in the Dental Department, this was temporarily placed on hold. Additionally, corrective action plans were made for many individuals with poor oral hygiene. Since the Monitoring Team's last visit, the multifaceted approach had a positive impact with improvement of oral hygiene ratings. There was less progress with offering suction tooth brushing to other individuals.
- However, no information management system had been created to capture the energy and activity toward these endeavors, or to determine which approaches were most successful. From the documentation received, dental desensitization had not commenced at the pilot home, and the Facility needed to prioritize this endeavor. All residents in the pilot home had completed a dental task analysis. A tooth brushing task analysis was underway.
- The system to determine the cause of missed appointments appeared to be in place, but the challenge was to decide which areas could be resolved at the Dental Department or Facility level and focus on those areas. The Dental Department submitted several volumes of correspondence to the residences as well as to the Nursing

Department concerning missed appointments, and other dental issues. To date, collaboration with nursing to complete a dental oral sedation monitoring protocol remained an ongoing issue.

Communication

- Positive developments for this section included a fully staffed Speech and Hearing Department, SLP attendance at annual PSPs had increased, SLPs had developed staff instructions for communication strategies and individual-specific AAC systems that were an extension of the PNMP, and significant progress had been made in the provision of competency-based training and check-offs for individuals with AAC systems.
- The Presentation Book for Section R indicated that the Speech Update template was revised, and was being piloted at AUSSLC. The Monitoring Team's review of multiple SL assessments did not reflect the development of individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of plans or programs.
- No Facility policy existed to define the SLPs' role and responsibilities.
- During the last two reviews, the Monitoring Team raised concerns related to the absence of resources for individuals who were deaf and/or significantly hearing impaired. This concern continued to be warranted. An individual who could sign fluently did not have staff that were proficient in sign language, nor was a translator available. This continued to place this individual in a position of not being able to communicate to the best of his abilities with peers and/or staff.
- As a result of the ongoing level of staff non-compliance with communication devices as documented on monitoring forms, the Facility and the HT Department should place a high priority on implementation of a monitoring system that will allow tracking and trending of data to analyze progress with staff compliance for communication devices.

Habilitation, Training, Education, and Skill Acquisition Programs

- The Facility is commended for its introduction of new and expanded measures of adaptive behavior and vocational skills. It is also commended for the improvement in identifying personal preferences and interests, and for attention to risk factors. It is important to note that these initiatives were in the early stages of development, and initial implementation showed the need for continuing improvement. The challenge remained to ensure that comprehensive Personal Support Plans were developed based on objective assessment of an individual's needs.
- Training objectives remained quite limited in scope and were defined poorly. Teaching opportunities remained infrequent, methodologies were compromised by a lack of clarity and consistency, and data used to assess progress were below standard. The environments did not promote high expectations for growth and development. Activities available to individuals at the Facility were often of poor quality, not individual-specific, and often without functional outcome or purpose. Residences remained areas where active engagement was very limited.

Most Integrated Setting

- Individuals' ISPs had begun to include determinations by professionals with regard to whether community placement was appropriate. Each assessor was now expected to include a specific recommendation regarding whether or not the individual could be supported in a less restrictive setting. Some assessments included such statements, but many did not. However, professional members of teams had begun to have these discussions, make recommendations to the individual and his/her guardian, and document the results in the ISPs.
- Since the last review, six individuals had transitioned to the community. At the time of the review, 18 additional individuals had been referred for transition to the community.
- IDTs 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. However, teams still did not consistently identify the full array of essential and nonessential supports that individuals needed to transition safely to the community. This placed individuals at risk, and jeopardized their successful transitions. However, improvement was seen in the measurability of the supports.
- Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. Efforts were being made to add information regarding the interviews conducted, the documents reviewed, and the observations made. However, issues were noted with regard to both the quality of the reviews, and the follow-up activities necessary to ensure that supports and services were provided.

Consent

- At the time of the review, DADS State Office was still in the process of finalizing policies on guardianship and consent. These policies were expected to provide guidance to the Facilities with regard to the implementation of the Section U Settlement Agreement requirements.
- Although the Facility did not have a formal process yet to determine which individuals did not have decision-making capacity or had limits to their decision-making ability, at the time of the review, 114 of the 351 individuals the Facility served (32%) did not have guardians.
- As noted in the previous report, 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. Since the last review, the Facility's Social Workers had begun to complete draft tools for each of the individuals on their caseloads. The next step would be sharing the drafts with the individuals' teams, and finalizing the tools with input from the teams. It was unclear if the State Office had reviewed or approved the tool the Facility was using.
- As the Monitoring Team reported in previous reports, Facility staff made ongoing attempts to obtain guardians for individuals. For example:

- Since the baseline review, a total of 11 individuals had obtained guardians. Three of these guardianships had been ordered since the last review.
- AUSSLC continued to make referrals to a private, nonprofit guardianship agency called Family Eldercare. Unfortunately, the waiting list for this program was long.
- The Facility had formed a Guardianship Committee that currently was composed of eight Facility staff, with plans to expand the membership to include community members.
- Members of the Committee met with the local Travis County Probate Court to discuss the 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. Based on these recent conversations, it was hoped that a number of guardianship hearings would be held before the end of 2011.

- A position had been approved for a Guardianship Coordinator position to assist with all of the tasks related to ensuring individuals had adequate supports related to decision-making. It was anticipated that this position would be posted soon.

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

- Since the last review, the Facility had taken some specific steps to address the issues related to the timely availability of documents in the Active Records, resulting in substantial improvement. Except for a few documents, documents generally appeared to be in the records. In addition to streamlining the submission of medical documents, a tracking system was set up to log the submission of documents through to when they were filed in the records.
- AUSSLC also had addressed the issue of the security of records, particularly ensuring that the whereabouts of records was known. Specifically, a procedure had been developed, staff training, and implementation begun of a sign-out process.
- 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.
- However, because the Facility did not provide requested documentation, no evidence was found to show that new policies were being disseminated. In addition, a system was not yet in place to track the training provided. Based on staff interview, systems were not yet in place to ensure staff had the necessary knowledge and skills to implement the policies.
- Audits were being completed of records. No action plans had been developed yet to address issues related to records.

V. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>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.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

The complete restraint records, when provided, including restraint checklist form, face-to-face form, the debriefing form, review documentation, and, where available, the individual's Safety Plan for twelve individuals included in Sample #C.1, including Individual #23, Individual #33, Individual #56, Individual #74, Individual #77, Individual #202, Individual #283; Individual #344, Individual #380, Individual #395, Individual #406, and Individual #421 for the following restraint episodes:
<table>
<tr><th>Individual</th><th>Date of Restraint</th><th>Time of Restraint</th><th>Type of Restraint</th></tr>
<tr><td>Individual #23</td><td>9/26/11</td><td>10:11 a.m.</td><td>Physical</td></tr>
<tr><td>Individual #33</td><td>9/30/11</td><td>12:15 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #56</td><td>10/9/11</td><td>6:35 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #74</td><td>8/29/11</td><td>7:00 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>9/20/11</td><td>2:30 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>10/6/11</td><td>7:37 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #77</td><td>10/10/11</td><td>12:59 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #202</td><td>8/27/11</td><td>1:54 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #283</td><td>8/23/11</td><td>8:40 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #344</td><td>10/5/11</td><td>2:40 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #380</td><td>8/21/11</td><td>11:49 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #395</td><td>7/19/11</td><td>7:55 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>8/22/11</td><td>5:46 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>8/25/11</td><td>9:15 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>9/10/11</td><td>1:15 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>9/10/11</td><td>7:05 p.m.</td><td>Physical</td></tr>
<tr><td>Individual #406</td><td>7/10/11</td><td>3:00 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>7/11/11</td><td>10:36 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>8/10/11</td><td>10:42 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>10/15/11</td><td>3:42 p.m.</td><td>Physical</td></tr>
<tr><td></td><td>11/1/11</td><td>5:50 a.m.</td><td>Physical</td></tr>
<tr><td>Individual #421</td><td>9/24/11</td><td>6:15 p.m.</td><td>Physical</td></tr>
</table>

The training transcripts and signed forms acknowledging the obligation to report abuse, neglect, and exploitation provided for 13 randomly selected AUSSLC employees (Sample #C.2.);
The chemical restraint documentation for six individuals included in Sample #C.4: Individual #30, Individual #109, Individual #195, Individual #325, Individual #350, and Individual #374;

</td></tr>
</table>

Individual	Date of Restraint	Time of Restraint	Type of Restraint
Individual #30	8/2/11	6:25 p.m.	Chemical
Individual #109	6/20/11	5:56 p.m.	Chemical
Individual #195	7/24/11	4:20 p.m.	Chemical
Individual #325	8/17/11	4:05 p.m.	Chemical
Individual #350	9/19/11	8:06 p.m.	Chemical
Individual #374	7/1/11	4:00 p.m.	Chemical

- Presentation Book for Section C;
- Prevention and Management of Aggressive Behavior (PMAB) training curriculum;
- List of Individuals (42) Restrained, from 4/1/11 through 10/1/11;
- List of individuals (0) restrained off campus by AUSSLC employee;
- List of Individuals (22) with a Safety Plan;
- List of employees delinquent in PMAB Basic training, and/or abuse, and neglect training and unusual incident training;
- List of Restraints by Resident and Type, from 4/1/11 through 10/1/11;
- Staffing reports for 6/6/11 and 7/5/11 for Individual #109;
- Human Rights Committee Meeting minutes, from 5/26/11 to 10/6/11;
- Incident Management Review Team meeting minutes for each Monday, since the last onsite review;
- Quality Assurance/Quality Improvement Council meeting minutes, from 4/6/11 to 10/19/11 (some minutes were missing);
- Restraint Trend Report, Quarters 3 and 4, for FY11;
- Do Not Restrain or Restrain with Extreme Caution Lists, with the names of 88 individuals, dated 10/18/11;
- List of injuries during the use of restraint for the last year;
- Restraint Checklists and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint for: Individual #406 (7/10/11 at 3:00 p.m., 7/11/11 at 10:36 a.m., 8/10/11 at 10:42 a.m., and 10/15/11 at 3:42 p.m.), Individual #421 (9/24/11 at 6:15 p.m.), Individual #23 (9/26/11 at 10:11 a.m.), Individual #283 (8/23/11 at 8:40 p.m.), Individual #380 (8/21/11 at 11:49 a.m.), Individual #395 (7/19/11 at 7:55 a.m., 8/25/11 at 9:15 a.m., 9/10/11 at 1:15 p.m., and 7:05 p.m.), Individual #33 (9/30/11 at 12:15 p.m.), Individual #202 (8/27/11 at 1:54 p.m.), Individual #74 (10/6/11 at 7:37 a.m., and 9/20/11 at 2:30 p.m.), Individual #344 (10/5/11 at 2:40 a.m.), Individual #195 (7/24/11 at 4:20 p.m.), and Individual #109 (6/20/11 at 5:56 p.m.);
- Restraint Checklists for: Individual #406 (11/1/11 at 5:50 a.m.), Individual #374 (7/1/11 at 4:00 p.m.), Individual #395 (8/22/11 at 5:46 p.m.), Individual #77 (10/10/11 at 12:59 p.m.), Individual #74 (8/29/11 at 7:00 p.m.), and Individual #56 (10/9/11 at 6:35 p.m.);
- Restraint Checklists, Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint; and Administration of Chemical Restraint Consults for: Individual #325 (8/17/11 at 4:05 p.m.), and Individual #30 (8/2/11 at 6:25 p.m.);

	○ Positive Behavior Support Plans for: Individual #325, Individual #406, Individual #374, Individual #421, Individual #30, Individual #23, Individual #283, Individual #380, Individual #395, Individual #77, Individual #33, Individual #202, Individual #74, Individual #344, Individual #195, Individual #56, and Individual #109; ○ PSP Addenda for Individual #406, dated 5/5/11, 5/23/11, 7/15/11, 7/27/11, 8/22/11, 8/31/11, 9/7/11, 10/10/11 (x2), 10/11/11, and 10/13/11; ○ PSP Addenda for Individual #395, dated 5/13/11, 6/23/11 (x2), 7/20/11, 8/10/11, 8/25/11, 9/13/11, 9/14/11, 10/4/11, 10/19/11, 10/21/11, 10/25/11, 10/31/11 (x2), and 11/8/11; ○ PSP Addenda for Individual #74, dated 5/11/11, 5/18/11, 6/20/11, 6/29/11, 7/13/11, 8/1/11, 9/2/11, 9/16/11, 9/19/11, 10/5/11, 10/6/11, 10/13/11, 10/20/11, and 11/9/11; ○ Safety Plan for Crisis Interventions for: Individual #175, Individual #445, Individual #406, Individual #284, Individual #395, Individual #74, Individual #360, Individual #109, and Individual #382; ○ At-Risk Rating Spreadsheet; ○ Pre-Treatment Sedation Committee meeting minutes, dated 6/2/11, 6/30/11, and 11/17/11; ○ Dental Task Analysis, revised 6/8/11; ○ Austin State Supported Living Center Policy – Pre-Treatment Sedation, revised 7/6/11; ○ Personal Support Plan objectives related to dental desensitization for: Individual #251, Individual #92, Individual #183, Individual #332, Individual #258, Individual #128, Individual #12, Individual #324, Individual #321, Individual #48, Individual #290, Individual #369, Individual #372, Individual #248, Individual #374, Individual #450, Individual #193, Individual #180, Individual #347, Individual #144, Individual #454, Individual #102, Individual #224, Individual #64, Individual #319, Individual #381, Individual #268, Individual #198, Individual #229, Individual #155, Individual #143, Individual #185, Individual #100, Individual #16, Individual #422, Individual #115, Individual #395, Individual #241, Individual #378, Individual #433, Individual #385, Individual #196, Individual #67, Individual #43, Individual #99, Individual #272, Individual #264, Individual #194, Individual #278, Individual #14, Individual #288, Individual #306, Individual #147, Individual #423, Individual #222, Individual #338, Individual #437, Individual #15, Individual #52, Individual #235, Individual #56, Individual #287, Individual #416, and Individual #188; and ○ Proposal: Transferring Residents During Hazardous Weather Conditions, dated 9/14/11. ▪ **Interviews with**: ○ Vira Benson, Facility Director; ○ Jose Levy, Director of Behavioral Services; ○ Raynard Burnett, Incident Management Coordinator; ○ Derrick Bunton, Director of Residential Services; ○ Jo Ann Villasana, Human Rights Officer; ○ Tammy Snyder, Director of Quality Assurance; and

	○ Malika Pritchett, Associate Psychologist, on 11/17/11. ▪ **Observations of**: ○ Incident Management Meetings, held on 11/14/11 and 11/16/11; ○ Restraint Reduction Committee Meeting, on 11/14/11; ○ Human Rights Committee Meeting, on 11/17/11; ○ Quality Assurance/Quality Improvement Council Meeting, on 11/16/11; and ○ Clinical Care Committee meeting, on 11/16/11; ○ 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 acknowledged that there were no areas of Section C in substantial compliance with the provisions of the Settlement Agreement. The Monitoring Team concurred with the Facility's findings regarding its compliance with Section C. The Plan of Improvement (POI) submitted during the current onsite review was notably lacking any documentation of actions taken to address the mandates of Section C. For example, despite the significant findings of non-compliance during the previous monitoring visit, no review of restraint documentation occurred between 3/1/11 and 10/12/11. The POI stated that training in monitoring and documentation was to begin on 7/15/11, and be completed by 12/15/11. Reportedly, at the time of the onsite review, this training had not yet started.
	Summary of Monitor's Assessment: During the previous 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. As a result, it was not possible to fully evaluate the Facility's use of restraint with any degree of confidence at that time. The Director of Quality Assurance was urged to work with the Director of Behavioral Services to establish a timely, comprehensive and reliable system for reporting the use of restraint. Regrettably, there was no evidence of improved outcomes during this recent site visit. Troubling concerns about the integrity of the restraint data again were documented, and there was a disturbing lack of urgency in implementing appropriate remedial actions. Again, as previously reported, at the time of the recent 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. It also was not clear that the issue of restraint use was a priority for the Facility as a whole. Based on the evidence reviewed, 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. Restraint documentation remained inconsistently complete. A complete description of events necessitating restraint and steps taken to avoid restraint was not consistently evident in restraint reports. Similarly,

	debriefing information or administrative consult for chemical restraint was not always provided. Efforts to reduce the use of restraint and/or sedation for dental procedures remained a very slow process. No dental desensitization plans had been developed and implemented at the Facility. Although the Facility had developed a format for Personal Support Plan addenda to address application of more than three restraints in 30 days, a review of documentation revealed this was not consistently implemented. Further, staff response to frequent restraint was often limited. Required assessments were not identified or completed, changes to the individual's habilitation and/or behavior support plan were not implemented, and in-service training often was identified as the strategy of choice to ensure improved implementation of positive behavior supports. Although in-service training could be beneficial, it should not have been the only response.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Based on information provided by the Director of Behavioral Services, between 4/1/11 and 10/1/11: • There was no use of prone restraint; • A total of 42 individuals experienced a form of restraint; • Thirteen individuals experienced five or more episodes of crisis restraint, including Individual #332, Individual #406, Individual #374, Individual #284, Individual #421, Individual #395, Individual #77, Individual #350, Individual #74, Individual #360, Individual #56, Individual #109, and Individual #382. During the onsite review, the Facility acknowledged serious deficiencies in the completion and timely submission of restraint documentation. As a result of the Facility's failure to monitor the use of restraint with sufficient vigilance, serious questions existed about the integrity of the data provided for the preparation of this report. According to its Plan of Improvement, in reference to this provision, a lapse of over seven months (from 2/28/11 to 10/15/11) occurred in the Facility's review of restraint documentation. Furthermore, given the deficiencies cited in the Monitoring Team's last report, the extent of the Facility's review was extremely limited. Since the Monitoring Team's last visit, no changes had occurred in the Facility's policy. Although, as noted previously, the documentation the Facility provided was questionable, a sample, referred to as Sample #C.1, was selected based on the information available. This included twelve individuals, representing 29% of the 42 individuals restrained over the last six-month period. This sample was selected to ensure representation of individuals with a range of restraint use, not only those individuals with the most	Noncompliance

#	Provision	Assessment of Status	Compliance
		frequent use of restraint. The individuals in this sample included: Individual #23, Individual #33, Individual #56, Individual #74, Individual #77, Individual #202, Individual #283, Individual #344, Individual #380, Individual #395, Individual #406, and Individual #421. Individual #74 and Individual #395 were two of the individuals with the highest restraint use in the last six months. Individual #344 and Individual #23 each had a single episode of restraint. After the Sample was selected, it was noted that Individual #23 was on the list of individuals not to be restrained unless necessary and then with extreme caution. <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 twelve individuals, none (0%) showed use of prone restraint. The Facility reported that prone restraint had not been utilized since the last onsite review. However, the general lack of reliable data regarding the use of restraint (as is detailed below) made it difficult to place any confidence in the Facility's statement, especially since there was evidence of improper restraint use documented in the findings of an investigation (#40220398) regarding Individual #74. In this incident, sheets were used as a 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	

#	Provision	Assessment of Status	Compliance
		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. There was no documentation at all provided for two restraint episodes (7/1/11 and 9/17/11) for Individual #74. As a result, information about those restraints had to be deleted from the sample. Furthermore, there were eight restraint episodes (for Individual #33, Individual #283, Individual #395, and Individual #406) that lacked the presence of a Restraint Monitor. The restraint for Individual #283 occurred on 8/23/11 at 8:40 p.m. and was over by 8:43 p.m. The switchboard did not contact the Restraint Monitor until 9:15 p.m., and his arrival time was not noted on the checklist. Nonetheless, a checklist was completed. The Restraint Monitor for the single episode involving Individual #33 was not present, but signed the form. Another (second) staff person signed the debriefing form, but this staff person was not present either. A Restraint Monitor was not present for the 7/11/11, 8/10/11, 10/15/11, and 11/01/11 restraint episodes for Individual #406. The first restraint without a Restraint Monitor for Individual #395 occurred on 8/22/11. A Restraint Monitor was not at all present, and no explanation was provided for this absence. A restraint checklist for the episode was completed and signed on 9/6/11. The second restraint for Individual #395 without the presence of a Restraint Monitor occurred on 9/10/11 at 1:15 p.m. A restraint checklist was completed sometime later that day. Since the reliability of the information documented on these eight checklists was questionable, the sections to be completed by the Restraint Monitor were deleted from the sample. In summary, only 64% of the Restraint Checklists were completed as required by State and Facility policy and by the provisions of the Settlement Agreement. With these incomplete documents deleted from Sample #C.1, there were a total of 14 restraint checklists reviewed in their entirety. Based on the records available, the following are the results of this review: ▪ In ten of the 14 records (71%), 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 #56 had drawn blood as a result of biting his hands prior to the application of restraint (10/9/11 at 6:35 p.m.). o Individual #74 was scratching staff in the face and grabbing at their clothing. When staff moved away, the individual pursued them (10/6/11 at 7:37 a.m.). o Individual #395 was described as scratching, hitting, and kicking staff	

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		prior to restraint (8/25/11 at 9:15 a.m.). o Individual #195 was hitting, kicking, and throwing items at others (7/24/11 at 4:20 p.m.). Example where this was not the case included: o Individual #74 was reported to leave the home on one occasion (8/29/11 at 7:00 p.m.), and "showed a behavior" on another occasion (9/20/11 at 2:30 p.m.). Although aggression and self-injury were checked as the reason for restraint, the narrative did not explain what behavior the individual was displaying that necessitated restraint. o Individual #406 reportedly became "agitated" when he was told there was no more of the pizza his mother had brought him. Although aggression and property destruction were checked as the reason for restraint, the narrative did not describe the individual's behavior that necessitated restraint (7/10/11 at 3:00 p.m.). o Individual #77 became upset, indicated she wanted to leave, and started towards the gate. Although self-injurious behavior was noted as the reason for restraint, no description was provided of the individual's observable behavior (10/10/11 at 12:59 p.m.). o Individual #325 was reported to have engaged in "persistent aggression throughout the day." However, no description was provided of the immediate behavior that resulted in restraint (8/17/11 at 4:05 p.m.). o No description was provided of the events leading to restraint or the interventions attempted to avoid restraint on the checklist for Individual #30 (8/2/11 at 5:25 p.m.). ▪ The narrative describing the use of restraint was very brief for all episodes reviewed. However, there was no evidence in any instance (0%) that restraints were being used for the convenience of staff, or as punishment. ▪ In eight of the 14 records (57%), 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 #380 (8/21/11 at 11:49 am) and Individual #344 (10/5/11 at 2:40am). Examples where this was not the case included: o Individual #395 (9/10/11 at 7:05 p.m.); o Individual #77 (10/10/11 at 12:59 p.m.) Facility policies identified a list of approved restraints. Based on the review of 14 restraints, involving twelve individuals, ten (71%) were approved restraints. Restraint documentation indicated that Individual #23 is on the	

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		Restrain with Extreme Caution List. The physician was called for approval only after the restraint. Similarly, physician approval was obtained after the use of restraints for Individual #202, Individual #344, and Individual #380. Other concerns raised when reviewing these checklists are described below: ▪ Staff informed Individual #74 that the reason for the restraint was "that today is not her birthday" (10/6/11 at 7:37 a.m.). Although the individual was reportedly confused about her birthday, which led to her aggressive behavior, this was clearly not the reason she was restrained. ▪ There were multiple occasions where it appeared that another individual was displaying behavior that was upsetting to Individual #395. Follow-up should be provided to staff to identify steps to take to better manage disruptive behavior in the home and reduce the negative impact such disruption has on others. ▪ Although chemical restraint was employed with Individual #195 (7/24/11 at 4:20 p.m.) and Individual #109 (6/20/11 at 5:56 p.m.), it appeared that the Administration of Chemical Restraint Consult had not been completed. A review was completed of the Positive Behavior Support Plan for the individuals in this sample. General comments regarding PBSPs are provided with regard to Section K.9 of the Settlement Agreement. Comments specific to the three individuals who experienced more than three restraints in any rolling 30-day period are provided below: ▪ For all three individuals, the schedule of reinforcement for the absence of challenging behavior or the use of appropriate alternative behavior was very lean. Staff were advised to "try to" provide reinforcers every hour if Individual #406 was not engaged in his target behaviors. Although food was noted as a potentially strong reinforcer, praise was the recommended reinforcer for Individual #395. Food was not recommended due to the individual's weight. As this individual was increasingly refusing to participate in any habilitation services, it is strongly recommended that alternatives to praise be considered. The plan for Individual #74 referenced behavior contracts, but the specifics (including schedule of reinforcement) of these contracts were not provided. ▪ None of the plans reflected the completion of a preference assessment. ▪ Similarly, none of the plans referenced a current, comprehensive Functional Behavior Assessment. PBSPs, as currently written, did not provide adequate or effective treatment. Therefore, it is likely that restraint was sometimes used in the absence of adequate treatment. This is discussed in further detail regarding Section K. However, in general behavior support should be improved with the following: a) operational definitions of replacement behavior that will serve the same function as the identified problem behaviors; b) teaching strategies that will help the individual learn to engage in these replacement	

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		behaviors independently without relying on staff prompts to do so; c) sufficient opportunities to learn identified replacement behaviors; d) identification of potential reinforcers through systematic assessment of preferences; and e) comprehensive and current functional behavior assessment for individuals who display challenging behaviors. Further, staff should review treatment implementation and efficacy on a regular basis to ensure that revisions to behavior support plans are made as necessary and in a timely manner. In an effort to minimize the use of restraint under certain circumstances and in response to recent incidents, the Director of Behavioral Services developed a policy draft entitled Transferring Residents During Hazardous Weather Conditions, dated 9/14/11. Two months later, at the 11/16/11 meeting of the Clinical Care Committee meeting, this policy was still under review. While a thorough and thoughtful approach to policy development is appropriate, staff should act more quickly to ensure timely response to identified problems to protect the individuals served and provide appropriate training and support to direct service professionals.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	According to the documentation provided in the restraint checklists, all but one of the twelve individuals in the sample were released from restraint when no longer an immediate and serious risk of harm to self or others. The release codes for Individual #74 on 8/29/11 were not clearly written and could not be determined. However, due to the numbers of restraint records that had not been completed accurately as a result of restraint monitors not being present that were excluded from the sample, adequate protections were not in place to ensure that individuals were released timely from restraints. As a result, a finding of noncompliance has been made. There were Safety Plans approved for seven individuals in Sample #C.1, including Individual #56, Individual #74, Individual #77, Individual #283, Individual #395, Individual #406, and Individual #421. Section C.7.e, provides further discussion about the quality of the Safety Plans.	Noncompliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop 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	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.	Noncompliance

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	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.	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 13 AUSSLC employees. Based on the review of Sample #C.2, all (100%) staff had been properly trained on restraint and its related topics. In its comments to the POI, the Facility reported that 93% of the staff that required training in PMAB were current with this training obligation. As noted above with regard to Section C.1 of the Settlement Agreement, 58% 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. Although in some cases staff did document when redirection and verbal prompts were attempted prior to restraint use, it is probable that increased staff knowledge and experience with alternatives to restraint would most likely show a reduction in overall restraint use. Based on review of the individual restraint records, the techniques documented to avoid restraint were not particularly individualized, creative, or effective. In addition, the environmental conditions at AUSSLC contributed to the escalation of undesired behavior in certain individuals. For example, on 6/6/11, the staffing report for Individual #109 stated: "…[Individual] was upset over the chaotic/noisy nature of 796 and was displaying significant maladaptive behaviors. These included aggression, property destruction, and LDA. [Individual] was restrained several times on this day and received emergency medication to help her calm." According to the documentation provided, staff assigned the responsibility to work in the residential units did not always possess or demonstrate the skills and judgment required. In some cases, this was the result of unanticipated staffing assignments based on the need to meet minimum staffing ratios. The use of "pulled" staff who are unfamiliar with the PSPs and PBSPs of the individuals under their responsibility was a significant factor influencing the rate of restraint at AUSSLC. For example, another staffing report for Individual #109, written on 7/5/11, described a Code Red called when this Individual ran away. It also noted: "DCS was unfamiliar with (Individual #109's) BSP."	
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	In ten of the 14 records (71%), there was evidence documented that restraint was used as a crisis intervention. As discussed in earlier reports, at the time of the onsite review, the Facility reported that it did not track the use of restraint for medical purposes. The Director of Quality	Noncompliance

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	medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Assurance 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. During the most recent site visit, the Director of Quality Assurance did not know who was responsible for this assignment. On the cover sheet for records request TX-AU-1111-11.10d, it was stated that there was "(N)othing to submit for medical restraints." This is an example of the lack of coordination between the various departments and the lack of clarity about the definition of medical restraint. As part of the document request for the site visit, there was a request for "any documentation available regarding medical restraints since 5/1/11 for the following Individuals: Individual #202, Individual #332, Individual #246, Individual #261, Individual #249, Individual #127, Individual #103, and Individual #304. However, the documentation provided for Individual #332 related to restraint for aggression and, for Individual #202, for failure to come indoors. The documentation involving Individual #246 and Individual #261 related to self-injurious behavior. The documentation for Individual #249, Individual #103 and Individual #304 was incomplete. There was no documentation provided for Individual #127. As referenced above, Individual #23, who is diagnosed with osteoporosis, was included on the Restrain with Extreme Caution List. On 9/26/11, he was restrained without a physician's prior authorization. A request was made for documentation of evidence regarding efforts the Facility had made to reduce the use of restraint and/or sedation for dental procedures. The Facility provided information on service objectives, training objectives, and/or participation objectives from the Personal Support Plan for 64 individuals. For 49 of these individuals (77%), objectives related to tooth brushing. Visits to the dental clinic were addressed in the PSPs for only eight individuals (13%) with the frequency of visits limited to one to four times per month. These plans reflected a poor response by the Facility to providing desensitization training to the individuals who require restraint and/or sedation for dental care. When the Director of Behavioral Services was asked about desensitization plans, he reported that these had not been developed. Further, a review of meeting minutes from the Pre-Treatment Sedation Committee revealed a very slow process in addressing this critical issue. Although during the 6/2/11 meeting, a pilot home had been identified, the first individual for whom a desensitization plan was to be written was not identified until four months later at the 11/17/11 meeting. At this time, it was also noted that a tooth brushing task analysis would be necessary before the plan could be written. Staff who are	

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		trained in Applied Behavior Analysis should have been able to develop this task analysis the same day the need was identified. To delay the development of a desensitization plan until the next meeting of this committee based on the need for a task analysis only highlighted the slow and overly cumbersome process. While a thoughtful approach to problem solving is appropriate and essential, the urgency of the matter cannot be underscored. Staff should address the need for changes to the continued use of restraint and/or sedation in the delivery of dental care. As noted above, the Facility was devoting a great deal of time to minimizing and monitoring the use of pre-treatment sedation for dental procedures. However, the documentation that detailed the utilization of pre-treatment sedation from 3/28/11 to 9/28/11 indicated that the majority of pre-treatment sedation at AUSSLC was utilized for medical appointments. The manner in which this data was organized made it difficult to actually compare the relative utilization rates of pre-treatment sedation for dental as opposed to medical procedures. For example, there was a discrete six-page listing of individuals who received pre-treatment sedation for dental procedures during this time period. However, orders were included for some dental procedures in the preceding 19 pages, which were primarily devoted to orders for pre-treatment sedation for medical procedures. As is discussed further with regard to Section J.4, the issue of Pre-Treatment Sedation Plans for medical procedures was discussed separately with the Lead Psychiatrist, the Director of Psychological Services, and the Medical Director. No initiative was underway to develop plans for these procedures at this time.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a	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. The Director of Behavioral Services reported, that since the last onsite review, training on monitoring and documentation was to be provided to Restraint Monitors and nurses, as necessary. As documented in this and the previous monitoring reports, based on the failure to adequately monitor all restraints, training was certainly required. This training was to begin by 7/15/11, and to be completed by 12/15/11. However, at the time of the most recent site visit, the training had not yet started. Despite the training documentation provided to the Monitoring Team, there were serious problems with Restraint Monitors' timely performance. As described above, for the individuals included in Sample #C.1, Restraint Monitors were not present for eight restraint episodes documented for Individual #33, Individual #283, Individual #395, and Individual #406. Therefore, a face-to-face assessment only was conducted in 14 out of 22 64%) of the restraint episodes: ▪ In nine out of 22 instances (41%), it could be confirmed that the Restraint	Noncompliance

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	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.	Monitor arrived within 15 minutes to begin the assessment. ▪ In 10 out of 22 instances (45%), the documentation showed that an assessment was completed of the application of the restraint. ▪ In 10 out of 22 instances (45%), the documentation showed that an assessment was completed of the circumstances of the restraint. Information regarding the completion of training requirements for each of the Restraint Monitors could not be located during the preparation of this report. The Facility did not provide any information regarding the use of alternative monitoring schedules. According to the Facility, there were no restraints used outside of AUSSLC. The section of the Restraint Checklist regarding physical/mental assessment were reviewed for all 22 restraints in Sample #C.1. Based on this review, there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 13 (59%) of the instances of restraint. Records that did not contain documentation of this included: Individual #74, on 8/29/11 and 9/20/11; Individual #395, on 8/25/11, and 9/10/11; Individual #406, on 11/1/11; Individual #421, on 9/24/11; Individual #344, on 10/5/11; Individual #56, on 10/9/11; and Individual #77, on 10/10/11. ▪ Monitored and documented vital signs in 18 (82%). Records that did not contain documentation of this included: Individual #395, on 8/25/11, and 9/10/11; Individual #406, on 7/11/11; and Individual #421, on 9/24/11. Problematic issues that resulted in noncompliance included vital signs not recorded or marked as refused. To obtain respirations, the individual's cooperation is not required. ▪ Monitored and documented mental status in 19 (86%). Records that did not contain documentation of this included: Individual #395, on 8/22/11, and 9/10/11; and Individual #406, on 11/1/11. Problematic issues that resulted in noncompliance included either the mental status not being recorded, noted to be back to baseline without a description included, or marked as refused. To obtain a mental status, the individual's cooperation is not required. The nurse should describe the status of the individual. For example, "Individual yelling, face red, spitting when talking with fists clenched." A description such as this clearly describes the individual's mental status without warranting any type of cooperation.	
C6	Effective immediately, every	After adjustments due to missing documentation, a sample (Sample #C.1) of 14 Restraint	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.	Checklists for individuals in crisis restraint was available for review. The following compliance rates were identified for each of the required elements: ▪ In 14 out of 14 restraint episodes (100%), continuous one-to-one supervision was documented as provided. ▪ In 14 out of 14 episodes (100%), the date and time restraint was begun was documented; ▪ In 14 out of 14 episodes (100%), the location of the restraint was documented; ▪ In 14 out of 14 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 13 out of 14 episodes (93%), the actions taken by staff prior to the use of restraint were described. In most instances, the description was very limited and provided very little detail. Although the reason for restraint use was evident, the description was sparse. ▪ In 14 out of 14 episodes (100%), the specific reasons for the use of the restraint were indicated in the checkboxes. ▪ In 14 out of 14 episodes (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was checked on the form; ▪ In 14 out of 14 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 14 out of 14 episodes (100%), the observations were documented every 15 minutes and at release. o In 14out of 14 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 episodes. In one episode, an individual was offered water after the conclusion of the restraint; and ▪ In 14 out of 14 episodes (100%), the date and time the individual was released from restraint was included. Although the statistics described above seem encouraging, it is important to emphasize here that adequate documentation was not provided for eight restraint episodes; that the descriptions of the events leading up to the restraint varied significantly in the quality of the narration; and that the attempts to avoid restraint were described in a very cursory manner. As a result of these serious shortcomings, the finding of noncompliance has been made with regard to this provision. A finding of substantial compliance will require	

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		substantial improvement in the quality of the documentation. Based on a review of 22 restraint records for 12 individuals for restraints that occurred at the Facility (i.e., Individual #74, Individual #395, Individual #406, Individual #421, Individual #33, Individual #283, Individual #380, Individual #344, Individual #56, Individual #77, Individual #202, and Individual #23): ▪ In 15 (68%), 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 included. Records that did not contain documentation of this included: Individual #395, on 8/25/11, 9/10/11 at 7:05 a.m., and 9/10/11 at 1:15 p.m.; Individual #421, on 9/24/11; Individual #33, on 9/30/11; Individual #380, on 8/21/11; and Individual #344, on 10/5/11. Problematic issues that resulted in noncompliance included either this area being left blank, or the lack of appropriate nursing documentation regarding the specific descriptions of injuries. In a sample of 14 records (Sample #C.1), the restraint debriefing forms had been completed for 11 episodes (79%). The delayed completion of debriefing forms was discussed above with regard to Section C.1. Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last onsite review. This included the following individuals: Individual #30, Individual, #109, Individual #195, Individual #325, Individual #350, and Individual #374. This sample of six individuals who were the subject of a chemical restraint was reviewed. In four episodes (67%) there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. The documentation notes were brief and focused primarily on the individual's behavior with little attention to environmental or other factors.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to the restraint review provided by the Facility, during the six-month period (May through October) prior to the onsite visit, a total of 16 individuals were placed in restraint more than three times in any rolling 30-day period. A sample of three (19%) of	Noncompliance

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		these individuals was selected for review to determine whether the requirements of the Settlement Agreement were met. The three individuals reviewed were Individual #406, Individual #395, and Individual #74. Documents reviewed included the following: Personal Support Plan, Positive Behavior Support Plan, Safety Plan for Crisis Intervention, and addenda to the Personal Support Plan. The results are discussed below with regard to Section C.7.a through C.7.g of the Settlement Agreement. For three of the individuals (100%) reviewed, during the six-month period, the individuals' teams met to discuss issues related to the use of restraint. However, ongoing discussion regarding repeated restraint was not evident in the PSP addenda provided for Individual #406 or Individual #395. Only addenda for Individual #74 included a review and discussion of specific restraint incidents. Recognizing that the 30-day rolling period was not defined by months, but to provide a context for level of restraint used, below is a table indicating the total number of restraints employed for each individual over this six-month period:	

Individual	May	June	July	August	September	October
#406	5	1	3	4	4	5
#395	3	4	5	4	3	2
#74	5	5	6	2	4	6

For one of the individuals (33%) in the sample, the team effectively reviewed the individual's adaptive skills. The following are examples of individuals for whom this was done appropriately:

- Following a discussion regarding the difficulty Individual #406 experiences following family visits, the team agreed to explore improved communication strategies. There was also recognition of the need to "set up preferred activities," although these were not specified.
- The team for Individual #406 met to review work objectives that had not been included in his PSP.

The following are examples where teams failed to do this adequately:

- Although the team for Individual #395 met to discuss her consistent work refusal, a number of issues were noted. Ideas for different work environments and activities were generated. However, implementation of these changes was lacking. Over one month after the initial meeting, there was no update on a possible job in the Infirmary. Further, it was determined that a computer would need to be found and located in her former workshop to create a data entry position. Almost three months later, the computer was placed in the workshop. The individual continued to refuse to attend this workshop for which she clearly

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		had expressed a dislike. ▪ At the end of October, the team for Individual #395 again met to discuss her continued work refusal. It was agreed that she could try working at Austin State Hospital, but only if she agreed to attend her former workshop for five consecutive days. As this had clearly become an environment she avoided, it was unlikely that this plan would be successful. ▪ Individual #395 repeatedly refused to participate in fire drills. While the team agreed that she could call her mother contingent upon participation, there was no discussion regarding specific teaching strategies to gain her participation. Eventually, the team agreed to seek a doctor's note ordering the physical removal of the individual in a true emergency. ▪ Individual #74 had a replacement behavior included in her PBSP in which she was to learn to make healthy choices. Although her desire for food was repeatedly identified as a problem related to her challenging behavior, no revisions were suggested to improve the teaching of healthy choices. For all three of the individuals, the team reviewed the biological, medical, and psychosocial factors affecting the individual. However, for only one of the individuals (33%) was this done adequately (i.e., Individual #406). The following are positive examples of such reviews: ▪ The team for Individual #406 met to discuss the increased risk of dehydration resulting from one of his prescribed medications. The team agreed to develop a tracking sheet and in-service staff to ensure adequate fluid intake. • For this same individual, the team met to discuss challenging behavior exhibited following family visits during which preferred food was provided. The team further recognized that attendance at workshop has been limited due to staffing issues. Staff agreed to make every effort to resolve the staffing issues so that the individual could continue to earn money to purchase preferred meals. • Following two allegations, the team for Individual #395 identified her viewing of the television show, *Law and Order*, as a contributing factor to her verbal reports. • The team for Individual #74 repeatedly discussed her medication regimen and difficulties with food due to her Prader-Will Syndrome and diabetes diagnoses. Concerning the former, there was discussion regarding a change in the time of medication administration in an attempt to improve her behavior during the afternoon and evening shift. The following are examples where teams failed to do this adequately: ▪ Although the team for Individual #395 recognized the influence of the television show, *Law and Order*, on her verbal report of abuse and intent to harm, it was not until the second incident that the team took action to address this matter.	

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		▪ Weekends and afternoons/early evenings were identified as particularly difficult for Individual #74. Although recommendations were made for the psychologist to complete observations during these times, no follow-up occurred, or there was not indication that it had, in fact, occurred. ▪ The team for Individual #74 noted that counseling services had been recommended in her past. There was no indication that this potentially therapeutic service had been explored to help this individual in her present situation. ▪ In the PBSP for Individual #74, dated 9/16/11, the team noted concerns related to a lesion under her tongue and possible seizure activity. Although recommendations included referrals for medical exams (i.e., biopsy of lesion and neurological consult respectively), no staff assignments or expected dates of completion were identified to ensure that these exams were conducted in a timely manner. No references were made to these exams in the PSP addenda through 11/9/11.	
	(b) review possibly contributing environmental conditions;	For all of the individuals reviewed, the individual's team reviewed the possibly contributing environmental conditions. However, for only one individual (33%) was this done thoroughly and appropriately. The following are examples of appropriate review and response: ▪ The team for Individual #406 discussed his aversion to loud environments as a contributing factor to his refusal to participate in fire drills. While the situation was recognized, there was no discussion of teaching strategies designed to improve compliance. Rather, staff were advised to continue to use verbal prompting during drills. ▪ A move was recommended for Individual #74 to ensure that she resided with individuals with whom she would be able to interact. The following are examples where teams failed to do this adequately: ▪ Due to a health matter, the home for Individual #406 was closed suddenly. Although movement from this home was appropriate, the individual was moved to a residence that previously had been closed. During the first review of the Facility, the Monitoring Team visited this residence and reported on its inappropriateness as a home. At the time, it was void of any materials, furnished with only chairs and tables that were not homelike. During this onsite review, the only change that had been made to this residence was the addition of a television. It remained a poorly designed and sparse environment that was did not meet the needs of the individuals served at the Facility. ▪ Although Individual #74 did change homes, it was unclear whether this move followed a careful transition plan. A move was recommended on 9/16/11. Three days later, it was noted that the move would occur on 9/23/11, but on	Noncompliance

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		10/5/11, the move was noted to have occurred on 9/15/11.	
	(c) review or perform structural assessments of the behavior provoking restraints;	A review of the master list of Functional Behavior Assessments (FBAs), updated 10/1/11, revealed that for the three individuals reviewed, assessments were dated or absent. As noted on the master list, an FBA had been completed for Individual #395 and Individual #74 in 2007. It is likely that many variables had changed over the past four years. No FBA appeared to have been completed for Individual #406, because his name did not appear on the list. Comments specific to each individual are provided below: ▪ The PBSP for Individual #395 indicated that an assessment had been completed in May 2011. However, this consisted only of indirect measures (e.g., rating scales) completed by staff. Direct observation is an essential element of the assessment process. Additionally, staff should consider interviewing the individual and her guardian in an attempt to gain greater insight into the dramatic change in this individual's presentation. ▪ The PSP addenda for Individual #74 included recommendations for an updated FBA and preference assessment to be completed in the near future. This recommendation was repeated from 5/11/11 through 7/13/11. By 8/1/11, the team made no further reference to these assessments, and there was no indication that these had been completed. ▪ While the master list indicated that an assessment had not been completed for Individual #406, his psychologist informed the Monitoring Team that an assessment recently had been completed. The Facility should develop and implement a standard policy of conducting or updating an assessment of behavioral function whenever a person experiences a significant and/or prolonged worsening of targeted challenging behavior.	Noncompliance
	(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 be taught to the individual to replace the behavior that	The Safety Plan for Crisis Intervention was reviewed for each of the three individuals. Additionally, six other plans were reviewed. The following summarizes the results of this review: ▪ In all nine plans (100%), the type of approved restraint was identified, the maximum duration of the restraint was 30 minutes, situations in which restraint could be applied were described, and criteria for termination of restraint were identified. However, as described in greater detail below, the quality of the plans was not adequate. ▪ None (0%) of the plans were signed. ▪ In seven of the nine plans (78%), the date of implementation was noted.	Noncompliance

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	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;	Steps should be taken to ensure that Safety Plans are developed, approved, and implemented in a timely manner. Further, documentation provided to staff should be dated and signed by the author. Although the plans reviewed included the basic elements outlined in the Settlement Agreement, significant concerns remained regarding the individual plans. These are reviewed below. ▪ The plan for Individual #175 had been revised in June of 2011. The monitor of the plan was identified as a psychologist who was no longer employed at the Facility. In this same plan, the duration of restraint was not clear. The Facility's policy of limiting restraint to no longer than 30 minutes was noted, but then guidelines were provided if the individual remained in restraint for 55 minutes. Staff should check plans to ensure clear instructions to staff that comply with Facility policies. ▪ Several plans included steps to take to avoid restraint when the individual first began displaying challenging behavior. For Individual #445, Individual #284, Individual #395, and Individual #382, staff were advised to offer a preferred activity if the individual stopped displaying the targeted behavior when intervention was first applied. Caution is advised, because this might result in a strengthening of this chain of behaviors that begins with the challenging behavior. ▪ Individual #406 was to be released from a restraint after three consecutive minutes without struggling (e.g., no yelling, cursing, or attempts to hurt others). This release criterion was the same for Individual #74. Other plans had similar guidelines regarding release of the individual from restraint. Individual #445 was to have her mittens removed after two consecutive minutes without biting and Individual #175 was to remain in mittens until she had been calm (e.g., no yelling, cursing, name calling) for 15 minutes. Staff should review these criterion to ensure that the individual is released when "no longer a danger to self or others." ▪ Individual #74 and Individual #360 had plans that included dated information, because they did not reside in Residence 501 at the time the plan was implemented. Staff should review carefully all documents to ensure that information is accurate and current. In sum, Safety Plans should be developed with the intent of minimizing an individual's time in restraint. In combination with the individual's PBSP, steps should be taken to address setting events and antecedent conditions that lead to problem behaviors, and consequences should be developed that do not result in a strengthening of the individual's challenging behaviors. Functionally equivalent replacement behaviors must	

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		be identified and developed using effective teaching methodology. Lastly, the safety plans must clearly describe the unsafe conditions that necessitate restraint, specifically identify the approved duration of restraint, and ensure that individuals are released from restraint when no longer a danger to self or others. If criteria for release specify consecutive minutes of calm behavior, this calm behavior must be operationally defined for the individual, and ongoing assessment must occur to ensure that this does not result in a restraint lasting longer than necessary.	
	(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	At the time of the visit, the Facility had begun to monitor the implementation of treatment plans (as discussed in further detail with regard to Section K.12). However, for each of the three individuals reviewed, there was evidence that plans were not being followed as designed. For example: ▪ During a team meeting, the staff for Individual #406 reported that his communication systems were not being used consistently. ▪ Individual #395 was not receiving the habilitation services (including counseling) that she was scheduled to access, because she refused to leave her home. ▪ Staff were advised to arrange the environment so that Individual #74 was not exposed to others eating when she could not engage in this same activity. However, there were repeated examples of poor adherence to this guideline. In fact, during the onsite review, the individual was observed on a cart ride accompanied by several housemates, one of whom was consuming a snack. Strategies to ensure high levels of treatment integrity will require ongoing support and training of the direct support professionals as they carry out their job responsibilities.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	No evidence was provided of revisions to the strategies outlined in the PBSP for the three individuals reviewed. Based on the review, changes should have been considered. For example: ▪ The PBSP for Individual #395 included a statement that she "does recognize and respond well to verbal praise (when she chooses to do so)." If praise does not consistently function as a reinforcer, alternatives should be identified. ▪ Similarly, the team for Individual #74 acknowledged that the current reinforcement schedule and the identified reinforcers were not effective in promoting behavior change. Ineffective reinforcers or weak reinforcement schedules will not result in positive behavior change. If the individual is not responding positively and his/her challenging behaviors are occurring at a rate that significantly interfere with skill development and greater independence, changes to the PBSP should be considered and implemented when appropriate. Staff also should consider consulting with the Facility's External Peer	Noncompliance

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		Review Committee regarding individuals who repeatedly experience restraint due to resistant challenging behavior.	
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 14 incidents of crisis restraint was reviewed (Sample #C.1), including any debriefing forms provided, any attached PSP addenda, any notations of unit review, and any notations from the Incident Management meeting. This documentation showed that: ▪ In five out of 14 restraint episodes (36%), it could be confirmed that a reliably informed review occurred within three days of the restraint episode. Despite the Facility's stated practice of prompt review at the Unit meeting and the Incident Management meeting, there were repeated examples of the failure to provide a thorough review in a timely manner. For example: o The notation regarding the Unit's review of the 8/29/11 restraint episode for Individual #74 indicated that the review occurred 16 days later than the actual episode. o There was no indication of a Unit review for the restraint episode on 7/19/11 involving Individual #395, or for the episode on 8/21/11 involving Individual #380. o The Unit review of an incident on 10/5/11 for Individual #344 took place on 10/17/11. o The review of the incident for Individual #23 was held seven days later. o The review of the incident for Individual #77 was held 11 days later. ▪ Although the Facility had developed a format for Personal Support Plan addenda to address application of more than three restraints in 30 days, a review of documentation revealed this was not consistently implemented. Further, staff response to frequent restraint was often limited. Required assessments were not identified or completed, changes to the individual's habilitation and/or behavior support plan were not implemented, and in-service training often was identified as the strategy of choice to ensure improved implementation of positive behavior supports. Although in-service training could be beneficial, it should not have been the only response. Since the last visit, the Restraint Reduction Committee had met only once. While the minutes indicated a review of restraint incidents and discussion of problems related to restraints, no clear plan of action was provided. Problems noted included difficulty arranging a meeting of the Restraint Review Team, incomplete restraint documentation, and delayed submission of these documents. Staff should develop a plan of action, including identification of responsible staff and expected dates of completion, to address these matters. All teams that review restraint should implement a similar protocol. As restraint is a critical issue to be addressed by the Facility, regularly scheduled meetings of	Noncompliance

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		the Restraint Reduction Committee should occur. The Director of Behavioral Services informed the Monitoring Team that commencing the week of the onsite review, review of restraints for individuals at high risk for challenging behaviors would occur within one business day of the event. This policy is admirable, however, with only three individuals identified as high risk for challenging behavior, it will likely result in little response to many individuals most in need of services. Of the 17 individuals who had experienced more than three restraints in a rolling 30-day timeframe between May and October, only two were identified as high risk. The State and the Facility should re-examine the criteria used to assess risk level with regard to challenging behavior.	

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 Assurance 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. Staff should clearly describe the events that lead to restraint application. (Section C.1)
4. Staff should address the following components of Behavior Support Plans: a) results of a comprehensive functional behavior assessment, including direct observation of problem behaviors; b) formal preference assessment; c) operationally defined replacement behaviors, with adequate teaching guidelines and opportunities for learning; d) preventative strategies; e) dense schedules of reinforcement; f) individual-specific consequences relevant to the hypothesized function of the problem behavior(s). (Section C.1)
5. Staff should revise Dental Desensitization Plans to include the following: a) increased opportunities for training; b) collection of objective baseline measures; c) personal task analyses that clearly describe the individual's behavior; and d) application of individual specific reinforcers as determined by formal preference assessment. Staff also should consider changes to teaching objectives as outlined with regard to Section S.1 of the Settlement Agreement. (Section C.4)
6. The Director of Quality Assurance should work with the appropriate clinical staff to develop a process for tracking the use of medical restraint. (Sections C.4 and C.5)
7. 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)
8. 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)
9. The Facility should ensure that nursing staff assess and appropriately document any restraint-related injury. (Section C.6)
10. Staff should consistently review teaching of adaptive skills to individuals who experience frequent restraint, and implement necessary changes in a timely manner. (Section C.7.a)
11. Staff should consistently review the biological, medical, and psychosocial factors related to individuals who experience frequent restraint, and

implement necessary changes in a timely manner. (Section C.7.a)

12. Staff should consistently review environmental conditions for individuals who experience frequent restraint, and implement necessary changes in a timely manner. (Section C.7.b)
13. As recommended with regard to Section K.5, improvements should be made to functional behavior assessments, including increased direct observation. These assessments should be current and/or revised when changes occur in the individual's presentation. (Section C.7.c and Section C.7.d)
14. Staff should ensure that necessary Safety Plans for Crisis Intervention are developed, approved, and implemented in a timely manner. (Section C.7.e)
15. Ongoing improvement to competency-based training should occur to ensure high rates of treatment integrity. (Section C.7.f)
16. As appropriate, staff should make changes to the Positive Behavior Support Plan and/or Personal Support Plan, when events leading to restraint are identified. (Section C.7.g)
17. Consultation from the Facility's External Peer Review Committee should be considered for those individuals who experience repeated restraint. (Section C.7.g)
18. Staff should review the section of this report that addresses Section K.9 of the Settlement Agreement in which recommendations are made regarding revisions to Positive Behavior Support Plans. (Section C.7.g)
19. Staff should ensure timely follow-up to all recommendations made by the Personal Support Team. (Section C.7)
20. When problems are identified with regard to systemic issues related to restraint or the management of restraint, action plans should be developed to address these problems in a timely manner. Plans should include identification of responsible staff and expected dates of completion. (Section C.4 and Section C.8)
21. The State and the Facility should re-examine the criteria used to assess risk level with regard to challenging behavior. Such criteria should include better definition of how the use of restraint impacts an individual's risk level. (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;" DADS Policy #021.1: "Protection from Harm – Abuse, Neglect and Explanation;" and DADS Policy #002.3: "Incident Management;" o AUSSLC draft policy for handling allegations from individuals with a history of making false allegations; o Presentation Book for Section D; o Incident Management Review Team meeting minutes for each Monday since the last onsite review; o Quality Improvement Committee meeting minutes, from 4/6/11 to 10/19/11 (some minutes were missing); o Rights Poster, Rights Booklet (2007), 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, and Exploitation Protocol; o Abuse/Neglect/Exploitation Quiz; 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 (17) requiring one-to-one supervision at the time of the monitoring visit; o List of individuals (22) with a Safety Plan; 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 13 randomly selected employees (documentation was requested for 25 employees); o Data Summaries and Trends Report, Quarter 3; o List of employees delinquent in abuse and neglect training (43), and unusual incident training (34); o Human Rights Committee Meeting minutes, from 5/26/11 to 10/6/11; o Self Advocacy Group minutes, from 5/25/11 to 9/28/11; o Investigation Reports, including the following 25 reports for DFPS: 39426330, 39510940, 39657747, 39668834, 39728567, 39823187, 39827961, 39853467, 39964427,

	40036928, 40211163, 40220398, 40223493, 40228172, 40230190, 40230294, 40247856, 40251079, 40255907, 40262888, 40264770, 40268062, 40268242, 40279107, and 40285006; and the following 15 Facility reports: 110510, 110516, 110517, 110518, 110614, 110616, 110718, 110719, 110727, 110807, 110808, 110817, 120907, 120923, and 120928. These 40 investigation reports involved a total of 38 individuals and constituted a sample of 20%; and o Investigation Reports regarding Individual #180 (40467557) and Individual #109 (40255487) were reviewed as a result of observations during the site visit, but are not included in the above sample. ▪ **Interviews with**: o Vira Benson, Facility Director; o Tammy Snyder, Director of Quality Assurance; o Raynard Burnett, Incident Management Coordinator; o Adrian Watson, Lead Facility Investigator; o Jo Ann Villasana, Human Rights Officer; o Jose Levy, Director of Behavioral Services; and o Derrick Bunton, Director of Residential Services. ▪ **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 11/14/11 and 11/16/11; o Quality Assurance/Quality Improvement Council Meeting, on 11/16/11; o Human Rights Committee Meeting, on 11/17/11; o Personal Support Plan meeting for Individual #366; and o Restraint Reduction Committee Meeting, on 11/14/11.
	Facility Self-Assessment: Based on its review of documentation, interviews, and observations during the site visit, the Monitoring Team concurred with the Facility's self-assessment of areas in which it was still in noncompliance with the Settlement Agreement. According to its Plan of Improvement, dated 11/2/11, the Facility stated that it was in noncompliance with the following subsections: D.2, D.2.a, D.2.e, D.2.i, D.3, D.3.e, D.3.f, D.3.g, D.3.h, D.3.i, and D.4. 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 Monitoring Team found serious deficiencies in each of these areas. There was agreement for some of the areas in which both the Facility and the Monitoring Team found substantial compliance. However, the Facility found itself to be in compliance with three subsections for which the Monitoring Team found noncompliance. These included Sections D.1 (no tolerance for abuse and neglect), D.2.c (competency-based training), and D.2.d (employee acknowledgements).

	However, the Facility continued to be unable to produce reliable and consistent data with which to measure its performance in such critical areas as health and safety, and protection from harm. The Facility's POI included virtually no reference to any data to support its findings with regard to compliance or no compliance. The only data that was included was a reference to the percentage of staff that had completed training on abuse, neglect, and exploitation. Some narrative information was provided with regard to steps the Facility was taking to achieve compliance. Although this information was helpful, as stated in earlier monitoring reports, 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. In its POI, the Facility had included a number of action plans. These related to the development of policies and procedures, development and implementation of staff training, development of a system to track disciplinary action, and developing a tracking system for unusual incidents, injuries, and investigations. At the time of the review, the Facility was still in the process of completing most of the action steps within these plans.
	Summary of Monitor's Assessment: The Facility indicated that the findings of Immediate Jeopardy that the State survey and certification issued in the months just prior to the site visit had detracted from its efforts to achieve substantial compliance with Section D. It is critical that the Facility as a whole demonstrate a greater sense of urgency about compliance with the Settlement Agreement, particularly with regard to protection from harm. Throughout the site visit, repeated examples were seen of the failure to develop and implement strategies to correct environmental and other deficiencies that contributed to increased levels of risk for the individuals living at AUSSLC. Despite routinely scheduled meetings to review serious incidents, including allegations of abuse and neglect, there was a disturbing lack of activity in addressing well-documented problems or areas of vulnerability. The lack of aggressiveness in responding to the support needs of individuals with potentially problematic behavioral issues, and the lack of reliability in implementing Corrective Action Plans was deeply troubling. This very failure to address recurrent problems was reflected in the investigation reports reviewed for this report. These investigations confirmed physical abuse, neglect, ineffective supervision, and the lack of adherence to interventions and initiatives prescribed in the Personal Support Plans. As a result, the vulnerable individuals entrusted to AUSSLC were not only not protected from harm, but they were subjected to increased risk. With the appointment of an experienced Incident Management Coordinator, the Facility expected to develop more sophisticated analysis of serious reportable incidents, to establish tracking and trending processes, and to improve its coordination with other key areas of management performance.

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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 Policies #021, #021.1, and #002.3, as referenced above in the documents reviewed section. AUSSLC relied on the DADS policies, and had not issued any of its own. 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 information regarding abuse and neglect reporting, including the numbers that employees were to call to report any allegations. 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 investigations reviewed for Sample #D.1 and #D.2 documented that 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. For example, as a result of the Facility investigation (110517) of the failure to ensure one-to-one staffing for Individual #163, an employee was terminated and the Office of the Inspector General found evidence of criminal activity. After the DFPS confirmed physical abuse of Individual #165 in Investigation 39426330, two employees were discharged from AUSSLC. The confirmation of physical abuse in Investigation 40220398 led to the termination of three employees and the resignation of two others involved in the incident. At the same time, as the Facility itself recognized, it was of very 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. In fact, less than half of the incidents reviewed were reported as mandated by State policy. For example, the incident that led to the termination or resignation of five employees was not reported until more than four hours later. In addition, the Facility had not completed the process of educating individuals, guardians, and family members about abuse and neglect, or the mechanisms for reporting allegations. In order to fully protect individuals, and have an environment of zero tolerance for abuse and neglect, it is essential that individuals, families, and guardians be trained on how to identify potential abuse and neglect, and how to report it. Without this important component, the Facility cannot be assured that all potential allegations are being reported. Despite the presence of policy and a stated commitment to zero tolerance of abuse and neglect, the lack of timely reporting, as well as the lack of education of individuals and	Noncompliance

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		their families about the identification and reporting options for abuse and neglect has led to a finding of noncompliance with this provision of the Settlement Agreement.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(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 #021.1, which required staff to report immediately (within one hour) any allegation of abuse, neglect, exploitation, and/or any other serious incident. Based on investigation records and interviews with employees, it appeared that they were aware of this mandate, but many simply ignored it. As noted above, there were serious deficiencies in timely reporting. Despite the confirmation of delayed reporting evident in the investigation reports reviewed for this report, the Facility had imposed no consistent consequences for the failure to report in a timely manner. Based on interviews with 12 direct support professionals, 12 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on interviews with 12 direct support professionals, 12 (100%) were able to describe the reporting procedures for other serious incidents. None of these staff expressed any fear of retaliation for reporting an allegation of abuse, neglect, or exploitation. In its Data Summaries and Trends Report for Quarter 3, the Facility reported a total of 25 unusual incidents, excluding abuse, neglect or exploitation. According to this report, there were: ▪ Two deaths; ▪ One incident of pica; ▪ Ten serious injuries, including eight lacerations, one fractured patella, and one ankle fracture; ▪ Seven incidents of unauthorized departures; and ▪ Five other incidents, including an incident of peer aggression that resulted in a serious head injury.	Noncompliance

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		The summation of information related to abuse, neglect, and exploitation was not as clearly delineated. According to this report, a total of 104 allegations were reported in Quarter 3, of which DFPS investigated 26. No breakdown of Facility investigations was provided in this report. The allegations were not categorized by type. As a result, the Monitoring Team is unable to report any meaningful summary data regarding investigations. During the site visit interview, the recently appointed Incident Management Coordinator indicated that the presentation and analysis of reliable incident data was a priority. If the Facility is to have a firm grasp on the nature of abuse, neglect, and exploitation at AUSSLC, it is imperative that reliable fact-finding and analysis take place without further delay. Two samples of investigations were selected for review. These included investigations that had been completed since the Monitoring Team's previous review: ▪ Sample #D.1, which included a sample of DFPS investigations of abuse, neglect, and/or exploitation. This sample included the following investigation numbers: 39426330, 39510940, 39657747, 39668834, 39728567, 39823187, 39827961, 39853467, 39964427, 40036928, 40211163, 40220398, 40223493, 40228172, 40230190, 40230294, 40247856, 40251079, 40255907, 40262888, 40264770, 40268062, 40268242, 40279107, and 40285006. ▪ Sample #D.2, which included a sample of Facility investigations. Some of these were investigations that DFPS had referred to the Facility, while others were investigations the Facility completed related to serious incidents. This sample included the following investigations: 110510, 110516, 110517, 110518, 110614, 110616, 110718, 110719, 110727, 110807, 110808, 110817, 120907, 120923, and 120928. These two samples involved 38 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. Based on a review of the 40 investigation reports included in both Sample #D.1 and Sample #D.2: ▪ Eighteen (45%) 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: 39426330, 39853467, 110718, and 110727.	

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		▪ Forty (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. Due to significant concerns related to the timely reporting of incidents and allegations, the Facility was not in compliance with this provision of 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 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.	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 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 and/or offered counseling to the victim. Despite the evidence of consistent and prompt reassignment, there had not been a reliable tracking log of reassignments implemented at AUSSLC during the last site visit. The Incident Management Coordinator had developed a system that went into effect on 11/1/11. The tracking log was to document information about employees reassigned due to allegations of abuse and neglect, including the employee's name, investigation number, date of return to contact work, or date of termination. This full implementation of this database will be reviewed during the next site visit in the spring of 2012.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating 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. The quality of the instructional materials appeared to be adequate, and there was evidence that the materials were reviewed periodically to maintain their effectiveness. For example, as an added measure, supplemental instruction was added regarding the prohibition on retaliation for reporting abuse, neglect, and other serious incidents. The training was competency-based. The quizzes administered on the residential units were	Noncompliance

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		a good example of a periodic refresher of the material taught at new employee orientation and the required annual classes. AUSSLC used quizzes to test the knowledge of staff working in the living units. Program Monitors for the Quality Assurance Department tracked the results of the quizzes. This was consistent with the requirements of the Settlement Agreement that this training includes a competency-based component. The Trend Analysis reports indicated overall compliance rates of 96.6% for 6/11, and 93.1% for 7/11. Quizzes were suspended during 8/11, and resumed the following month. The most recent data was not provided. The Director of Quality Assurance indicated that she intended to continue the quizzes, and to introduce additional probes to test additional areas of staff knowledge and competency. Review of the 13 randomly selected staff records provided during the site visit 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 43 employees were delinquent in abuse and neglect training, and that 34 employees had not completed the requisite training in the reporting of unusual incidents. A member of the Facility's leadership team was included in the cohort of delinquent staff for both substantive areas. As a result of the numbers of staff who had not completed annual refresher training, as well as the outcomes discussed above regarding staff not reporting allegations and incidents in a timely manner, the Facility was found to be noncompliant with this provision.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's	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 employees was selected randomly to determine if annual statements had been signed. As noted in the documents reviewed section, the Monitoring Team requested documentation for a sample of 25 staff members. However, the Facility only provided documentation for 13 staff. Based on a review of 13 of these forms, the requirement of the Settlement Agreement appeared to have been met. However, without the additional documentation, the Monitoring Team could only conclude that the documentation did not exist. As a result, the Facility's compliance with this requirement was 13 out of 25 (52%). The Facility was asked for a list of staff identified as having failed to report abuse and/or	Noncompliance

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	failure to report abuse or neglect.	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." For example, based on the review of investigations for this report, and past reports, disciplinary action was taken, as appropriate, for staff's failure to report. 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 that 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 supposed to be 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. PSPs were reviewed for five individuals: Individual # 406, Individual #325, Individual #374, Individual # 30, and Individual # 195. None (0%) of these documents contained any reference to education about rights, or about the mechanisms for identifying and reporting unusual incidents. Information included in the "Rights" section of the PSP related primarily to the restriction of rights through behavioral interventions, money management, weight control, etc. The materials used for this purpose were evaluated during a previous monitoring visit, and they were found to be satisfactory. As is discussed with regard to Section F.1.c, the Facility had begun to include a discussion of any incidents or allegations in the annual planning meeting. This was a very positive step. However, as evidenced during the annual Personal Support Plan meeting for Individual #366, it was not clear whether all team members knew this information in sufficient detail, or whether it was factored into the assessment and planning processes that occurred in preparation for the annual meeting. This aspect of the annual meeting requires additional attention, if it is to be effective. Furthermore, the guardian for Individual #366 stated that he had not yet been provided with any current information about the reporting process for unusual incidents, although he was generally familiar with it from previous years. The Facility reported that it had not taken any action steps or initiatives in the last two months to strengthen its performance of this provision.	Noncompliance

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		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 by policy. The Unusual Incident Report form documented whether such notification took place. Appropriate notification was made, or at least attempted, in the investigations reviewed. The Facility provided FY 2011 and FY 2012 lists of serious incidents or allegations that were reported by either the Individual or by someone (not staff) significantly involved in the individual's life. There were three individuals included for both years: Individual #19, Individual #77 and Individual #175. Each of these individuals was included on the "streamlined investigation" list. An investigation involving an allegation of sexual abuse that Individual #19 reported was included in Sample #D1. Despite this individual's history of unfounded allegations, the DFPS investigation was conducted promptly, and all requisite notifications were made.	
	(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. In compliance with the wording in the Settlement Agreement, posters were evident in each of the residences, and several were displayed in the workshop and day program areas. There were four posters that were not displayed in an easily accessible manner. In Residence #501, the poster was locked behind glass in a hallway cabinet and was not easily noticed. This issue has been noted in previous reports. In the Infirmary, a poster was present, but it was in the hallway leading to staff offices. In Residence #787, the poster was on the floor of the staff office. In Residence #786, the poster was placed too high up on the wall to be useful/accessible to the individuals living there. The Facility should ensure that these variances are corrected so that the intent of this provision (i.e., the use of the poster as a teaching tool) is more likely to be fully met in every programmatic and residential area. 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 Human Rights Officer at AUSSLC continued to be an energetic proponent for self-advocacy. The Right of the Month materials were informative and especially helpful. Some of the staff in the residences described them as more useful than the posters. The Self-Advocacy Group meetings continued to be held monthly, and outreach to the individuals residing in Castner Estates had resulted in the attendance of 15 to 33 individuals at each meeting. Since the Monitoring Team's last visit, the Self-Advocacy Group had elected officers, and during August 2011, members attended the statewide	Substantial Compliance

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		Self-Advocates Conference. The position of the Assistant Independent Ombudsman had been filled. The Assistant Ombudsman participated in the Human Rights Committee meeting. There appeared to be close collaboration between the Assistant Ombudsman and the Human Rights Officer. Although the Human Rights Committee continued to meet, its role appeared to be focused primarily on the review of restrictive control procedures, rather than on the broader scope of human/civil rights at the Facility. For example, the Committee did not review data regarding serious incidents, nor was it utilized to review environmental conditions or the implementation of active treatment. The Facility had posted rights posters that were easily understood in all of the living units and day program sites, and the great majority of these were posted in areas to which the individuals served had easy access. As a result, the Facility was found to be in substantial compliance with this provision.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	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 was to notify 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. Additional information is provided below with regard to Section D.3.c about the numbers of referral that were made 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.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats	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.	Substantial Compliance

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	or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The Facility did not know of any staff person who had experienced retaliation for reporting an allegation of abuse or neglect. Informal interviews with 12 direct support professionals did not reveal a fear of retaliation. However, in the review of Investigation 40036928, it was documented that the alleged perpetrator sought to learn who had reported him for physical abuse. This employee was terminated after the abuse allegation was confirmed. The Facility reported that no staff members have been disciplined for participating in retaliatory action. Individual #342 was asked if she feared retaliation, if she reported abuse, neglect, or any harm. She was not afraid to report.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to the Director of Quality Assurance, the Facility had concentrated its efforts on the identification of data, but had not yet focused on corrective action plans. Therefore, information about injuries was collected, but remedial actions were not tracked across the Facility, and no process was in place for completing semi-annual audits of the data. The Facility reported that there had been no action steps or initiatives taken to move towards compliance during the last six months. As stated in previous reports, there was valuable information available to the Facility on the occurrence of injuries. The Quarterly Trend Analysis reports were thoughtfully prepared and were informative. However, although action might be taken on individual cases, no evidence was found of a systemic approach to the development and implementation of corrective action plans or proactive strategies. No evidence was provided during the monitoring visit that a reliable Facility-wide process existed to determine whether significant injuries of individuals were in fact reported. An analysis of the failure to report was not evident. This was an area of the Settlement Agreement that required further work, and the Facility remained out of compliance.	Noncompliance
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		

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	involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DADS Policy #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 #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 #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. None of the DFPS or Facility Investigators were within the direct line of supervision of alleged perpetrators. 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 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. A total of 14 DFPS investigators were involved in the conduct of the investigations reviewed. The training records for these investigators were reviewed with the following results: ▪ Al 14 DFPS investigators (100%) had completed the requirements for investigations training. ▪ All 14 DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. A total of five Facility investigators were involved in the investigations reviewed. The training records for these investigators were reviewed with the following results: ▪ All five Facility investigators (100%) had completed the requirements for investigations training.	Substantial Compliance

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		▪ All five Facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. 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 all but one of the investigations reviewed (24 out of 25, or 96%), Facility staff at all levels cooperated with DFPS investigators. There was one reported instance of the failure to cooperate. However, physical abuse was substantiated against that employee, and he was terminated so additional follow-up was not warranted.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	As discussed in earlier reports, the Memorandum of Understanding (MOU), 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 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 25 investigation records from DFPS (Sample #D.1), 21 had been referred to law enforcement agencies. For all of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the 15 investigation records from the Facility (Sample #D.2), five had been referred to law enforcement agencies, including 110517, 110616, 110718, 110808, and 120907. For all of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. In 110517, the Office of the Inspector General found evidence of criminal activity with the failure to ensure one-to-one coverage. The staff person was terminated in this case.	Substantial Compliance

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	(d) Provide for the safeguarding of evidence.	The investigations reviewed for this monitoring report did not require the safeguarding of physical evidence. As in past interviews, discussion with the 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., 39426330) involving allegations of physical abuse and/or neglect. Its availability was of enormous significance in the ability to discharge employees who violated the rights and protections of individuals living at AUSSLC.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	Based on 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 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: ▪ Fourteen out of 25 (56%) 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 39853467, 40279107, and 40268242. The following is an example of an investigation for which adequate investigatory process did not occur within the first 24 hours or sooner, if	Noncompliance

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		necessary: o In incident 40255907, an allegation of neglect, Individual #448 fell when not supervised adequately. The incident occurred on 8/26/11, was reported on 8/29/11, and was investigated on 9/1/11. Based on the Monitoring Panel's discussion with DFPS in December 2010, DFPS is in the process of developing a format to better document activities that occur within the first 24 hours of the investigation. The Monitoring Team looks forward to reviewing such additional information during upcoming reviews. ▪ Nine out of 25 investigations (36%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. ▪ For the 16 that were not completed within 10 days, 12 (75%) 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. However, two of the 12 were still late (i.e., beyond the extension date). The four investigations without requests for an extension were: #40268242, #40285006, #40268062, and #39728567. The two investigations that were still late, despite the written extension, were: #40220398, and #40211163. ▪ All 25 (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 13 of the investigations reviewed (52%), specific programmatic 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 is an example of an investigation that included appropriate recommendations: o In incident 39728567, after Individual #154 was left unattended on the toilet, in-service training regarding supervisory responsibilities was recommended. The alleged perpetrator was discharged from AUSSLC. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Eight out of 15 (53%) 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 were investigations for which adequate investigatory process did not occur within the first 24 hours or sooner, if necessary: 110616, 110719, 110727, 110807, 110808, and 120907. Time of commencement could not be	

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		determined for 110510. ▪ Seven out of 15 (47%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; ▪ For the eight that were not completed within 10 days, two (25%) 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. ▪ Fourteen out of 15 (93%) resulted in a written report that included a summary of the investigation findings. There was no report found in the file for incident 110510. This incident involved an incident of neglect regarding fire drills. It was referred for administrative action. 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 nine of the investigations reviewed (60%), adequate recommendations for corrective action were included. In three of the investigations, peer review was recommended (20%). There was no documentation about the corrective action that was implemented. The following are examples of investigations that included appropriate recommendations: o After Investigation 110727 was completed, the Interdisciplinary team met to review the supervision level for Individual #277, as the investigation had recommended. For one investigation (#110510) this was unclear. A copy of the incident report was included, but there was no investigation report regarding this allegation of neglect due to the failure to conduct fire drills as required. The following are examples of investigations for which concerns were noted with regard to the adequacy of the recommendations: o In incident 120907, the nurse's performance was referred to peer review. The incident was reported on 9/15/11, and the follow-up action was to be completed by 11/4/11, almost 50 days later. In this incident, Individual #291 complained of a rash. The nurse told him he was not important. The recommendation should have required a quicker response time. o In Incident 110616, neglect was alleged for the failure to change soiled diapers. The matter was referred back to the Unit as a staff performance issue with no further detail. Based on issues related to investigations not being started timely, a lack of approval for investigations that took more than 10 days to complete, and concerns about the adequacy of recommendations, a finding of noncompliance was made.	
	(f) Require that the contents of the report of the investigation of 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	Noncompliance

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	serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	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. 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 utilized the same standardized reporting format. This reporting format was clear, well organized, and permitted sufficient information to be included for follow-up. Unlike earlier investigation reports, a specific section of the report was now designated for a description of the history of allegations, if any, documented for the alleged perpetrator and for the victim. However, the facts involved in the alleged perpetrators history usually were not discussed in detail or analyzed in any meaningful way, only referenced. <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 applicable cases, the name(s) of all (100%) 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	

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		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 <u>all</u> 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> One investigation, #110510, had no report. Of the remaining 14 investigations, the following summarizes the results of the review: ▪ In eight of the 14 investigations reviewed (57%), 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 of the investigations (100%), each serious incident or allegations of wrongdoing; o In nine of 12 (75%) applicable cases, where there were witnesses, the names were provided; o In all (100%), the name(s) of all alleged victims were provided, but for only 13 (93%) alleged perpetrators; o In the 14 investigations, the names of all persons interviewed were provided in nine (64%) cases; o In the 14 investigations, 10 (71%) included, for each person interviewed, an accurate summary of topics discussed; all (100%) included a recording of the witness interview or a summary of questions posed, and 13 out of 14 (93%) included a summary of material statements made; o In all (100%), all documents reviewed during the investigation; o It could not be determined whether <u>all</u> 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 eight out of 14 (57%) investigations, the investigator's findings; and o In eight out of 14 (57%) investigations, the investigator's reasons for his/her conclusions.	
	(g) Require that the written report, together with any other relevant documentation, shall	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,	Substantial Compliance

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	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.	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 23 out of 25 investigation files reviewed (92%), there was evidence that the supervisor had conducted a review of the investigation report. The two that did not include this review were: 40279107 and 39510940. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 15 out of 15 investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ For those reports that had received a supervisory review, no revisions were noted as necessary.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility's compliance with the completion of investigations for serious incidents is discussed in detail with regard to Section D.3.f.	Noncompliance
	(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. 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.	Noncompliance

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		Although the Facility had begun to develop a tracking log for recommendations, there was no evidence of a thorough analysis as to whether the recommendations were implemented as expected. The Incident Management Coordinator was very aware of this problem, and was working diligently to implement remedial actions. In general, concern was expressed that recommendations were often delayed, postponed, or the subject of requests for an extension. 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.	
	(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 incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	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. However, trending had not been well developed. The Facility had concentrated on collecting data, and had not focused on developing and implementing corrective action plans. The Quality Assurance Director acknowledged that there was considerable work needed to move towards compliance with this provision. The recent appointment of the Incident	Noncompliance

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		Management Coordinator was viewed as an excellent opportunity to establish a strengthened approach to gathering and analyzing this information. The new Incident Management Coordinator demonstrated competency and experience in system analysis, so that the data from the review of incidents and from the investigation findings potentially can now 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. 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 each instance, her decisions were based on the facts, and were mindful of her responsibility to safeguard the individuals and staff of the Facility.	Substantial Compliance

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. (Sections D.2.a and D.2.c)

2. When it is identified that staff have failed to report a serious incident or allegation in a timely manner or do not understand their responsibilities with regard to reporting, the Facility should evaluate reasons, and address the underlying issues. (Section D.2.a)
3. The Facility should include the Resource Guide in the PSP development process, so that individuals and those closest to him/her will be provided education to be able to identify and report unusual incidents, including allegations of abuse, neglect, and exploitation. (Section D.2.e)
4. 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)
5. The Facility should develop an action plan to audit injuries twice yearly and report for investigation those that due to frequency or other criteria raise suspicion of possible abuse or neglect. (Section D.2.i)
6. The Director of Quality Assurance should work with the Director of Behavioral Services to ensure the tracking and trending of injuries during restraint. (Section D.2.i)
7. With regard to appropriate follow-up for investigations:
    a. The State and the Facility should focus on improving the identification of issues and appropriate recommendations in investigation reports so that recommendations address all possible aspects of the situation.
    b. The Incident Management Coordinator should review DFPS reports and ensure that all concerns raised are addressed through recommendations in the Incident Management Report that accompanies each investigation.
    c. If concerns are not identified or raised in a DFPS report, the IMC should identify them and raise them.
    d. Expected outcomes for the corrective actions identified should be set forth. (Section D.3.e)
8. In-depth analysis about previous incidents involving both the victim and the alleged perpetrator should be completed to assist in the formulation of conclusions and the development of recommendations. (Section D.3.f)
9. 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)
10. 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)
11. The Facility should continue its efforts to finalize a tracking and trending system. (Section D.4)
12. 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)

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 for Section E; o Plan of Improvement, dated 11/02/11; o Centers for Medicare and Medicaid (CMS) report of survey by the State Survey and Certification Team, completed on 10/31/11; o Data Summaries and Trend Report for Q3 FY11; o Incident Management Review Team meeting minutes for each Monday since the last on-site review; o Quality Assurance/Quality Improvement Council meeting minutes, from 4/6/11 to 10/19/11 (some minutes were missing); o Training module regarding the AUSSLC Abuse, Neglect, and Exploitation Protocol; o AUSSLC Quality Assurance Manual; o Abuse/Neglect/Exploitation Quiz; o Human Rights Committee Meeting Minutes, from 5/26/11 through 10/6/11; 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 Assurance; o Jose Levy, Director of Behavioral Services; o Raynard Burnett, Incident Management Coordinator; o Derrick Bunton, Director of Residential Services; and o Jo Ann Villasana, Human Rights Officer. ▪ **Observations of**: o Quality Assurance/Quality Improvement Council Meeting, on 11/16/11; o Incident Management Meetings, held on 11/14/11 and 11/16/11; o Human Rights Committee Meeting, on 11/17/11; and o Site visits to all living units and day program areas. In general, site visits included observation of the living environment, interactions between employees and the individuals served, interactions between individuals, interactions between employees, implementation of active treatment, observation of any potentially problematic behavior, and informal discussions with employees, as well as some of the individuals.
	Facility Self-Assessment: The Facility's Plan of Improvement/Self-Assessment was dated 11/2/11. For Section E of the Settlement Agreement, the Facility had not determined that it was in substantial compliance with any of 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 actions included the completion of the Quality Assurance Manual, including the revision noting the addition of the Incident Management Coordinator and his staff to the Quality Assurance Department; the hiring of the Incident Management Coordinator; the training of staff regarding the

	timelines for reporting abuse, neglect and exploitation; and the initial implementation of a tracking system for Corrective Action Plans (CAPs). 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. The Facility acknowledged that the findings from two recent surveys conducted by the State Survey and Certification agency for the Centers for Medicare and Medicaid Services had diverted its attention from the planning for and implementation of the responsibilities of the Quality Assurance Department.
	Summary of Monitor's Assessment: The Monitoring Team concurred with the Facility's own findings of non-compliance for all subsections of Section E. There had been a lack of significant progress in the implementation of strategies that contributed to the development of a comprehensive quality assurance system, as well as to compliance with the requirements of the Settlement Agreement. The QA Department had continued or revised certain initiatives implemented previously, including the 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. On 8/31/11, a Facility-wide in-service on revised procedures for abuse and neglect reporting was completed, and on 9/1/11, a revised quiz on these reporting procedures was implemented. As discussed with regard to Section D, the newly appointed Incident Management Coordinator had begun to refine the collection of data regarding allegations of abuse, neglect, and exploitation. The availability and analysis of reliable data will be essential to the formulation of corrective action strategies to reduce risk. As previously reported, the QA 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 still was not evident that this information was being used in a comprehensive and continuous manner for improvement across the Facility. Although a mechanism for the tracking of Corrective Action Plans (CAPs) was initiated on 9/1/11, actual implementation of the tracking system appeared to be inconsistent. Although timely completion of the CAPs was essential for improved performance at the Facility, delays were noted throughout the site visit. A sense of urgency appeared to be lacking throughout the Facility, thus contributing to the lack of progress towards compliance with the provisions of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	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 with ideas about the type of indicators or outcome measures that should be included in such a system. The Facility had included a QA Plan as Chapter 3 of the document entitled "Quality Enhancement Manual." This QA Plan focused on the monitoring activities that the QA Department was to conduct, including the selection of monitoring samples for each of the sections of the Settlement Agreement. Monitoring forms were included for the observation of meals/snacks; planned activities related to active treatment; notification and response to injuries; and the quiz regarding abuse, neglect, and exploitation. However, with the exception of very brief directions regarding the observation of planned activities, instructions were not included in the QA Plan material. The issuance of appropriately detailed instructions is key to ensuring inter-rater reliability. A monitoring matrix, including the frequency of review and the sample size, and a process for the development of Corrective Action Plans were included as part of the QA Plan. However, the QA Plan failed to include sufficient information as to how the analysis of this data would be utilized to identify areas of strength and weakness. Findings from these reviews should be presented at the Quality Assurance/Quality Improvement Council meetings. In addition, the QA Director had indicated previously, 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 QA Director. Information about injuries and serious incidents was discussed at the daily Incident Management meetings, and at the QA/QI Council meetings. Since the last site visit, the collection of data regarding the extent of injury during restraint episodes was initiated. However, no evidence was presented to confirm that this information was analyzed and utilized to improve staff competencies, thus resulting in improved outcomes.	

#	Provision	Assessment of Status	Compliance
		As previously reported, AUSSLC had begun using eight of the newly adopted Settlement Agreement review tools required by the State Office. Work still needed to be done to refine these tools for the Facility's use and their implementation, including enhancing the guidelines or instructions associated with each tool, ensuring inter-rater reliability and accuracy of monitoring, ensuring that quality was measured as opposed to the mere presence or absence of items, as well as identifying the priorities for the tools' implementation so as to not overwhelm the system with data that could not be used effectively. The tools were not weighted, and were not designed to produce overall scores. 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 Program Auditors who work in the QE Department, along with other Facility staff such as the Human Rights Officer, continued to conduct quizzes on the living units to determine the extent of staff knowledge on the reporting of abuse, neglect, exploitation, and other serious incidents. Two quizzes per month, on different shifts, were to be completed with a full review of all living units to be performed by the end of the fiscal year. Although the results of the quizzes were to be discussed at the QA/QI Council meetings, it was not clear if the findings would be used for any actions beyond staff development and training. For example, if overall staff performance on a residential unit was less than expected, it was not clear if this would prompt a review of leadership/supervision on that unit, or if a closer look would be taken to determine whether all unusual incidents were being reported in a timely manner. On April 1, 2011, the QA Director assumed supervisory responsibility for the Incident Management responsibilities, including the investigation of serious incidents and allegations of abuse, neglect, and exploitation. Since the last site visit, an Incident Management Coordinator has been appointed. Based on interactions with him during the onsite review, it appeared that he had competency and experience in system analysis. Currently, he was designing and initiating actions 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. However, it was reported that his efforts were impeded by a lack of timely response from other Departments. For example, the recommendations from investigation reports were assigned to staff from the relevant Departments. To date, a number of the confirmations of follow-up actions had not been forwarded, according to the agreed-upon timeframe, to the Incident Management Coordinator. Extensions frequently were requested, at the last minute. The Incident Management Coordinator was engaged in developing a tracking system in order to remind his colleagues of the need to respond to the investigation findings/recommendations. This problem required immediate attention from the	

#	Provision	Assessment of Status	Compliance
		Facility leadership. As indicated in the Facility's Plan of Improvement, the Facility was not in substantial compliance with the requirements of this subsection. The QA Director reported that the findings of Immediate Jeopardy from two recent surveys by the State Survey and Certification agency for the Centers for Medicare and Medicaid Services had diverted her attention from the ongoing work required to achieve compliance with the Settlement Agreement. Corrective Action Plans were being developed to address the deficiencies cited by the surveyors. Review of these CAPs was scheduled to occur immediately after the site visit by the Monitoring Team.	
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 Incident Management Coordinator was beginning to collect and analyze data regarding allegations of abuse, neglect, and exploitation. The Trend Analysis reports were thoughtfully prepared and were informative. However, although action might be taken on individual cases, no evidence was yet found of a systemic approach to the implementation of corrective action plans or proactive strategies. During an interview with the Monitoring Team, the QA Director discussed the progress of the tracking system for Corrective Action Plans. This included: 1) individual meetings were held with each Department head to ascertain what monitoring was currently underway and what CAPs were in place; 2) QA Program Auditors were trained on identifying and implementing CAPs, as needed; 3) implementation of the tracking system and a monitoring schedule for CAPs was started on 7/15/11, and was scheduled to be completed by 12/1/11. The review of completion of the CAPs at QA/QI meetings was scheduled to begin on 1/15/12. In addition, a private company had been retained to assess the processes for trending and tracking of data. This work was scheduled to begin in 3/12. The QA Director reported that she was unaware as to the person responsible for the tracking of medical restraints, a problem referenced in the last site visit. Furthermore, the Medical Department had been delinquent in completing its Plan of Improvement. Since the Monitoring Team's last visit, the Quality Assurance/Quality Improvement Council has continued to meet regularly, and was designed to be a forum for presentation and discussion of data. Department heads were scheduled to report on the progress being made in their areas of responsibility, and also were expected to identify areas of	Noncompliance

#	Provision	Assessment of Status	Compliance
		concern. Corrective Action Plans were to be discussed at this meeting, beginning in 1/12. However, the Monitoring Team's observation of a meeting during the week of the onsite review showed that a number of staff were unprepared to provide relevant data, or discuss analysis of data in any meaningful way. In order for the Council to fulfill its responsibilities, this dynamic will need to change, and the group will need to use a team approach to identifying areas requiring attention, and developing, implementing, and monitoring plans to institute change. As recommended in earlier reports, 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. These individuals 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.	As discussed above, the tracking system for Corrective Action Plans had been initiated, but full implementation was not expected until 12/11. As of this site visit, corrective action plans had not been implemented. A schedule for monitoring the CAPs was to be finalized by 12/11. 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 discussed above with regard to Section E.3, this will be reviewed further during future monitoring visits, when corrective action plans are available and are being implemented. Furthermore, it will be important to determine whether the problems identified by the Incident Management Coordinator were remedied in a complete and timely manner.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	As with Sections E.3, and 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 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 QA 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. The Settlement Agreement monitoring tools should continue to be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the enhancement of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, and development of scoring sheets, as appropriate. (Section E.1.)
5. It will be essential for the Facility to develop and implement formal procedures for establishing inter-rater reliability for all of the monitoring/audit tools being used. (Section E.1.)
6. The State and Facility should identify the priorities for the monitoring tools' implementation so as to not overwhelm the system with data that could not be used effectively. (Section E.1)
7. 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 QA 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)
8. The Quality Assurance/Quality Improvement Council would benefit from the inclusion of a direct support professional representative as a member. These individuals 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)
9. 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)
10. 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)
11. The Incident Management Coordinator should complete the promising efforts to restructure and strengthen the work of the incident management and investigation functions. Other Departments should be held accountable to the timelines established to complete their assignments related to the investigation of abuse, neglect, and exploitation. The Facility leadership should support the Incident Management Coordinator by refusing to grant extensions of time without a complete analysis of the reasons why an extension would be justified. (Section E.4)
12. 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)

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 (PSP) Process (Integrated Protections, Services, Treatments, and Supports): no changes since last review; o DADS Policy Number 004: Personal Support Plan Process (Integrated Protections, Services, Treatments and Supports), dated 7/30/10; o Blank monitoring form entitled: "State Supported Living Center Personal Support Plan Meeting/Documentation Monitoring Checklist," dated 7/23/10; o Draft "Q Construction: Facilitating for Success: QMRP [Qualified Mental Retardation Professional] Facilitation Skills Performance Tool," dated 5/10/11; o PSP Review and Recommendations, undated; o List of Qualified Developmental Disabilities Professionals (QDDPs) with their assignments, dated 10/16/11; o POI for Section F, dated 11/2/11; o Presentation Book for Section F; o Over the last one year period: a) the total number of PSP annual meetings that occurred more than 365 days after the previous meeting; and 2) the total number of PSPs that were filed more than 30 days after the annual PSP meeting was held, dated 10/25/11; o An alphabetical list of each individual at the Facility, with the most recent Individual Support Plan (ISP) meeting date, the date on which the ISP documented was completed/filed, and the date of the previous ISP meeting, dated 10/25/11; o Plan of correction related to survey and certification visit, entitled: "Plan of Correction – Delinquent and Missing PSPs," undated; o Draft Lead QDDP Job Expectations, dated September 2011; o In response to request for last 10 monitoring tools completed by the QDDP Coordinator and Quality Assurance Department, the following: "We are revising the monitoring tools to match the new format;" o AUSSLC Personal Support Planning module from New Employee Orientation Handbook; o Agendas for Lead QDDPs weekly meetings with QDDPs, various dates; o In response to request for a list of QDDPs who have been deemed competent in PSP facilitation and development, the following: "List available for review first day of compliance review; working with PSP consultant from State Office to determine criteria for compliance;" o Personal Support Plans, related assessments, Personal Focus Assessment (PFA), sign in sheets, any ISP Addendums (ISPAs), skill acquisition programs, last three monthly reviews, and last two quarterly reviews for: Individual #210, and Individual #293; o Personal Support Plans, related assessments, Personal Focus Assessments (PFA), sign in sheets, ISP Addendums, last three monthly reviews, last two quarterly reviews, daily schedule, and special considerations list for: Individual #154, Individual #378, Individual

	#385, Individual #165, Individual #363, Individual #60, Individual #258, and Individual #368. o Personal Support Plans and assessments for Individual #278 and Individual #473; o Personal Support Plans and Personal Focus Assessment (PFA) for Individual #33 (this information was reviewed, but not included in the sample of twelve above due to incomplete documentation); o Personal Support Plan and Personal Support Plan Addenda for Individual #406 (this information was reviewed, but not included in the sample of twelve above due to incomplete documentation); o Sample ISP and related assessments from Presentation Book for Individual #278; and o Examples for five individuals at high risk of monthly reviews completed for the last three months, including for: Individual #65, Individual #81, Individual #72, Individual #182, and Individual #402. ▪ **Interviews with**: o Holly Lindsey, QDDP Coordinator; o Sarah Knowles, Director of Active Treatment; o Keith Robinson, QDDP Educator; o Jim Sibley, State Consultant; o Sally Schultz, State Consultant; and o William Davis, DADS SSLC QDDP and Programs Coordinator. ▪ **Observations of**: o ISP annual review meeting for Individual #62; o ISP annual review meeting for Individual #366; 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: In its Plan of Improvement, the Facility indicated that it was not in compliance with any of the sub-sections of Section F. This was consistent with the Monitoring Team's findings. The POI provided a narrative description of steps that the Facility had 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, or from relevant data sources (e.g., the attendance or assessment tracking database, or statistics related to timely ISP meetings or filing of ISP documents). As is discussed in greater detail, based on the documentation provided, it was unclear what level of monitoring, if any, the Facility was currently completing with regard to Section F. 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.

	The Facility's POI included two action plans related to Section F. One addressed the need to improve the facilitation skills of QDDPs, and the other involved improving the skill acquisition programs developed and implemented for individuals. Both of these were important areas to address. A number of the action steps in each of the plans were noted to be "in process." It is anticipated that with the new leadership in the QDDP Department, additional action plans will be developed to structure the improvements that still need to be made for the Facility to comply with Section F.
	Summary of Monitor's Assessment: Although some progress had been made in this area, which should not be diminished, Section F requires everyone's cooperation and involvement. A number of factors stymied teams' abilities to develop adequate plans, including but not limited to late assessments, inadequate assessments, team members' lack of meaningful participation in team meetings, and the development of plans without adequate information being sought from relevant team members, particularly direct support professionals. If team members continue to work in isolation or with no regard for how their lack of meaningful participation impacts the rest of the team, success will not be achieved. Since the last review, steps had been taken to increase QDDPs' skills with regard to the facilitation of meetings, as well as teams' overall knowledge of the team process and their roles in it. In addition to providing classroom training, the State consultants had begun to provide technical assistance to teams at AUSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to QDDPs facilitation skills. More limited changes were noted with regard to teams' ability to integrate supports, develop comprehensive action plans, and include all team members in the process. As would be expected, significant changes had not yet occurred in the ISP documents themselves. 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' ISPs. Furthermore, the members of the Interdisciplinary team should devise ways to ensure the full participation of guardians and family members. For example, during the team meeting for Individual #366, there was a lengthy discussion of the risk factors. Although this issue was the predominant focus of the annual meeting, there was no introduction to the issue for the guardian, and no attempt throughout the discussion to include the guardian and/or inform him of the significance of the at-risk rating scale. In addition, although it is very positive that information about incidents now was included in the teams' discussions, there was scant attempt to discuss the nature of the incidents and relate the causes to either the risk factors or the environmental conditions present in the residential unit. The objectives and training tasks contained in the ISPs 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 were trying to expand action plans to include more of the protections, supports, and services individuals required. However, ISPs 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. Continuing problems were noted with regard to the timeliness of ISP meetings, as well as the completion of the final documents to allow implementation to occur. The Facility had developed a corrective action plan to address these issues, and was in the process of implementing it. It appeared to be an appropriate plan, and, hopefully, will result in improved outcomes. AUSSLC continued to be at the initial stages of developing and implementing quality assurance mechanisms to ensure compliance with Section F of the Settlement Agreement. Due to other priorities, the QDDP management team had not yet begun to conduct auditing. Although it was reported that the QA Department was conducting monitoring, the Facility did not submit adequate documentation for the Monitoring Team to substantiate this assertion. No information was submitted to show that the Facility was aggregating data, and using it to identify issues, and develop plans to correct them.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	DADS Policy #004 Personal Support Plan Process was issued on 7/30/10. The DADS Personal Support Plan Process policy and associated procedures outlined the basics of ISP planning, including the focus on the individual, the role of the QDDP, and the use of the Personal Focus Assessment. The policy addressed ISP monitoring, staff training, and quality assurance. Where it fell short was in describing how to design Action Plans, Skill Acquisition Plans and Service Objectives so that they reflected the interdisciplinary coordination that is required. As noted in the previous report, 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	

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		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 ISPs was requested, along with related assessments, sign-in sheets, monthly and/or quarterly reviews, ISP addenda, daily schedules, and special consideration lists. This sample included ISPs for 12 individuals, including Individual #154, Individual #378, Individual #385, Individual #165, Individual #363, Individual #60, Individual #258, Individual #368, Individual #293, Individual #278, Individual #473, and Individual #210. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and PSTs had been responsible for the development of the plans. While on site, the Monitoring Team also observed a number of ISP meetings.	
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.	Although some progress had been made in this area, which should not be diminished, Section F requires everyone's cooperation and involvement. A number of factors stymied teams' abilities to develop adequate plans, including but not limited to late assessments, inadequate assessments, team members' lack of meaningful participation in team meetings, and the development of plans without adequate information being sought from relevant team members, particularly direct support professionals. If team members continue to work in isolation or with no regard for how their lack of meaningful participation impacts the rest of the team, success will not be achieved. Within this context, it is important to recognize some of the steps that had been taken to improve the facilitation of ISPs by one person from the team who ensured that members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included: ▪ DADS Policy #004 at II.C.1.b continued to indicate that the QDDP would plan and facilitate the ISP meeting. ▪ A new QDDP Coordinator and QDDP Educator had been hired. In addition, the Facility had hired three Lead QDDPs. Although at the time of the review, many of these staff had only been in their positions and/or were able to commit full time attention to their positions for a short time, this strengthening of the oversight and supports available to QDDPs should have a significant impact on the QDDPs performance of their roles. ▪ At the time of the review, there were 22 QDDPs. Two positions had become vacant due to staff taking on new positions. These were in the process of being filled. A floater QDDP also was being hired for the Castner Unit. Lead QDDPs	Noncompliance

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		maintained small caseloads. This generally allowed one QDDP to be assigned to each residence. The overall goal of maintaining a ratio of approximately 1:16 was being achieved, with a range of 1:5 to 1:22, and an average of 1:15. ▪ A QDDP also continued to be assigned to the PNMT. This was a positive addition to that group. This, of course, should not supplant the role of the QDDP and team assigned to the individual in the PNMT process, but should facilitate their involvement. ▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including team meetings. Reviews of ISPs also suggested that the QDDP was the team leader and responsible for ensuring team participation. ▪ The QDDP Coordinator and QDDP Educator were scheduled in December to take the training to become certified trainers for the Q Construction Facilitating for Success training. Beginning in April 2011, the QDDPs had completed the classroom portion of the training. At the end of the training sessions, the QDDPs took a written test. The competency-based component of the training is discussed in further detail below. ▪ In addition, State Office had hired consultants to provide training and technical assistance to QDDPs and teams on the PSP process. They had provided classroom training to AUSSLC teams, which is discussed in further detail with regard to Section F.2.e, met with the QDDPs as well as discipline-specific staff, and had begun to sit in on team meetings and provide technical assistance. ▪ During the week of the review, the Monitoring Team observed a number of team meetings. Progress had begun to occur with regard to the facilitation of meetings. Based on these limited observations and review of ISPs, some of the areas in which progress had begun included: o At annual PSP meetings, an agenda was clearly set forth, along with ground rules. The QDDP introduced the purpose and format for the meeting and ensured that introductions were made. o Efforts were made to include the individual, and focus the discussion on him/her. There was sensitivity to the length of time that an individual could participate in the meeting. o Paper hung on the walls or white boards were used to track some of the key components of the ISP process, such as action plans that needed to be developed. However, this mechanism also could have been used to track the agenda, and the individuals' preferences to help remind team members of these components throughout the meeting. Moreover, based on the skills of the facilitator and recorder, success with this technique varied. o Reportedly, a staff person also was designated to take typewritten notes during the meeting. This process should help to ensure that important discussion is documented, while still allowing the QDDP to facilitate the	

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		meeting. o More efforts were made than in the past to elicit information from all team members. However, not all team members participated to the extent they should have. In at least one meeting, there was an insufficient attempt to include the guardian in the discussion. Based on review of ISPs as well as observations of meetings held the week of the onsite review, facilitation of team meetings was improving, but for none of the plans reviewed or meetings observed was it resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. Areas in which improvements should be made in order to achieve compliance, included: ▪ The Q Construction: Facilitating for Success training included a competency-based component. At the time of the review, the QDDP Educator and PNMT QDDP had conducted competency checks for approximately seven QDDPs. This process was assisting in identifying areas in which the QDDPs needed to improve their meeting facilitation skills. Six QDDPs had been deemed competent using this tool. An action plan had been developed to address the process for determining QDDPs competence with regard to facilitation of meetings. It set forth some parameters with regard to actions that would be taken to assist QDDPs who did not originally meet the competency requirements, as well as other steps that would need to be taken if competency could not be achieved. Such a process should be memorialized in Facility policy. ▪ Based on review of PSPs as well as during observations of meetings held the week of the on-site review, missed opportunities continued to be noted with regard to: o Although all plans reviewed had preferences listed, the depth of the preferences was often limited to items, food, or activities. QDDPs should continue to challenge teams to define what it is the individual prefers about such items, foods, or activities to allow teams to offer the individual new experiences, and to expand the discussion to include preferences related to work, relationships, past experiences, future opportunities, etc. o As is discussed below, ISPs did not consistently show adequate incorporation of preferences into action plans. o During onsite observations, as well as in ISPs reviewed, although some improvement was noted, adequate integration of supports, and services continued to be lacking. QDDPs should continue to challenge team members to offer their expertise in problem-solving or developing action plans, even when the action plan does not fall squarely within their domain (e.g., psychologists should assist with addressing mealtime issues, such as fast eating pace, as well as toileting issues, refusals to	

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		attend day/vocational programs, and dental refusals; nursing staff, habilitation therapies staff, and dental staff should discuss strategies related to physical and nutritional management supports to ensure adequate coordination; speech/communication staff should provide expertise, including, for example, replacement behaviors for PBSPs, integration of communication devices throughout an individual's daily programing, choice-making, etc.); o Although some minimal improvements were seen, QDDPs should seek data from various team members to assist in decision-making, and justify the teams' conclusions. For example, in ISPs reviewed, data was not cited consistently, such as test/lab results, or data from PBSPs and skill acquisition programs. In addition, historical information or causation was not always investigated fully enough by teams (e.g., causes for falls or fractures, history of issues related to previous failed community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services. o Little discussion occurred or was documented regarding prevention, particularly with regard to health risks/issues. Much of team's focus on these areas appeared to be reactive, once an issue occurred (e.g., constipation, weight, skin integrity, infections, etc.). In other instances, the prevention activities were merely providing prescribed medication, as opposed to assisting individuals to make lifestyle changes (e.g., exercise, fluid intake, good hygiene habits, etc.). o Teams' discussion of action plans was limited. Based on a review of the sample of ISPs, the number of action plans continued to grow. However, none of the 12 (0%) included a sufficient array of action plans to adequately define the supports and services the individuals' required, as required by Section F.2.a.3 of the Settlement Agreement, and the quality of the action plans remained an issue. o Methodologies often were absent. In other words, teams did not discuss how outcomes would be accomplished. o Likewise, teams generally did not discuss measurable, functional objectives during team meetings. As a result, they often were not included in ISPs, and when they were, they often were not individualized. o Teams continued to struggle with articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., individual will participate in one community outing per month), rather than as a change in the individual's life (e.g., individual will cross busy streets safely, or the individual will take an art class to learn jewelry making).	

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		Progress had been made. However, based on observations as well as review of ISPs, 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 as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified in the Personal Focus Assessment as appropriate, as well as professionals dictated by the individual's strengths, needs, and preferences. According to documentation the Facility provided, prior to 9/1/11, when the new PFA process was instituted, teams indicated the required team composition for the ISP meeting by placing an asterisk by the title of the team member on the PFA sign-in sheet. Since then, the State Consultants had been emphasizing the need for the ISPA that documented the third quarterly review to describe teams' decisions regarding ISP team attendance. Some progress had been made with regard to tracking attendance at ISP meetings. Specifically, beginning in approximately October 2011, the Facility had begun using a database that the State Office had provided. This process was at the beginning stages of implementation. A column just recently had been added to sign-in sheets to document whether a team member's attendance was required or not, and this information was going to be entered into the database. This should assist in creating a usable set of data, because without this information, the data did not assist in revealing trends or patterns that required attention. However, the criteria for determining when a team member's attendance at an ISP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. More specifically, the Settlement Agreement requires that: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs." Based on review of individuals' PFAs, it was not clear how teams were making this determination. As the Facility noted, when PFAs were available, if his/her attendance was required at the annual meeting, an asterisk was placed beside a team member's title. However, no justification was provided for these decisions. As the Monitoring Team reviews individuals' ISPs, as well as the related assessments, if needs are identified for which the presence of a team member was warranted, but the requisite team member was not in attendance and no justification is provided, then the conclusion is drawn that a duly constituted team was not present. Teams will need to do a better job of justifying team composition, but might need guidance in order to make appropriate decisions.	Noncompliance

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		In addition, for the aggregate data provided, it was unclear what the total number of the population included in the sample (N) was. Based on the Monitoring Team's review of PSPs, the data provided appeared to be overly optimistic. The total number of meetings also should be identified on the aggregate printout. In an effort to increase participation of team members at meetings, AUSSLC was instituting a new ISP schedule. Specific days of the week were assigned to each of the units, and to the extent possible, meetings would be held at 2:15 p.m. from Monday through Thursday. This was after shift change to allow direct support professionals' participation. It also was anticipated that this schedule would reduce the number of missed medical and dental appointments, because they could be scheduled around this time period. An effort also was being made to ensure that QDDPs had no more than two or three annual ISP meetings per month. PSPAs also would be scheduled directly following unit meetings to encourage participation of team members already at the morning meetings. It was anticipated that this schedule would begin in January 2012. Reportedly, accommodations were being made to ensure the participation of individuals, guardians, and their families. Based on the sample of 12 ISPs the Monitoring Team reviewed, sign-in sheets were provided for 11. For none (0%), it appeared that a duly constituted team was in attendance. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. Examples of concerns related to team composition have been provided in previous reports, and issues were similar during this review. However, of note, based on the sign-in sheets, direct support professionals often were not in attendance (e.g., Individual #154, Individual #210, Individual #293, and Individual #368). Based on the Monitoring Team's observations during the week of the onsite review, even when they were present, they often did not fully participate, and were only occasionally asked questions, as opposed to being involved as integral members of the team. Their primary assigned role appeared to be taking care of the individual rather than being a fully recognized member of the team. As the Settlement Agreement requires, their attendance and participation is essential for a number of reasons, including but not limited to their direct knowledge of the individual, and their role in implementing many of the supports discussed at the meetings. Although some progress had been made in developing a database to track attendance as well as to develop a reasonable schedule for ISP meetings, the Facility remained out of compliance with this provision.	
F1c	Conduct comprehensive	Limited progress had made and/or sustained with regard to the conduct of assessments.	Noncompliance

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	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.	This continued to be an area that required the attention and contributions of all disciplines across campus. Positive developments included: ▪ DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her 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. ▪ In an effort to ensure assessments were available in a timely manner, using the database mentioned above, the QDDP Educator and Clerk recently had begun the process of determining if assessments had been submitted prior to ISP meetings. By talking to the QDDP or reviewing the PFA, they determined what assessments were necessary. If the assessments had not been turned in 12 days prior to the ISP, they sent a reminder email. If the assessment was not subsequently submitted, they continued to send reminders with additional supervisory staff being copied, up to and including the Facility Director. Even though this process had just begun the week before the Monitoring Team's review, it was hoped that this would be helpful to QDDPs, as well as supervisors, who now had a better way to track issues with the timeliness of assessments. ▪ Based on information that State Office staff and consultants previously provided, plans were underway to develop and provide specific training for disciplines regarding assessments. This would be an important development, given the centrality of assessments to adequate planning processes. At the Facility, some discipline heads reportedly were taking more of an active role in trying to improve the quality of assessments. For example, the Nursing Operations Officer (NOO) had discussed her plans to conduct a quality check of nursing assessments, and was working with the QDDP Coordinator in this regard. In order for assessments to improve to the extent they need to, all discipline heads will need to play a role. However, at the time of the review, little improvement was noted with regard to the	

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		quality of the assessments or the completeness of the assessments used in developing ISPs. Areas in which improvements should be made in order to achieve compliance, included: ▪ In none of 12 (0%) PSP files reviewed, adequate assessments were present. At times, assessments that appeared to be key to the team's deliberations were missing. For example, psychiatric assessments typically were not provided. Assessments of individuals' functional skills were either missing altogether, or did not include summary information analyzing the results. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. This was particularly true for vocational assessments, which provided little analysis of information that would lead the teams to discuss alternatives beyond the typical activities offered in the Facility's work centers. Assessments did not consistently and concisely list individuals' strengths, needs, and preferences. Examples of concerns related to assessments have been included in previous reports, and were similar for this review. ▪ With regard to timeliness, anecdotally, there were times when assessments were three to four months late. In addition to the tracking system identified above, a decision had been made to have disciplines conduct the assessments that were needed for upcoming ISP meetings, and clear the backlog as time allowed. This appeared to be a reasonable solution to address this issue. ▪ Generally, no justification was provided regarding whether or not a particular assessment was needed. This made it difficult to determine if teams had made appropriate decisions in requesting assessments. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such assessments would be beneficial to the individual. ▪ At the State Office level, the PFA had been reformulated to focus on some broader preferences, providing teams, for example, with more information with which to discuss where the individual wanted to work and/or live. The revised version included more open-ended questions, but overall fewer and more targeted questions. AUSSLC staff had been trained on the new format, and reportedly had begun using it as of 9/1/11. The results of the new process were not yet evident in the plans reviewed. Although very few newly formatted PFAs were included in the sample, some concerns were noted with regard to implementation. Based on interview, a blank copy of the PFA was left in the shift log to allow all staff to contribute. Although the intent of this is a good one, it likely will result in limited information being gathered. Consideration should be given to identifying a direct support professional who knows the individual best	

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		to play a leadership role in collecting information from other staff. Although ultimately the QDDP will likely need to collect additional information or fill in gaps, this would provide a more formalized approach, and would involve direct support professionals meaningfully in the assessment process. ▪ At AUSSLC, some further direction had been provided to staff responsible for assessments, including that each assessment should include a statement regarding whether or not an individual could transition to the community, as well as the supports needed. If not, the assessor needed to identify the reasons. Based on the review of sample plans, this was not occurring consistently, but was seen in some assessments. ▪ As recommended in previous reports, one assessment that would prove useful for some individuals would be an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment was not found in any of the ISPs reviewed. However, based on a review of the new ISP shell, it appeared that this would be a standard discussion topic for teams. ▪ 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 vocational, habilitation 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. Overall, 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 bring the Facility into substantial compliance.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As indicated in previous reports, although the new ISP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ In none of the 12 plans (0%) were all recommendations resulting from assessments addressed in the PSPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. In fact, in each of the plans reviewed, multiple recommendations had not been addressed. These oversights often resulted in teams failing to identify supports that were essential to the wellbeing of the individuals, as well as in meeting their	Noncompliance

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		needs for growth and development. ▪ Often, recommendations were discussed in the narrative section of the report, and the team appeared to agree that the recommendation needed to be implemented, but a corresponding action plan was not developed to implement the recommendation. ▪ Two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, an ISP that outlined the protections, services and supports provided to the individual were: 1) based on observations and review of documentation in ISPs, there was a lack of consistent interdisciplinary discussion and coordination in the development of ISPs. 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 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. The State and the Facility should ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Person-centered planning is not a reason to not have plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences, strengths, etc.	
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. To highlight some of the issues of concern: ▪ Teams were not consistently providing independent assessments of individuals' ability to transition to a more integrated setting. In six of the 12 plans reviewed (50%) of individuals with guardians, teams offered a recommendation independent of the guardian (i.e., Individual #165, Individual #210, Individual #258, Individual #278, Individual #473, and Individual #293). ▪ 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	Noncompliance

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		summary, the Facility was at the very initial stages of complying with this component of the Settlement Agreement.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
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 the Action Plan 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." This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. <u>Identification and Use of Individuals' Preferences and Strengths</u> As noted in the last report, teams were making efforts to identify individuals' preferences. The 12 ISPs reviewed all included some information regarding the individual's preferences. However, the following concerns were noted with regard to the identification and incorporation of preferences and strengths into ISPs: ▪ All 12 of the ISPs reviewed included a listing of individuals' preferences. Some plans included an objective or two that, for example related to a preferred activity of the individual (e.g., Individual #154, Individual #165, Individual #293, Individual #363, Individual #368, Individual #378, and Individual #385). However, none (0%) had effectively incorporated their preferences into related action plans. For example, none of the individuals' teams had used these preferences in creative ways to address individuals' needs (e.g., building in incentives for individuals who refused to attend vocational or day programs) or to expand individuals' horizons. Even when work was a preference, teams did	Noncompliance

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		not capitalize on this by expanding the individuals' vocational opportunities. Individuals with weight issues were noted as liking the outdoors, but teams did not utilize this preference to build in regular outdoor exercise. These are just a few examples of many missed opportunities. ▪ As noted above with regard to Section F.1.a, most of the preferences identified for individuals related to items, food, or activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. ▪ Little, if any, information about individuals' specific strengths was discussed in PSP documents. Strengths were not regularly built upon to address other need areas. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> All plans reviewed, included a list of priority needs. However, in none of the plans (0%) was a justification or explanation of how these priority needs were determined provided, except to say it was based on the team's review of the assessments. For example, no rationale was provided regarding why one of the individual's specific needs (e.g., one daily living skill as opposed to another, or a particular medical need) took precedence. In addition, although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs, careful delineation of barriers to addressing needs was generally not found. More specifically, in none of the 12 PSPs reviewed (0%) were barriers identified and addressed. <u>Identification of Supports Needed to Encourage Community Integration</u> In reviewing objectives related to individuals' involvement in the community, many individuals' ISPs still included community participation objectives that were extremely generic, and offered no individualization or specification to ensure that such participation was meaningful to the individual. In the eleven (92%) of plans where community integration activities were included as action plans, they all were general in nature (e.g., "engage in community activity one time per month"), and none of them incorporated the individuals' preferences or were written in a manner to actually encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. Only one of the 10 PSPs (10%) reviewed included a skill acquisition action plan for implementation specifically in the community (i.e., Individual #210). Even for this individual, the frequency was dependent on his successfully completing another	

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		objective of saving money in order to make a purchase. Other individuals had "community" checked as the place in which the action plan would be implemented. However, often these were overall supports that needed to be provided wherever the individual was (e.g., implementation of BSP). In other cases, no specific requirements were included for the community being the venue for the objective's implementation, because it was listed as one of many (e.g., vending machine goal that could be implemented on campus or in the community). Despite some limited progress in this area, the Facility remained out of compliance with this provision.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	This continued to be an area in which substantial effort was needed in order for AUSSLC to comply with the Settlement Agreement. The action plan section of the ISP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. Facility staff recognized that action plans were not adequate. The Monitoring Team agrees with this assessment. The following summarizes the concerns related to action plans: ▪ As noted in the last monitoring report, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. At AUSSLC, the scope of these goals and objectives continued to expand. Since the last review, teams clearly had made efforts to incorporate action plans into ISPs related to individuals' at-risk indicators. Action plans also continued to include skill acquisition plans, and now often included BSP objectives. ▪ However, none of the 12 plans reviewed (0%) included a full complement of measurable goals or objectives to address the 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. More specifically: o Most of the time, necessary objectives, supports, and services simply were not included in action plans. For example, no objectives were seen in relation to the implementation of psychiatric care plans, and, although some plans included objectives to implement PNMPs, nursing care plans, or PBSPs, they often were incomplete, and/or were not measurable. In order to provide health care supports to individuals served, direct support professionals as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' ISPs.	Noncompliance

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		o Objectives were not seen in any of the plans in relation to staff training requirements. o Although monitoring of supports was sometimes defined (e.g., PNMP implementation), this was not consistent. o Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. Although some money management programs were included, most restrictions had no associated plan identified. o Therapy plans, including walking programs, use of adaptive equipment, as well as integration of alternative or augmentative communication (AAC) devices were essentially nonexistent in the plans reviewed, despite reference to the need for them. o Even when risk plans were included in the body of the ISPs, they were not necessarily fully included in the action plan section. Moreover, they were inadequate, often because the assessments or other plans on which they were based were inadequate. For example, it often appeared that nursing care plans had been cut and pasted into the ISPs. As is discussed with regard to Section M, numerous concerns existed with regard to these plans. Although it was positive that teams were incorporating more of this information into the ISPs, until improvements are made with regard to nursing care plans, the ISP action plans will continue to be inadequate. o Frequently, the body of the ISP indicated that the team had discussed the need for certain supports, but these were not included in the action plan section (e.g., Individual #154's involvement in counseling, music therapy, psychiatric treatment, as well as her desire to identify a job or volunteer position; Individual #165's psychiatric, nursing, and medical treatment plans, or Individual #293's need to learn pedestrian safety skill, or to have a desensitization plan developed for dental work). ▪ ISPs 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. In reviewing the action plans that had been developed to address individuals' risk areas, the objectives included were generally inadequate. Many read: "will have zero incidents of…" No individualization had occurred taking into account baseline measurements. This also did not show an awareness of the precursors that needed to be identified and addressed to prevent bad outcomes from occurring, or the need to improve individuals' functional outcomes. In addition, major pieces that were missing from most of these plans were: 1) ongoing assessments; and 2) proactive measures, beyond medication administration to assist individuals to improve their health (e.g., exercise, fluid intake,	

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		responsibility for healthy eating, etc.) This is discussed in further detail with regard to Section I of the Settlement Agreement. The Facility remained out of compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Numerous examples are provided throughout this report regarding how plans, supports and services were not integrated through the ISPs. ISPs 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. Although it was clear the teams were attempting to include more objectives in action plans that related to these various supports, action plans did not comprehensively address the plans in a way that showed integration was occurring. For example: ▪ The medical, psychiatric, counseling, and nursing care plans frequently still were separate plans that were not integrated in any measurable way into the ISP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Also, a continued lack of integration was seen with OT/PT/SLP programs in the ISP in general, and with other disciplines, such as psychology, medical, and nursing. ▪ Action plans often did not recognize the multiple staff and disciplines that needed to be involved in the training of staff, implementation of the programs/plans, monitoring of the implementation, and updating/maintenance of the plans and/or related equipment. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. For example: o The action step stating: "Individual will not refuse his medications ordered by the physician," or "Individual will follow all positioning instructions in her PNMP" did not detail all of the various roles of staff who needed to work in an integrated fashion to accomplish the ultimate objectives for these individuals of maintaining good health. Often the persons responsible for these broad outcomes were "nursing," or "the PNMP Coordinator and QDDP." Again, this did not recognize the need for such supports to be integrated with the roles of many disciplines, including direct support professionals. o Although PBSP objectives often were included in the ISPs, which was positive, the ISPs merely reiterated the objectives related to target behaviors, and sometimes replacement behaviors. Often the action plans did not even include objectives that the PBSPs would be	Noncompliance

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		implemented as written. No detailed action steps were included related to staff training, monitoring of the plans, sharing of information with the psychiatrist, etc. In addition, evidence generally was not found that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). A number of ISPs identified issues in which psychology should have been involved, but was not, such as refusals to attend day programs or behaviors that were not included in PBSPs, but were having a negative impact on the individual's life (e.g., Individual #165 defecating and urinating in inappropriate places). o Similarly, efforts were being made to incorporate the requirements of the PNMPs into the ISPs. However, as noted above, PNMPs lacked measurable outcomes, and, as a result, these were not included in ISPs. In addition, action plans in ISPs often stated that the PNMP or a portion of it would be implemented. Little detail was provided in relation to all of the various roles of team members necessary to ensure full implementation. ▪ Examples of issues related to the lack of integration were found between nursing, dental, and physical and nutritional supports to incorporate PNMPs with medication administration and dental work, and dental and psychology to develop and implement desensitization plans. All of these are examples of coordination and integration that should be occurring as part of the individual planning process, but were not. Numerous individual-specific examples of these concerns have been provided in previous reports. The Facility remained out of compliance with this provision.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	DADS Policy #004.II.D.4.d included the required elements. As noted previously, the Facility had adopted the DADS policy. Generally, for the action items identified by teams, timeframes and staff responsible were identified. However, the timeframes often were confusing, because the ISPs frequently did not distinguish between timeframes for implementation of action steps, and monitoring or oversight of implementation. This was further confused by the fact that the action plan format for at-risk issues appeared to be different from that for other action plans. This varied somewhat from ISP to ISP. 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. In addition, although this was a rather infrequent occurrence, some timeframes were weak, referencing "as requested," or "when unit off-campus activities are offered," or	Noncompliance

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		"ongoing." Such undefined terms make it difficult to ensure that supports and services are provided based on the individual's needs. Whenever possible, specific timeframes should be delineated, or some form of measuring staff's level of involvement should be included. For example, if it is the individual's choice to send cards or call family when desired, a mechanism for measuring when staff have offered to assist with such tasks might be appropriate. Methods for implementation were not always adequate or present. In other words, the "how" was not provided. In none of the 12 plans reviewed (0%) was the methodology sufficiently described for the action plans included. For example, action steps that read: "will maintain the best possible health as evidenced by zero documented episodes of serious injury," "will lose weight in the next 12 months," or "pica will be reduced to zero episodes" did not provide a methodology for accomplishing the implementation phase. Each of these is an example of an issue that should have resulted in the integration of numerous supports, which should have been detailed in the ISPs, but were not. In addition, as is discussed with regard to Section I, action plans for individuals identified as being at risk did not include adequate methodologies to reduce to the extent possible the at-risk factors. The plans included in individuals' ISPs often repeated that plans already in place would be implemented, or set forth plans that were not sufficiently aggressive to either further evaluate and/or address individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. It was positive to note that during the annual meeting for Individual #366, the team made a concerted effort to identify action plans for the at-risk areas noted for this individual. It will be important to determine whether the actual Personal Support Plan incorporates, and even, strengthens the action steps proposed by the team. In addition, staff responsible often did not include direct support professionals, when they should have been identified. Some improvement was seen in this area, but this was not consistent. Even within the same ISP, clear delineation of the roles of direct support professionals was not consistently provided. Even when they were mentioned, their specific role was not identified. For example, they often were listed along with numerous other staff (e.g., nurse, psychologist, PNMP Coordinator), and it was unclear what each person's role was. The specific roles of direct support professionals in plan implementation should be set forth in the action plans.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for	Although all of the plans included some practical and functional interventions, none of the 12 plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report with regard to plans to address conditions that placed individuals at-risk, psychiatric treatment plans,	Noncompliance

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	services and supports and are practical and functional at the Facility and in community settings; and	nursing care plans, PNMPs, OT/PT treatment plans, and PBSPs. In addition, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility, was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Only two of the 12 plans reviewed included a goal related to cooking. None of the plans reviewed included goals related to housekeeping or yard work, which would be typical activities for independent adults. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at AUSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when appropriate). Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community.	
	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 previous reviews, for the goals and objectives included in ISPs, generally, the ISPs 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 ISPs 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 specifically which team member was responsible for data review.	Noncompliance

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		The overarching concern was that many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., health management plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. None of the 12 ISPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. Although some improvement was seen with regard to data being used to inform some of the at-risk discussions, significant data was missing in the ISPs reviewed. Data that should have been included, but was not, related to test/laboratory results, skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, nursing care plans, weights, numbers of seizures, etc.), and information related to past events, such as causes of fractures or falls, details regarding individuals' successes or failures, etc. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet in place to determine the reliability of the data, but efforts were beginning in this regard. 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 Monitoring Team's previous reports, and based on the current review of ISPs, 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 ISPs 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 comprehensible to the staff responsible for implementing it.	DADS Policy #004.II.D.4.m required the ISP to be accessible and comprehensible to staff who must implement it. As noted previously, the Facility had adopted the State policy. Copies of the ISP were being maintained in the Active Records in the residences to which staff working with the individuals had access. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. The majority of the ISPs reviewed were written with minimal clinical jargon. Another major issue related to comprehensibility of the ISPs 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 ISPs as written and determine what his/her	Noncompliance

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		responsibilities were for the individual during the course of the 24-hour day. This, in large part, was due to the fact that the ISPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall ISP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members. Also, of note, the Special Considerations documents often contained valuable information that was not consistently reflected in the ISP document. These documents generally were written in a style that was easily understood, and highlighted some of the key needs and preferences of the individual. It was concerning that many of the essential requirements for providing appropriate supports and services to the individuals were reflected in this document, but not in the ISP (e.g., staffing ratios/supports, allergies, need to monitor for side effects of medications, specific preferences, best way to approach the individual, etc.). Again, a staff member should not have to look at multiple documents to obtain a full picture of an individual's strengths, preferences, and needs. They all should be available in the ISP document.	
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 QDDP Coordinator candidly shared with the Monitoring Team that the completion of monthly and quarterly reviews of ISPs was an areas that required improvement. She explained that efforts had been made to complete monthly reviews for at-risk action plans, but that overall, the monthly reviews required by this provision of the Settlement Agreement had not been completed. She 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 QDDP Coordinator's assessment. The last three 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 individuals, no monthly reviews were submitted. Even for those individuals for whom they were submitted, they were not adequate. For Individual #154 and Individual #368, two monthly reviews were submitted for each. These reviews did not summarize specific data. Rather, the terms "not met" or "met" were used to describe individuals' progress in meeting objectives. In addition,	Noncompliance

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		particularly for Individual #368, one of the reports identified issues that required follow-up, but the report did not clearly indicate what the QDDP's plan was to address the issues identified. 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, as well as physical and nutritional management supports.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	As reported in previous reports, training on ISPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. As indicated above, since the last review, additional training sessions and resources had been initiated. The following summarizes areas in which progress had been made or sustained: ▪ As noted previously, a new QDDP Educator had been hired. This should be helpful in providing ongoing training and technical assistance to QDDPs. ▪ DADS Policy #004.IV addressed staff training on the ISP process that generally comported with the Settlement Agreement requirements. As noted previously, the Facility had adopted the DADS policy. Although no policy was presented that further delineated how competency would be assessed, the Facility's POI included an action plan that set forth a process for training QDDPs on facilitation skills, assessing their competency using the "Q Construction" format, providing additional technical assistance or training as needed, and taking action if competency could not be achieved. This was a positive development. These procedures should be set forth in Facility policy. ▪ The new QDDP Coordinator and QDDP Educator were scheduled to complete training in December 2011 to become certified trainers for the Q Construction: Facilitating for Success training. All QDDPs had participated in the initial training. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. The competency checklist generally provided a good format for reviewing a number of planning and facilitation skills. As is discussed further below, as the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. However, its implementation already was providing some valuable information to assist QDDPs in refining their skills. At the time of the review, initial checklists had been completed for seven of the 22 QDDPs. The Facility indicated that six of the seven had been determined to be competent. This process had helped to identify areas in which work was needed. ▪ The State had hired consultants to provide training, and work hands-on with teams on the ISP process. The consultants had provided some basic training to	Noncompliance

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		AUSSLC PSTs. It included an overview of the philosophical and historical context of individual planning, a discussion about differences in ICF/MR and Settlement ▪ Agreement requirements related to individual planning, and some of the logistics of planning. The specific planning topics included preferences, strengths, and needs; the cycle of planning, including assessment, planning, implementation, re-evaluation, and more planning; developing action plans; the Integrated Risk Rating form; community referrals; and barriers to implementation. The consultants also provided some training just to the QDDPs. In addition, at AUSSLC, they had sat in on six ISP meetings, and provided technical assistance to QDDPs and teams. All of the AUSSLC QDDPs had observed or participated in one of these team meetings. They had begun to develop a number of resources for teams to use, such as lists of questions to ask when reviewing risk categories, a description of what the third quarterly meeting should include, hints about identifying individuals' preferences, the Supreme Court's *Olmstead* decision, and lists of acronyms and definitions of frequently used terminology. The consultants also had met separately with the QDDPs, as well as with the various disciplines to discuss their roles in the ISP planning process. These efforts appeared to be having a positive effect, and were well received by Facility staff. In fact, according to the QDDP Coordinator, a number of QDDPs had expressed the sentiment that the training and tools being provided were helping them to see the direction they needed to take to competently complete their jobs. ▪ The State Coordinator for Specialized Services also provided teams additional training on the at-risk screening process. ▪ In response to a document request, the Facility presented a copy of the section of the New Employee Orientation Handbook that addressed Personal Support Planning, as well as the corresponding PowerPoint presentation, and trainer's notes. This appeared to provide a succinct, but comprehensive overview of the planning process in an easily understood manner. It also provided participants with a handout that could be referenced in the future. ▪ The Lead QDDPs had begun to hold weekly meetings with the QDDPs they supervised. A component of these meetings was training. Based on a review of a sample of meeting minutes, the Lead QDDPs were generally using a standardized agenda each week. In addition to providing updates, some of the agenda items included a training component. These meetings should provide an important forum for QDDPs to share ideas, and increase their skills and knowledge. ▪ As noted previously, based on a limited number of observations of ISP meetings while onsite, improvements had begun to be seen with regard to the team process. As would be expected, the results of this training were not yet reflected in the ISP documents that the Monitoring Team reviewed.	

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		Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QDDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. As noted above, work was underway to address the facilitation component of competency-based training. At the time of the review, the Facility reported that six of the QDDPs had successfully completed the competency check-off. As the QDDP Coordinator recognized, this would be an ongoing process until each QDDP demonstrated competency in this area. As the facilitation skills performance tool evolves: o Inter-rater reliability should be established between those responsible for the implementation of the process. o The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified. o Guidelines should be provided as necessary to support reviewers' understanding of the indicators. o Two areas related to quality that should be added to the checklist include: the QDDP's ability to solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and to facilitate the adequate integration of the various disciplines to problem-solve, where appropriate. ▪ The Facility had not yet begun to implement competency-based measures for the writing of ISPs. ▪ Competency measures for other team members had not yet been identified. Such measures should be identified and used to evaluate whether additional training is needed. ▪ Based on interview, in late August 2011, the QDDPs had participated in Webinar training on the implementation of the revised Personal Focus Assessment. Although implementation began in September, the Facility had identified this as an area in which additional training was needed. ▪ As recommended in the previous report, additional training should be provided on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. This was an area that the State consultants had identified as a priority, and had begun to work on with teams.	

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		▪ As noted above, the State consultants as well as the QDDP Coordinator had begun to sit in on team meetings and provide technical assistance in real time. These efforts should continue, because they likely will have the greatest impact on improving the process. ▪ As noted in several other sections of this report (e.g., Sections K, O, P, R, and S) adequate processes were not in place to ensure that staff had successfully completed competency-based training on the implementation of components of the ISPs, such as behavior support plans, physical and nutritional management plans, indirect therapy plans, use of alternative and augmentative communication, and/or skill acquisition plans. Progress was being made on training staff, but the Facility remained out of compliance with this provision. In addition to focusing efforts on providing additional training and technical assistance to improve the team process during team meetings, competency measures needed to be developed and implemented for the development of the ISP documents, and the Facility needed to ensure that staff responsible for the implementation of the plans successfully completed competency-based training.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Based on information the Facility provided, of the 351 individuals AUSSLC supported, 33 (10%) had ISPs that had been completed more than 365 days after the previous meeting, resulting in a compliance rate of 90%. Some of the individuals' ISP meetings were held within a few days of their anniversary date, while others were late by hundreds of days (range 366 days to 723). For the 33 individuals, the average number of days between meetings was 427. It is important to note that the Facility was not yet sure of the integrity of this data, and was taking steps to ensure the information was correct. A related problem was the timeliness of plans being available and in effect within 30 days. As noted in the last report, the Facility currently had no automated way of tracking this indicator. Although the Facility estimated that 48 of the 351 plans were implemented more than 30 days after the meeting, resulting in a compliance rate of 86%, this data was not considered reliable. The QDDP Coordinator recognized that timeliness was a problem. In addition to working with the State's consultant on a tracking system to allow the collection of valid and reliable data, a corrective action plan had been developed to address similar findings from the State's survey and certification team. At the time of the Monitoring Team's review, this plan was in the process of being implemented. It included action steps for meeting with QDDPs who were delinquent; identifying issues, and providing assistance and instruction, as needed; taking disciplinary action, as appropriate; hiring Lead QDDPs to assist in monitoring and mentoring; reconvening ISPs for seven individuals whose QDDPs had left without finishing the documents; retraining QDDPs on the ISP process, as	Noncompliance

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		well as the completion of skill acquisition programs; and creating a tracking system to monitor and address issues related to discipline assessments to ensure they were turned in at least 10 days prior to the annual meetings. This represented a reasonable approach to addressing the issue of timeliness. Although improvements were not seen since the last review with regard to timeliness, it appeared AUSSLC was putting the infrastructure in place to improve compliance with this sub-provision of Section F. The Facility is encouraged to continue implementing the steps in its corrective action plan, monitor the results, and make modifications, as necessary.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	As noted in the previous report, DADS Policy #004.V addressed quality assurance processes to ensure ISPs are developed and implemented consistent with the provisions of the Settlement Agreement. 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. Moreover, extremely limited information was provided in relation to any monitoring the Facility was completing with regard to Section F. The following concerns were noted: ▪ Although in the past, the Facility reported using four different monitoring tools to assess compliance, for this review, only one monitoring tool was provided. It was the AUSSLC Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 7/23/10. It was unclear if the Facility was using the tool entitled Settlement Agreement Cross Referenced with ICF/MR Standards, Section F, with guidelines, revised 12/10, which the State Office had distributed for use, and which the Facility indicated previously that it was using. ▪ Although the Facility's POI indicated that: "QE [Quality Enhancement] completes at least 8 PSP monitoring forms per month. State Office monitors 4-5 Living Options Discussions records per month by reviewing PSPs. Both assessments yield plans of correction and/or feedback, which is then shared with the QDDP," adequate documentation was not provided to substantiate this statement. More specifically, in response to a request for: "The last 10 monitoring tools completed by the: a) QMRP Coordinator; and b) Quality Assurance Department staff," AUSSLC submitted no completed monitoring tools, and the cover sheet for this request stated: "We are revising the monitoring tools to match the new format." Based on interview with the QDDP Coordinator, due to the change in management and the other priorities for addressing concerns related to ISPs, the QDDP management team had not been completing any monitoring. However, it was reported that the Quality Assurance Department was monitoring using the Personal Support Plan Meeting/Documentation Checklist, and feedback was	Noncompliance

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		then provided to the QDDPs. As noted, no documentation was provided in response to the Monitoring Team's request. The only documentation found in relation to this requirement consisted of two completed checklists included in the Presentation Book for Section F. One did not identify any problems, and the other identified a number of problems. Although a plan of correction was submitted for the latter, it was not adequate. It did not address all of the issues identified, and did not describe specifically how change would occur. Rather, the action items simply reiterated that in future meetings or plans, the QDDP would meet the requirements not met for the meeting that was monitored. ▪ Different reviewers completed the two tools included in the Presentation Book. However, no indication was provided that an appropriate process was being utilized to establish inter-rater reliability. ▪ In relation to Section E of the Settlement Agreement, the Monitoring Team also asked for aggregate monitoring data summaries or trend reports. Although AUSSLC provided some information, none related to Section F. Based on this lack of information, it did not appear that any trending or analysis of information had yet occurred in relation to these requirements of the Settlement Agreement. AUSSLC continued to be at the initial stages of developing and implementing quality assurance mechanisms to ensure compliance with Section F of the Settlement Agreement. Since the last review, no progress had been made. 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. With regard to the process of determining whether or not QDDPs are competent with regard to meeting facilitation skills, Facility policy and/or procedure should set forth the parameters with regard to actions that will be taken to assist QDDPs who do not originally meet the competency requirements, as well as other steps that would need to be taken if competency could not be achieved. The Facility had begun to do this in a related POI action plan, and these steps could be expanded upon and memorialized in policy and/or procedure. (Section F.1.a)
3. The criteria for determining when a team member's attendance at an annual ISP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. Such criteria should take into consideration the Settlement Agreement requirement that: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs." Although this is an issue that should be carefully coordinated with the State Office, now that risk levels were being established for individuals, this might be one mechanism that teams could use to determine which team members should attend an individual's annual planning meeting. (Section F.1.b)
4. Once the system to aggregate the data being collected at team meetings regarding attendance is finalized and implemented, this data should be analyzed, and, if problematic trends are identified, they should be addressed. (Section F.1.b)
5. Efforts should be made to: 1) ensure direct support professionals' attendance at ISP meetings; and 2) increase their meaningful participation as integral members of the teams, including sharing information about the individual, contributing ideas about what does and does not work, and

developing the services and supports that will be provided. (Section F.1.b)

6. 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' ISPs. Discipline heads should take a lead role in this process. (Section F.1.c)
7. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such assessments would be beneficial to the individual. (Section F.1c)
8. In completing the revised PFA, consideration should be given to identifying a direct support professional who knows the individual best to play a leadership role in collecting information from other staff, and summarizing it on the form. (Section F.1.c)
9. The AUSSLC vocational assessment should continue to be revised and expanded, upon and/or alternatives to the vocational evaluations/assessments should be identified and implemented. Vocational evaluations should focus on potential work that is interesting to the individual, and on how that kind of work could be made available to the individual. The evaluation should create a vocational profile based on, for example, objective data, situational assessments, a thorough work history, and/or interest inventories. (Section F.1.c)
10. ISPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the ISP, rather than stand-alone documents. These plans should be integrated further with other protections, supports, and services. (Sections F.1.d, F.2.a.2, and F.2.a.3)
11. The State and the Facility should ensure that person-centered concepts are integrated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc. (Sections F.1.d, F.2.a.1, F.2.a.2, and F.2.a.3)
12. 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' ISPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
13. 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, F.2.a.6, and F.2.e)
14. Individualized, measurable goals and objectives should be defined in individuals' ISPs to support the implementation of essential plans, such as behavior support plans, nursing care/health management plans, psychiatric treatment plans, and physical and nutritional support plans. For example, in order to provide health care supports to individuals served, measurable goals and objectives should be included to define the roles of direct support professionals as well as nursing staff. The same is true for all of these other various plans. In addition, ISPs 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. (Section F.2.a.2)
15. As teams continue to receive training on the new PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers. (Section F.2.a.3)
16. Whenever possible, specific timeframes should be delineated in action plan. For action plans that involve service objectives, some form of measuring staff's level of involvement should be included. (Section F.2.a.4)
17. 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.5)
18. PSPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
19. 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, and that they clearly delineate the roles of direct support professionals. (Section F.2.c)

20. With regard to the completion of monthly reviews:
    a. The process for ensuring that each team member conducts monthly reviews of the programs which he/she is responsible should be formalized, and it should result in easy access for all team members to the information;
    b. Monthly reviews should incorporate data, as appropriate, to allow the QDDP and the team to assess the efficacy of the plans and programs in place, and determine if changes are needed, staff need to be retrained, more monitoring needs to occur, etc.; and
    c. QDDPs should document clearly follow-up activity and/or changes that are made to PSPs. (Section F.2.d)
21. QDDPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate ISP 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)
22. As the facilitation skills performance tool evolves:
    a. The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified.
    b. Guidelines should be provided as necessary to support reviewers' understanding of the indicators.
    c. Two areas related to quality that should be added to the checklist include the QDDP's ability to: solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and facilitate the adequate integration of the various disciplines to problem-solve, where appropriate. (Section F.2.e)
23. Ongoing training and technical assistance should be provided to address gaps in knowledge regarding the new ISP process, as well as to enhance the various team members' skills. (Section F.2.e)
24. Consideration should be given to adding examples of ISPs that are well done, while protecting the identity of the individual, to the training manual to assist in teaching QDDPs and teams what is expected. (Section F.2.e)
25. The Facility should ensure ISPs are completed in a timely manner and prepared to allow implementation to begin within 30 days. As it implements the corrective action plan to address the timeliness issue, AUSSLC should monitor the results, and make modifications, as necessary. (Section F.2.f)
26. The Facility should review the audit tools it is using for Section F to ensure that it is meeting the State Office's requirements with regard to monitoring, and that adequate data is being collected to allow AUSSLC to identify issues related to the planning process, and the resulting documents and their implementation. (Section F.2.g)
27. Staff responsible for conducting monitoring activities should be provided with necessary training, adequate guidelines and criteria should be included in the audit tools, and inter-rater reliability should be established. (Section F.2.g and Facility Self-Assessment)
28. As the Facility expands its self-assessment activities, the POI should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The POI also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

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 Consults/Integrated Progress Notes (IPNs) reviewed occurring in 2011 for one individual from each residence: Individual #251 (optometry, dated 7/20/11), Individual #183 (audiology, dated 7/20/11, speech pathology, dated 8/8/11), Individual #332 (ophthalmology, date not submitted, retinal specialist, date not submitted), Individual #282 (ENT, dated 2/17/11, ENT, dated 9/29/11, mammogram, dated 6/22/11), Individual #266 (optometry, dated 5/18/11, gastroenterology, dated 6/14/11, gastroenterology screen, dated 5/27/11, colonoscopy, dated 10/3/11), Individual #258 (mammogram, dated 8/16/11, audiology, dated 7/19/11, gastroenterology, dated 2/8/11), Individual #244 (ENT, dated 1/20/11, podiatry, dated 2/16/11), Individual #279 (no consults/clinics), Individual #128 (gynecology, dated 2/7/11, optometry, dated 5/18/11, gynecology, dated 7/27/11, colonoscopy, dated 3/24/11), Individual #351 (no consults/clinics), Individual #21 (neurology, dated 9/12/11, neurology, dated 6/13/11, neurology, dated 3/7/11, gastroenterology screen, dated 4/29/11, colonoscopy, dated 5/26/11), Individual #12 (Urology, dated 1/26/11, Neurology, dated 5/2/11, Neurology, dated 6/13/11, Neurology, dated 9/12/11, neurology, dated 2/11/11), Individual #321 (no consults/clinics), Individual #48 (ENT, dated 9/15/11, audiology, dated 6/20/11), Individual #72 (neurology, dated 9/12/11), Individual #151 (optometry, dated 5/18/11, eye clinic, dated 6/17/11, podiatry, dated 6/15/11, gastroenterology, dated 8/9/11), Individual #432 (no consults/clinics), Individual #204 (ENT, dated 10/27/11, ophthalmology, dated 8/12/11, ENT, dated 6/3/11, ENT date not submitted), Individual #178 (neurology, dated 5/2/11, eye clinic, dated 7/8/11, neurology, dated 8/4/11, ENT, dated 8/18/11, ENT, dated 8/4/11, hematology date not submitted), Individual #358 (radiology, dated 3/31/11, ophthalmology, dated 11/5/11), Individual #146, dated podiatry 10/19/11, optometry, dated 3/23/11, podiatry, dated 1/12/11, podiatry, dated 5/18/11); o Presentation Book for Section G, including: Draft AUSSLC Medical Services Policy: Minimum and Integrated Clinical Services, undated; AUSSLC Medical Services Policy: Management of Consultation Reports, dated 8/16/11, and training roster, dated 9/1/11; SSLC Statewide policy and procedures: #011, Pharmacy Services, dated 10/10/11; SSLC Nursing Protocol: Hospitalizations, Transfers, and Discharges, dated June 2011; Constipation Interdisciplinary Protocol, dated 7/6/11; Seizure Management Interdisciplinary Protocol, dated 7/6/11; Enteral (Tube) Feeding Interdisciplinary Protocol, dated 7/12/11; Aspiration Risk Reduction Interdisciplinary Protocol, dated 10/5/11; Clinical Care Committee minutes, dated 10/12/11, and 11/7/11; AUSSLC Pre-Treatment Sedation Committee minutes, dated 6/2/11, and 10/17/11; Pre-treatment Sedation Meeting with pilot home, dated 6/30/11; Pre-Treatment Sedation policy, dated 7/7/11; and PNMT Administrative meeting agenda, dated 9/27/11; and

	○ Plan of Implementation for Section G. ▪ **Interviews with**: ○ Fred Bibus, MD, Medical Director. ▪ **Observations:** ○ Clinical Care Committee, on 11/16/11.
	Facility Self-Assessment: The Facility determined it was not in compliance with this section. This was consistent with the Monitoring Team's findings. In the POI, as evidence of progress towards compliance with this section, the Facility provided a chronological list of steps completed. According to this list, since the Monitoring Team's last visit, there had been the creation of the Clinical Care Committee. Additionally, other interdisciplinary meetings continued to meet, including the: Polypharmacy Committee, Pre-treatment Sedation Committee, Medication Error Committee, and PNMT. A draft policy for Minimal and Integrated Clinical Services was written, and was in the process of being reviewed. One policy for management of consultation reports was completed, and implemented on 8/16/11. However, there was no follow-through with data collection and tracking, and analysis of this data to determine if progress was being made in these interdisciplinary areas. There had been no defined measure of integrated clinical care, or development of clinical or administrative tools to measure progress. An action plan had been developed related to the procedure on the management of consultation reports. However, the only progress that had been made was an in-service to the PCPs. No database development or tracking had begun. Although 17 steps were identified, only two had been completed. In addition, although committees had been developed, it was not clear how each committee related to the system care and the part each played in providing integrated services.
	Summary of Monitor's Assessment: The Facility remained out of compliance with this section, and no noticeable progress had been made. A number of committees had potential for developing, implementing, and monitoring integrated care. The morning medical meeting had the potential to provide a forum for integrated care, but struggled with implementation and follow-through to closure. The Clinical Care Committee was newly developed. It appeared to be an administrative committee overseeing several subcommittees, each of which had an interdisciplinary composition and was assigned selected goals. However, as these were all new subcommittees, no reports had been returned to the Clinical Care Committee. Important policies remained in draft form. The consultation management policy was implemented recently. However, no database or method to track any progress had been developed. None of the committees appeared to have a monitoring component to measure efficiency or effectiveness. In addition, there was no method to determine accountability in completing tasks assigned to the various committees.

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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.	The State Office had developed a number of interdisciplinary protocols to assist with providing guidance in implementing integrated clinical services. Examples included: Constipation Interdisciplinary Protocol, dated 7/6/11; Seizure Management Interdisciplinary Protocol, dated 7/6/11; Aspiration Risk Reduction Interdisciplinary Protocol, dated 10/5/11; and Enteral (tube) Feeding Interdisciplinary Protocol, dated 7/12/11. No information was submitted indicating if progress had been made in implementing any of these protocols, or that a timeline for their implementation had been created. As they had been released to the Facilities in October 2011, the reason for a several week delay in beginning or planning for an in-service education session, and discussion of implementation options was not provided. A number of committees were formed, with multidisciplinary representation, to provide forums for resolving concerns and creating integrated clinical systems. However, many of these were in the initial stages of development, and/or had made limited progress. The Clinical Care Committee was formed, and minutes from October 12, 2011 and November 7, 2011, indicated the topic of missed appointments was discussed, with follow-up action plans and a responsible person. However, no projected dates of completion were provided regarding missed appointments and/or other areas of concern to the committee. For missed appointments, the action step was identified as creating a data tracking subcommittee, but no date was provided by which a subcommittee would be expected to present findings or resolve the concerns discovered. The creation of a data tracking committee did not provide resolution to the challenge of missed appointments. The need for a number of other subcommittees was determined. These committees included Restraint Reduction Committee, Pica Committee, Skin integrity Committee, Enteral feeding Committee, Pneumonia Aspiration Committee, Weight and Dietary Committee, and Master Daily Schedule Committee. Chairs and co-chairs were assigned with first reports due in January 2012. A meeting of the Clinical Care Committee occurred during the Monitoring Team's visit, but focused on comments to proposed policy and procedures. It appeared more administrative in nature, as opposed to providing a forum for integrated discussion among disciplines. The content of the meeting was typical of a policy and procedure committee. It is recommended that the focus of the Clinical Care Committee be on integration of clinical services. The development of new and revised policies and procedures related to clinical care should be part of a subcommittee, but should not replace the necessary interdisciplinary discussions important to creating and implementing integrated services. The morning medical meeting had the potential to provide a forum for integrated care. However, as is discussed in greater detail with regard to Section L.1, it struggled with implementation and follow-through to closure.	Noncompliance

		Another example of integrated clinical services was the Pre-Treatment Sedation committee. It created a policy for reviewing medication use for pre-treatment sedation. This was an interdisciplinary committee represented by Psychiatry, Behavioral Services, the QDDP Educator, Active Treatment Services, Dentistry, and a home supervisor. This committee also was assigned the task of developing dental desensitization programs. As is discussed with regard to Section J.4 and Section C.4, extremely limited progress had been realized since the last review with regard to the development of strategies to minimize individuals' need for pre-treatment sedation for dental appointments, and no progress had been made in this regard in relation to pre-treatment sedation used for medical appointments.	
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.	An undated draft of an AUSSLC medical services policy entitled: Minimum and Integrated Clinical Services, was submitted. It included the expectation/directive that: "the appropriate clinician must review recommendations from non-facility clinicians and document whether to adopt the recommendations and to refer the recommendations to the PST, when appropriate, for integration with existing supports and services." As part of the record requests, the Facility submitted consultant reports for one individual from each residence, as well as any IPNs commenting on the consultant reports. Consultations for 22 individuals were submitted, with a range of one to six consultations per individual. Several reports/consults were submitted that were not included in this review (i.e., dental, DEXA scan reports, etc.), because they were reviewed in other sections of this report. A total of 55 consultant reports were reviewed. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 55 reviewed, 48 (87%) had the PCP initial and or IPN, indicating review by the PCP. However, of these, only 30 out of 55 (55%) had an IPN. From the submitted documents, seven out of 55 (13%) had no indication of a PCP review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs were reviewed. Of the 29 IPNs that had been completed, only six indicated agreement or disagreement with the consultant recommendations. Compliance for this section was six out of 55 (11%) consults included documentation of agreement or not with the consultant recommendations. A Medical Department policy had been issued that provided guidance to the PCPs concerning timeliness and completeness of the review, with additional guidance toward documentation. The policy was entitled: AUSSLC: Medical Services Policy: Management of Consultation Reports, dated 8/16/11. The policy included expectations regarding completeness of clinical information provided to the consultant, and follow-up on the	Noncompliance

		consultant report within seven days. Expectations were that if recommendations were not followed, an explanation was to be written. If the PCP determined the decision needed PST review, documentation of notification was to be written in the active record. On 9/1/11, in-service was provided to the PCPs. At the time of the review, the records reviewed did not consistently show the effects of this fairly new policy. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	

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

1. Action plans should have timelines. (Section G.1)
2. The focus of the Clinical Care Committee should be on integration of clinical services. Purely administrative areas, such as policy and procedure creation and revision, should be discussed as a subcommittee, and brought back to the larger committee for final review and approval. (Section G.1)
3. The Facility should list all the committees that are considered interdisciplinary and focus on integrated clinical care, then create a flow chart showing how they are interrelated. The Facility should review this information to identify areas needing improved communication, improved efficiency, as well as looking for duplication of efforts and gaps that need to be addressed. (Section G.1)
4. The Medical Department should maintain a list of signatures and initials used by the PCPs to allow easy identification of initials on consults and other medical documentation. (Section G.2)
5. A system should be created to track when consults are ordered, date of appointment, whether the appointment is completed, date the report is received, date it is reviewed and signed by PCP, and date of IPN referencing consult report. (Section G.2)
6. Further in-service training should be provided to the PCPs to increase understanding and compliance with the Settlement Agreement requirements related to Section G, as well as Sections L and N. (Section G.2)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H, including: Draft Policy, undated: AUSSLC Medical Services Policy: Minimum and Integrated Clinical Services; Annual Medical Assessment (AMA) Tracker, dated 11/3/11; Psychology list of individuals with a completed functional behavioral analysis, dated 10/1/11; RN Case Manager Tracking Calendar 2011; PNMT General Caseload Tracker, Psychiatry Completed assessments (details not provided); ICD-9 training roster, dated 10/13/11; Infirmary/Hospital Transition Policy/Protocol, dated November 2011; SSLC: Nursing protocol: hospitalizations, transfer, and discharges, dated June 2011; Constipation Interdisciplinary Protocol, dated 7/6/11; Seizure Management Interdisciplinary Protocol, dated 7/6/11; and Enteral (tube) Feeding Interdisciplinary Protocol, dated 7/12/11; and o POI for Section H. ▪ **Interviews with**: o Fred Bibus, MD, Medical Director
	Facility Self-Assessment: The Facility noted in their POI that there had been no initiatives undertaken for subsections H.3 through H.7. For Section H.I, the Facility stated it had created a tracking sheet for annual medical assessments, initiated 3/3/11. However, review of the data indicated there was no ongoing review of this important information, or follow-up meetings to address concerns. Much data was missing, and a number of assessments were overdue, but the information did not appear to be reviewed, nor was the responsibility delineated for anyone to conduct any analysis and follow-through. Large gaps in information remained eight months after initiation of the database. An in-service was held for PCPs concerning IDC codes, but the Facility could not provide evidence of the content of this meeting. Although two years had passed since the Settlement Agreement monitoring had started, for the other subsections, there was no activity. The Facility determined it was not in compliance with this section. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: There had been no progress made in this area. The lack of any attempts to address this section for over two years was striking. A vacuum of leadership and vision held the Facility back in this area. The Facility had not defined the goals for this section in the context of its campus, developed clinical and administrative tools to measure progress, developed databases that would be helpful in creating the evidence needed for compliance, or developed a system and schedule for data analysis. The Medical Department was unable to provide complete, accurate, and reliable assessment.

	However, the Dental Department was able to submit complete and accurate information for tracking of a number of dental concerns. It also has data on one important clinical indicator: oral hygiene rating scores across the campus. The Dental Department should develop other clinical indicators using its current database systems. The role of the Pharmacy Department in assisting with clinical indicators of efficacy of treatment remained important. The development of the "patient intervention" documentation needed follow-through, and the QDRR process had regressed, but appeared to be back on track with improved staffing in the department. The Pharmacy Department should review Section H to determine its role and how the current tools could be utilized to assist in compliance.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The draft AUSSLC Medical Services Policy: Minimum and Integrated Clinical Services included a list of assessments based on the Health Care Guidelines (HCG). This list should have, but did not include quarterly medical reviews. Several other areas were mentioned as assessments for which monitoring for timeliness was expected. One of these areas included annual medical assessments. Data was submitted dated 11/3/11. From the information provided, the following summarizes the analysis of this data: ▪ The baseline census for the data was 352 individuals. ▪ A total of 322 out of 352 (91%) had a current completed annual medical assessment. ▪ A total of 322 out of 352 (91%) had a current completed annual physical examination. ▪ The data included the previous annual medical assessment completion date for 97 out of 352 individuals (28%). This indicated a need for review of database management. ▪ The current annual medical assessment was completed within 365 days of the prior annual medical assessment for 60 of the 97 individuals (62%). ▪ The data included the previous annual physical examination date of completion for 98 of 352 individuals (28%). ▪ The current physical examination was completed within 365 days of the prior annual physical examination for 59 of 98 individuals (60%). ▪ There were no quarterly medical reviews completed. ▪ Annual dental examination completion compliance is discussed with regard to Section Q. ▪ The quarterly drug regimen reviews is discussed with regard to Section N. Data was submitted from other departments (i.e., psychiatry, psychology, nursing, and PNMT), and these are discussed in the corresponding sections. However, the format and	Noncompliance

#	Provision	Assessment of Status	Compliance
		information was different for each document the various departments submitted. This made any type of analysis difficult. In addition, overall, issues related to quality continued to be problematic in many areas of assessment. The Facility should provide a cohesive format, with timely trending and analysis per quarter. This review should be designed to determine if improvement is occurring over time, and to assist the departments in determining if they are reaching their compliance goal. Based on a review of records of 11 individuals, which is discussed in greater detail with regard to Section M.1, who had been sent to an emergency room and/or hospitalized for an acute illness, nursing assessments were not conducted on a regular basis or in response to changes in individuals' status. Since the initial baseline review, this has been a consistent finding. During the current review, the Facility was found to have made no progress in addressing these issues.	
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.	There was one in-service training session for the medical staff concerning ICD-9 codes. This was held on 10/13/11. Present were all but one PCP. Two psychiatrists also attended. No description was provided of the training content except through an email inquiry. The email indicated that the training focused on explaining the need for specific details of the diagnosis with examples of how phrasing was important. It is recommended that such training have a handout or PowerPoint document to verify the content and depth of detail of the training. As is illustrated with regard to Section J of the Settlement Agreement, the assessment processes used to determine diagnoses were not always consistent with DSM criteria or generally accepted standards of practice. The psychiatric diagnoses utilized at the 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 validity of the psychiatric diagnosis. Although some progress had been seen in this area, the Facility remained out of compliance.	Noncompliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The State Office released a number of clinical pathways in October 2011 that provided guidance to the Medical Department in a number of important clinical areas. These included Prevention Health Care Guidelines, Constipation Management, Seizure Management, Enteral Feeding, and Aspiration Prevention. These documents communicated the expected timeliness of treatments and interventions, as well as the clinically appropriate steps that are expected, based on history, physical assessment, and diagnoses.	Noncompliance

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		As discussed in greater detail with regard to Section L.3, and in the POI of Section H, the Medical Department had not initiated any internal review, nor had prior reviews been attempted internally to determine if clinically appropriate assessments, treatments, and interventions were being completed.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The new guidance from the State Office concerning medical care audits for several important and common diagnoses (e.g., aspiration, seizures, constipation, urinary tract infections, diabetes) included clinical indicators and critical questions to assist in analyzing quality of care. These should be reviewed carefully with the medical staff and medical compliance nurse, and this information should be used for the development of an internal medical quality improvement initiative. The draft policy on "Minimum and Integrated Clinical Services" required that "specific clinical indicators are to be identified, measured, tracked, trended, and analyzed to assess clinical problems and guide treatment interventions." The goal has been defined, and the clinical indicators had been determined. However, at the time of the Monitoring Team's visit, there was no evidence of any QA program incorporating the goals and clinical indicators into a system that provided a measure of quality care. Clinical indicators also need to be developed for disciplines other than medicine. 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. PNMPs also did not identify the clinical indicators or functional outcomes to be measured.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	There had been no progress for this section. The Medical Department had established databases for mammograms, and colonoscopies, but there was no information to suggest that there had been ongoing monitoring of results, and no quarterly analysis reports were submitted. The department had not begun to create a system to monitor health status. No information was submitted to suggest collaborative efforts with the Information Technology Department, or meetings with the PCPs concerning approaches to meet this goal. As is discussed above with regard to Section E.1, such indicators need to be incorporated into the QA/Risk Management systems to identify individuals, residences, and/or departments that need attention, as well as to detect and address systemic issues that impact the Facility's adequate response to clinical indicators.	Noncompliance
H6	Commencing within six months of	With the development of State Office guidelines including clinical indicator questions	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	included in the internal review tools, the next step for the Facility was implementation of these guidelines in specific areas such as constipation, seizures, etc. However, there was a wide range of other areas about which the department should be involved in ongoing review and analysis, such as the effectiveness of steps taken upon return from a hospitalization to prevent recurrence. In many clinical areas, monitoring of the process and measuring results should not require outside assistance.	
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.	There was a draft policy concerning minimum and integrated clinical services. It was an outline of expectations, but left details to be developed in each department. This should be a potential foundational policy, and other policies should be aligned with this policy. It is recommended that there be a flow diagram showing the intertwining of policies and how they interface and overlay, in order to reduce redundancy and provide evidence of a gapless system.	Noncompliance

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

1. In collecting and analyzing information related to assessments and other key healthcare information, the Facility should use one format/software program and use one system across the campus. (Section H.1)
2. Medical Department Administration should provide evidence of ongoing analysis of information related to healthcare information, including but not limited to assessments, preventative testing/evaluations, and healthcare indicators. (Section H.1)
3. For each topic assessed through the information management system (such as timeliness of annual medical assessments), Medical Department Administration should provide a quarterly report/review of important indicators, indicating areas of strength and weakness. Plans should be developed and implemented to resolve areas of concern, including identification of other departments that need to be involved in any interdisciplinary systemic resolution of the concern. (Section H.1)
4. Documentation related to in-service training should include a synopsis of the information covered. It not only provides documentation of subject matter covered, but also provides participants with reference material and assists in future planning of materials so redundancy is avoided. (Section H.2)
5. As the Facility had made no progress in this section two years after the Settlement Agreement began, the Medical Department Administration should prioritize these sections. The Medical Department Administration should use the information in the clinical guidelines that State Office distributed in October 2011, including the clinical indicators to begin to meet with Information Technology staff to develop a user-friendly information system. Then personnel should be assigned to input accurate information into the system. In addition, an internal set of questions should be developed to determine whether treatments and interventions are timely, and whether treatment is clinically appropriate. Sample size, sampling methods, and inter rater reliability should all be established to ensure the reliability and validity of data collected through monitoring. Data should be analyzed quarterly, with reports issued that address the quality of data completeness, content, as well as trend analysis and interpretation. (Sections H.3 and H.4)
6. Various clinical indicators should be used as measurements of health status. However, if results suggest the clinical indicators are too broad or not sufficient to detect concerns of health care quality (i.e., the results continually suggest 100% compliance), further review of clinical indicators should be completed to determine if the reviewer is interpreting the information correctly, or whether the indicator needs to be amended or replaced. (Section H.5)

7. For data that demonstrates that clinical indicators reflect ongoing need for improvement, there should be demonstration of additional testing, or consultations, or changes in medications or medication dosages. (Section H.6)
8. Policies and procedures need to be sufficiently detailed to be of practical assistance to the PCPs, the medical compliance nurse, other clinical departments, and administration. (Section H.7)
9. The scope of policies and procedures should include methods of communication between departments; timelines for responses to other departments; and structure of forums and committees that are interdisciplinary, including descriptions of the content areas they will cover, documentation requirements, measures for integrated tasks, departmental participation, and the development of action plans, including the creation of action steps, responsible persons appointed, timelines, and documentation of closure. (Section H.7)
10. A flow diagram should be created to show how policies interface and overlay, in order to reduce redundancy and provide evidence of a gapless system. (Section H.7)

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS SSLC "Risk Guidelines" laminated record; o AUSSLC Presentation Book for Section I; o AUSSLC POI and Action Plan for Section I; o AUSSLC At Risk List; o Clinical Care Committee meeting minutes, dated 10/12/11, and 11/7/11; o Presentation for Section I for Settlement Agreement Monitoring Team Visit, November 2011; o DADS SSLC Policy #006.1: At Risk Individuals, dated 12/29/10; o AUSSLC individuals admitted to community hospital for past year; o The following documents: Integrated Risk Tracking Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following 24 individuals: Individual #269, Individual #398, Individual #117, Individual #100, Individual #87, Individual #57, Individual #195, Individual #74, Individual #212, Individual #421, Individual #262, Individual #309, Individual #90, Individual #274, Individual #62, Individual #147, Individual #442, Individual #239, Individual #353, Individual #43, Individual #382, Individual #186, Individual #426, and Individual #82; o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP), and Nutrition assessments; Aspiration Pneumonia/Enteral Nutrition (APEN) assessment; OT/PT/SLP consultations for the last year; Personal Support Plan (PSP) and PSP Addendums (PSPA) for the last year, including PSPAs for Integrated Risk Rating Form and risk action plan; Physical and Nutritional Management Plan (PNMP) with pictures; Integrated Risk Rating Form; risk action plan; individual-specific monitoring for past three months; competency-based training for staff; supporting documentation for implementation of PST risk Assessment and action plan; Health Management Plan; Aspiration Trigger sheets for past six months; and Daily Schedule for the following 10 individuals: Individual #178, Individual #117, Individual #100, Individual #452, Individual #6, Individual #359, Individual #358, Individual #174, Individual #223, and Individual #403; o Most recent physician 180-day orders, most recent annual medical assessment, most recent PSP and subsequent addendums, radiologic reports for the past year, hospital discharge summaries for the past year, completed integrated risk rating form with attendance roster, and risk action plan for the following individuals: Individual #175, Individual #366, Individual #390, Individual #64, Individual #277, Individual #41, Individual #115, Individual #173, Individual #107, Individual #389, Individual #338, and Individual #109; and o Presentation Book for Section I, including: integrated risk ratings, dated 10/26/11; PSP tracking with PSP dates; lists of at-risk individuals and individuals with risk per home, as

	of 11/9/11 (i.e., aspiration, cardiac disease, challenging behavior, choking, circulatory, constipation/bowel obstruction, dental, diabetes, falls, fluid imbalance, fractures, gastrointestinal, hypothermia, infections, osteoporosis, polypharmacy, respiratory compromise, seizures, skin integrity, urinary tract infections, weight); and risk discussion prompts. ▪ **Interviews with**: o Connie Horton, FNP, State Consultant; o Priscilla R. Hackett, MSN, MPH, RN, CCM, Chief Nurse Executive; o Kim Ingram, MEd, CCC/SLP, Habilitation Therapies Director; and o Fred Bibus, MD, Medical Director. ▪ **Observations of**: o ISP Meeting for Individual #108, on 11/14/11; o ISP Meeting for Individual #366, on 11/15/11; o ISP Meeting for Individual #137, on 11/16/11; and o ISP Meeting for Individual #62, on 11/17/11.
	Facility Self-Assessment: The Facility's POI indicated that since the Monitoring Team's last visit, the main advance was the creation of an interdisciplinary committee to design and plan a process for tracking compliance with timeframes outlined in Section I. The effectiveness of this committee remained undetermined, because little information was submitted concerning progress toward this goal. Although Facility staff indicated that all individuals' teams had completed the at-risk process, and individuals had risk ratings and potentially action plans, the Facility's POI included no information indicating that the Facility had conducted a review of this process. The POI provided no information about the quality of the ratings, the quality of teams' rationales for the ratings, the level of agreement with the State Office risk guidelines, the quality of the action plans, and/or whether the action plans were completed in a timely manner. The Facility was unable to conduct a self-assessment in these areas, because it had not developed a monitoring system to review quality of the processes in place to identify and address at-risk concerns. However, the Facility determined it was not in compliance with Section I. This was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Since the Monitoring Team's last review, the teams appeared to have made improvements in assessing risk. However, wide variation was noted in the quality of the risk rating documentation. Some included a considerable amount of precise documentation, and others had none. At times, the State Office guidelines were not followed, and no rationale was submitted for the variation. There remained considerable need for the clinical/medical staff to participate in the risk-rating portion of the PSP or PSP addendum to provide valuable guidance in the clinical ratings. In addition, when reviewing the sampling of active records, one record did not have a completed risk rating form or action plan. This lack of evidence was not reassuring that all individuals had completed the risk rating process. An ongoing need also existed for aggressive pursuit of treatment or interventions to address individuals' ongoing needs. Tests, including the results and interpretation of results, should be part of the risk rating

	rationale, and, if further testing is needed, this should be part of the risk action plan steps. When gaps in clinical information exist, teams cannot decide on accurate risk ratings, or develop and implement appropriate plans. Although some progress was noted in all areas of this section, significant challenges continued to exist.

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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.	Since the last review, AUSSLC's POI indicated that the following steps had been implemented regarding the At Risk process: ▪ *"05/3/2011 Data analyst created report from new At-risk database of risks by category and risk level – used in presentation book* ▪ *05/13/2011 Data analyst completes data entry for first quarter at-risk assessments* ▪ *05/31/2011 Discussed status of database with data analyst, updated assessments are being received and entered into database on an ongoing basis* ▪ *08/03/2011 – Clinical Care Committee met for initial meeting."* Although the Facility had begun implementing the above steps, the Monitoring Team found that a significant amount of work was yet to be done to achieve compliance regarding the requirements of the Settlement Agreement addressing the individuals who were at risk. The initiation of the Clinical Care Committee was a promising step forward to provide a structured forum for the discussion and problem-solving process regarding clinical issues. The minutes of this committee indicated that a number of subcommittees were established that included the following committees, several that should positively impact the At-Risk system: ▪ Restraint Reduction Committee; ▪ PICA Committee; ▪ Skin Integrity Committee; ▪ Enteral Feeding Committee; ▪ Pneumonia Aspiration Committee; ▪ Weight and Dietary Committee; ▪ Master Daily Schedule Committee; and ▪ Data Tracking Committee. To assess the Facility's risk screening process, members of the Monitoring Team observed four individuals' ISPs meetings (i.e., Individual #108, Individual #366, Individual #137, and Individual #62) while on site. Specifically, the observations of the ISPs indicated that: ▪ All appropriate disciplines were present at two (50%) of the observed ISPs. The individuals' ISPs that did not have all appropriate disciplines present included	Noncompliance

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		Individual #108 and Individual #62. A dietician was not present at either of these ISPs for individuals who had significant weight issues. ▪ The staff present at the ISPs meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for all four (100%) of the ISPs. ▪ The individual was present at all four (100%) of the ISPs meetings, although two individuals had to leave the meetings before they were completed. ▪ The PST consistently used the Risk Level Guidelines when determining risk levels at all four (100%) of the ISP meetings. ▪ The PST consistently used supporting clinical data when determining risks levels for one of the ISPs observed (25%). The individuals' PSTs that did not consistently use supporting clinical data when determining risk levels included: Individual #108, Individual #137, and Individual #62. The Monitoring Team did note that there was overall improvement for this indicator. However, specific supporting clinical data was not uniformly used when determining risks levels. Compliance scores for this indicator reflect the consistency of the use of supporting clinical data when designating risk levels across all risk areas. ▪ Overall, the risk levels the PSTs designated were appropriate for each category for one of the ISP meetings observed (25%) based on information and data provided by the PSTs. The individuals' PSTs that did not consistently designate appropriate risk levels for each risk category included: Individual #108, Individual #137, and Individual #62. Due to these PSTs' inconsistent use of clinical data to determine risk levels, the Monitoring Team could not validate many of the risk levels that the PSTs assigned. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in two (50%) of the ISP meetings observed. The individuals' PSTs that did not have adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels included: Individual #108, and Individual #137. ▪ Team disagreements regarding risk levels were noted in three of the ISPs, and they were appropriately resolved for Individual #108, Individual #366, and Individual #62 (100%). No team disagreements were noted in the ISP for Individual #137. For this indicator, the Monitoring Team evaluated 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 ISP facilitator kept the team focused in three (75%) of the ISPs meetings observed. The individual's PSTs facilitator that did not consistently keep the team focused included: Individual #108. The Monitoring Team noted overall improvement for this indicator. Areas for continued focus include time management since some of the ISPs observed were exceptionally lengthy, and	

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		keeping discussions focused and productive. In addition, other positive observations from the Monitoring Team included: ▪ The PST for Individual #108 discussed appropriate options for community placement; ▪ The team for Individual #366 came to the meeting prepared in that there had been thought given to the risk ratings before the meeting, so the discussions were based on current information from each of the disciplines; ▪ The PST for Individual #366 had two staff, including the QDDP and a co-facilitator directing the ISP, which kept the meeting focused and within reasonable time constraints; ▪ There were some integrated discussions observed in the ISP for Individual #62. ▪ The QDDP for the ISP for Individual #137 asked good questions of the team to get information and reach consensus; ▪ During the ISP for Individual #62, most team members participated meaningfully in the discussion, and offered opinions and ideas outside of their direct realm of expertise. Also, these team members questioned the status quo. For example, the individual was prescribed Reglan, but the reason was unclear. By other team members raising this question, the Primary Care Physician (PCP) agreed to review the issue. Problematic areas needing focus or improvement included: ▪ Most of the PSTs observed did not consistently use specific clinical data when determining risk levels; ▪ The guardian for Individual #366 was essentially left out of the discussion when risk factors were being discussed. There might have been more of an introduction of this section so that the guardian could be more involved or prepared for what was being discussed and why it was important; ▪ The ISP meeting for Individual #137 contained very little discussion from the team members which gave the appearance that the team had little knowledge about the individual; ▪ Information about incidents was included in the material presented in the ISP for Individual #366, but did not include a meaningful discussion of the relationship between the risks and incidents; ▪ The action plans that were developed for Individual #62 during the ISP meeting were very weak, and often just involved continuation of existing plans. Persons responsible for implementing the actions plans were generally not identified, including the roles of direct support professionals; ▪ The PST for Individual #137 recognized that family had not been involved with the individual for a number of years. However, the PST did not aggressively pursue the process of obtaining a guardian;	

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		▪ Overall, objectives were not discussed by the PSTs in order to establish a measure of success or failure of the action plans developed; ▪ Although a direct support professional was present at the ISP for Individual #62, she did not sit at the table with the team. Team members occasionally asked her opinion, which was positive, but she was not fully involved in the discussion, and did not appear to view herself as an active and important member of the team; ▪ Most of the interventions mentioned during the PSPs addressing high/medium risks did not reflect the clinical intensity in alignment with the level of risk designated by the teams; and ▪ When discussing interventions for high-risk indicators, the PSTs did not focus on proactive measures to include in the action plans. To further determine whether a regular risk screening was in place to assess, prioritize risks, and manage risks, 12 active records were randomly selected for review of the integrated risk action forms and risk action plans. The Facility indicated that all individuals had completed the at-risk rating and action plan process. However, for the 12 active records submitted, one record (i.e., Individual #109) did not have a PSP, integrated risk rating form, or risk action plan submitted. This suggested that this information was not readily available to team members, or might not have been completed. Facility Administration should take steps to ensure that all such documents are readily available to team members. Of the 11 active records for which the integrated risk rating forms were submitted: ▪ Appropriate disciplines were present at the PSP or PSP addendum for discussion of the risk ratings for four out of 10 (40%). There was one of the 11 active records for which an attendance roster was not submitted for the PSP addendum meeting during which the risk ratings were discussed. The PCPs were not consistently attending and actively participating in the risk rating and risk action plan discussion at the PSP meetings. The PCP should participate and be sufficiently prepared to discuss work-ups that have been completed in the past, and should be able to provide details regarding the history, as well as current health status and suggest recommended next steps. ▪ The individual was present at the PSP or PSP addendum for discussion of the risk ratings for five out of 11 (45%) active record reviews. ▪ The PST used the State Office Risk Guidelines when determining risk levels in eight out of 11 (73%) active record reviews. ▪ The PST used supporting clinical data when determining risk levels in six out of 11 (55%) active record reviews. ▪ The designated risk levels were appropriate for each category/provided adequate justification in five out of 11 (45%) of active record reviews.	

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		Some PSTs appeared to understand the necessity of gathering sufficient detailed documents to justify the risk rating. Some followed the risk guidelines that State Office had provided, but there were inconsistencies. This suggested that the QDDP and PST should carefully review the criteria before assigning risk level. At times, the level of detail was available in the record, but not considered or documented as part of the rationale, which would have created stronger support for the risk level decision. In addition, as was discussed in further detail with regard to Section C.8, the Director of Behavioral Services informed the Monitoring Team that commencing the week of the onsite review, review of restraints for individuals at high risk for challenging behaviors would occur within one business day of the event. This policy is admirable, however, with only three individuals identified as high risk for challenging behavior, it will likely result in little response to many individuals most in need of services. Of the 17 individuals who had experienced more than three restraints in a rolling 30-day timeframe between May and October, only two were identified as high risk. The State and the Facility should re-examine the criteria used to assess risk level with regard to challenging behavior. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area, which comports with the findings of the Monitoring Team. From the Monitoring Team's observations, there had been some progress made regarding the structure, and process of the ISPs regarding the At-Risk process. However, considerably more efforts are needed to ensure that the risk levels are accurately determined using clinical data, that appropriate risk action plans that reflect the clinical intensity in alignment with the designated risk levels are developed, and that a system addressing the reassessment of risk factors for individuals experiencing significant changes in status is develop and implemented. In addition, AUSSLC should also continue to provide training and mentoring for the IDTs regarding the At-Risk process.	
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	Due to a number of missing documents, and clarification needed by the Monitoring Team regarding the Facility's assessment and documentation process, the following indicator could not be accurately and adequately addressed: ▪ Based on a review of records for individuals determined to be at risk, 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. <u>Nursing Assessments</u> Based on a review of 24 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	Noncompliance

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	assessment process as soon as possible but within five working days of the individual being identified as at risk.	did not contain documentation of this requirement included: Individual #269, Individual #398, Individual #117, Individual #100, Individual #87, Individual #57, Individual #195, Individual #74, Individual #212, Individual #421, Individual #262, Individual #309, Individual #90, Individual #274, Individual #62, Individual #147, Individual #442, Individual #239, Individual #353, Individual #43, Individual #382, Individual #186, Individual #426, and Individual #82. For individuals with designated risk indicators, the Chief Nurse Executive (CNE) reported that nursing was using the last quarterly or annual Comprehensive Nursing Assessment to meet the nursing assessment requirement noted in the current At-Risk Individuals policy, even if it had been completed months prior to or after the meeting determining risk levels. A review of the quarterly or annual Comprehensive Nursing Assessments for the 24 individuals found that none of them (0%) were adequate assessments of the specific high-risk health indicators identified by the PSTs. In fact, none of the 24 quarterly or annual Comprehensive Nursing Assessments provided any type of analysis of the high-risk health indicators in the Summary Section. From discussions with Chief Nurse Executive while on site, there was no specific procedure in place defining the process regarding nursing assessments for risk indicators. Consequently, nursing was still using the most recent Quarterly Comprehensive Nursing Assessment without providing any type of update regarding the risk health indicators. This was the same as was found during the last review. Based on interviews with the State Office Nurse Practitioner Consultant, the State was in the process of reviewing and redefining the "assessment" requirement noted in the At-Risk Individuals policy in an effort to clarify the expectations between providing information regarding risk indicators and conducting an assessment. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area, which comports with the findings of the Monitoring Team. <u>Medical Assessments</u> Based on a review of the active records of 11 individuals for whom assessments had been completed to address the individuals' at-risk conditions, three out of 11 (27%) included an adequate medical assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #366, Individual #64, Individual #41, Individual #277, Individual #115, Individual #390, Individual #389, and Individual #107. The following provides an example of an assessment that was not comprehensive: ▪ Individual #107 had five Emergency Room (ER) visits/hospitalizations for vomiting and fever. The team did not appear to evaluate the critical question, specifically the cause of the recurrent vomiting. No testing was done for GERD, gastric ulcer, or other causes. There was a history of esophageal stricture, but no	

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		recent esophagogaastroduodenoscopy (EGD) or other study to rule out pathology. Given the frequent hospitalizations associated with vomiting and aspiration pneumonia, surgical procedures to reduce this complication did not appear to be discussed or pursued. Further, the team needed guidance from the PCP, because the team had only rated the risk of osteoporosis as medium. Due to skeletal abnormalities, a DEXA was not completed, but the history of fractures in both hips, and the presence of diffuse osteopenia on an abdominal x-ray indicated the severity of his bone disease. The team needed guidance in reviewing the history and the assessments on bone health already completed in the past to provide a more accurate risk assessment of bone health. <u>Physical and Nutritional Management, and/or OT/PT/SLP Assessment</u> Based on a review of 10 individual records for which assessments had been completed to address the individuals' at-risk conditions, four of the 10 individuals (40%) included an adequate OT/PT assessment to assist the team in developing an appropriate risk action plan. Records that did not contain documentation of this requirement included: Individual #452, Individual #100, Individual #178, Individual #6, Individual #174, and Individual #403.	
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 43 records for individuals determined to be at risk (i.e., Individual #269, Individual #398, Individual #117, Individual #100, Individual #87, Individual #57, Individual #195, Individual #74, Individual #212, Individual #421, Individual #262, Individual #309, Individual #90, Individual #274, Individual #62, Individual #147, Individual #442, Individual #239, Individual #353, Individual #43, Individual #382, Individual #186, Individual #426, Individual #82, Individual #175, Individual #366, Individual #390, Individual #64, Individual #277, Individual #41, Individual #115, Individual #173, Individual #107, Individual #389, and Individual #338, Individual #178, Individual #452, Individual #6, Individual #359, Individual #358, Individual #174, Individual #223, Individual #403), 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 21 of the cases (49%). ▪ Implemented a plan that met the needs identified by the PST assessment in none of these cases (0%). One of the concerns was the lack of PCP direction in action plans. Most action plans did not provide the detail necessary to guide the IDT process, and the team also "did not know what they did not know," and needed PCP input to establish meaningful plans. It did not appear the PCPs had an active role in many of the action plans developed. ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). This was an area needing further discussion among team members. Pulse ox readings before and after meals, temperatures on all	Noncompliance

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		shifts for high-risk individuals, increased monitoring to ensure correct positioning when bathing and changing clothing, routine lab data, etc. are all potential preventive interventions. However, at AUSSLC there was little evidence that the teams attempted to review preventive measures or incorporate them into action plans. For those hospitalized, there was little documentation of steps taken to prevent a recurrence, whether from aspiration pneumonia or recurrent urinary tract infections. There was no reference to review of exercise programs or adjustments in diets for those with weight concerns, deconditioning, cardiac concerns, or environmental safety reviews for those at risk for falling, etc. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 20 of the cases (47%). Frequently, there was immediate inclusion into the PSP. However, the placement of the risk information was not optimal. It was usually found after the various training goals. It is recommended that it be placed separately and highlighted in the document, so the reader is able to find the needed information quickly. The risk action steps are sufficiently critical that there should be no impediment to any PST member finding them. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. From review of the available documentation, there did not appear to be evidence of interdisciplinary discussions. Several components of the plans appeared to be continuation of prior plans, with no integration of these discussions into the plans. The lack of PCP involvement in some of the plans reduced the final quality in some plans. ▪ For none of the plans (0%) were appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. The measures were more reflective of the absence of negative findings as opposed to positive goals. For many, there needed to be much more definition to the objective or goal. For instance, the goal should be more precise than "will not be constipated in the next 12 months." This would be difficult to measure. It might be helpful for the team to provide a more measurable objective, such as a percent reduction in suppository use, enema use, or percent increase in spontaneous bowel movements in each time period. The teams should define exactly what is in need of improvement, and incorporate that into a measurement that can be tracked for success. Adherence to a healthy diet was a goal for many. Reduction in soft drink/soda use or increased choice of healthy fruit juices, water, or other dietary recommendations would make this a more measurable goal.	

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		▪ Plans included the clinical indicators to be monitored and the frequency of monitoring for one of the individuals (2%) (i.e., Individual #107). Generally, the teams did not clarify the measurable objectives, and were then unable to determine clinical indicators of progress. Such indicators should be specific, such as a reduction in ER visits or hospitalizations, a reduction in enema use each 30 days, or successful participation in an active or passive range of motion program with improved range of motion as measured by OT/PT. Clinical indicators for a healthy diet could be improved blood glucose measurements, or desired weight loss. As clinical guidelines are developed, the clinical indicators from these guidelines would be an additional resource to the PSTs as they develop these measurements. Although no plan reviewed appeared adequate to address all of the at-risk factors, or address the needed assessments in determining level of risk or identifying treatment alternatives, the PSP addendum, dated 8/29/11, for Individual #107 provided clear measurable action steps to be taken to improve the health of the individual and reduce risk. Rationale was provided to allow members of the PST to understand the plan, and increase cooperation and compliance with the plan. Identification of triggers provided guidance to those caring for the individual, and the timelines set expectations for members of the PST and provided guidance to the QDDP in monitoring progress. This PSP addendum was the result of a meeting between the PST and the PNMT. It provided documentation of interdisciplinary support and collaboration in an area in which PNMT expertise was helpful to the individual and the team caring for the individual. On the other hand, the review of Individual #390's records indicated the need for further interdisciplinary discussion. The PST needed to review the risk action plans. Based on a brief review of the record, two areas of particular concern were noted. A Computed Tomography (CT) scan of the abdomen indicated stool throughout the colon, but there did not appear to be an increase in maintenance medications with the goal to reduce episodes of constipation requiring prn medication. There was no mention in the action plan to reduce enema/suppository/prn usage. As a proactive measurement, prn use of medications for constipation indicates constipation has already occurred. The PCP should consider an alternative goal of increasing maintenance medication in order to reduce or eliminate prn usage of constipation medication. There were two hospitalizations, each associated with a urinary tract infection. However, no action steps were recorded in the plan to assess the reason, or monitor the individual more closely to uncover early health status change that might lead to earlier treatment and prevent a hospitalization (e.g., temperature recorded twice daily, voiding log, fluid intake log reviewed each seven days, etc.). In addition, it was unclear why the PCP had not conducted a review to determine if an urological referral was indicated to rule out a	

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		bladder stone, or anatomic anomaly, incomplete bladder emptying, etc. Assessments, preventive steps, and clinical indicators to reflect measurable objectives needed further review and precision. The Facility should continue to focus its efforts on the process of developing specific and clinically appropriate risk action plans for each individual by the next review. The Risk Action Plans should meet the individuals' needs; contain functional, and measurable objectives; include clinical indicators to be monitored and the frequency of that monitoring; include preventative interventions; and be fully integrated into the ISPs. At the time of the review, AUSSLC indicated it was not in compliance with the requirements of the Settlement Agreement for this area, which comported with the findings of the Monitoring Team.	

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 and actively participate the at-risk discussion to ensure teams arrive at clinically appropriate conclusions. The PCP should be sufficiently prepared to discuss work-ups that have been completed in the past, and should be able to provide details regarding the history, as well as current health status and suggest recommended next steps. (Section I.1)
2. The PCP should provide background information concerning the diagnostic tests already completed, the dates of completion, with a brief entry concerning results. The PSTs cannot arrive at correct risk ratings without sufficient information, nor can further assessments be recommended if it is not known what assessments have already been completed. (Section I.1)
3. Facility Administration should ensure that the integrated risk rating form and risk action plan for each individual is readily available to team members. (Section I.1)
4. The State Office should consider the need for an additional high-risk category, a "stable high risk" category for those chronic conditions meeting the criteria of high risk. However, teams should focus on the "active" high-risk categories needing further discussion and intervention. Separating the two would allow teams to prioritize their attention, yet not lose track of the other high-risk categories. (Section I.1)
5. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the PSTs. Currently, the description of high risk for infection requires two or more Multiple drug resistant organism (MDRO) infections, or an open wound. It would be helpful to expand this to any hospitalization for an infection (e.g., sepsis, UTI, diverticular abscess, empyema, meningitis, etc.), because infections requiring hospitalization indicate the need for intense review for risk reduction, not only those with MDRO or a surgical wound. (Section I.1)
6. As detailed in the Monitoring Team's previous Austin report, the risk guidelines should be reviewed to determine if further subcategories are needed to address the diverse topic of challenging behavior. (Section I.1)
7. 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)
8. 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 for the risk process implementation, and attend as many of the PST meetings as possible to ensure basic aspects of the policy and procedure are followed. (Sections I.1, I.2, and I.3)

9. 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)
10. Each PST member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
11. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
12. 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, the PST should meet promptly to address any changes in health and functional status. (Sections I.1, I.2, and I.3)
13. 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)
14. The areas that the At-Risk Individuals policy designates that nursing is to assess should be reviewed to determine which discipline is the most appropriate to conduct those assessments. (Section I.3)
15. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
16. To ensure that therapists follow the OT/PT assessment and update instructions for risk levels, the Habilitation Therapies Department should begin to audit assessments and updates to ensure therapist compliance with instructions. (Section I.2)
17. Given that PSTs, at times, do not realize when more assessment is indicated, 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)
18. As individuals' risks are identified, and risk action plans are developed, teams should ensure that measurable objectives or indicators are 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)
19. The Facility should develop a monitoring system to review the quality of the ratings, the quality of teams' rationales for the ratings, the level of agreement with the State Office risk guidelines, the quality of the action plans, the quality of the measurable tools/clinical indicators, and/or whether the action plans were completed in a timely manner. The goal should be the creation and analysis of data to identify and address areas requiring further improvement. (Facility Self Assessment, and Sections I.1, I.2, and I.3)
20. As the ultimate goal is reduction in risk, the Facility should develop mechanisms for collecting and analyzing date to determine whether or not reductions in various areas of risk occur. (Sections I.1, I.2, and I.3)
21. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and 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. (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, submitted 11/17/11; o List of individuals for whom the new Quarterly Psychiatric Review format had been completed, submitted 11/17/11; o Three appendices that were developed to aid the Psychiatrists in the completion of the Quarterly Psychiatric documentation, submitted 11/17/11; 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 The following sections of the records for 24 individuals: • 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. The 24 individuals (15 percent of individuals) who were receiving psychotropic medication, included the following: • Individuals who were selected because of the acuity of their psychiatric illness, or secondary to observations made during the onsite review: Individual #33, Individual #353, Individual #291, Individual #300, Individual #374, Individual #60, Individual #350, Individual #74, Individual #56, Individual #370, Individual #406, Individual #357, Individual #175, and Individual #165; • Of the records that were produced in the pre-review document request, the Facility considered the following ten individuals to be stable: Individual #238, Individual #445, Individual #183, Individual #355, Individual #332, Individual #361, Individual #271, Individual #412, Individual #160, and Individual #59; o Blank chemical restraint consultation form; o Minutes of the Pre-Treatment Sedation Committee Meetings for the last six months;

	o Reiss Screen for Maladaptive Behavior documentation, Psychological Evaluation, and Comprehensive Psychiatric Evaluation (CPEs) for the following individuals: Individual #206, Individual #99, Individual #52, Individual #153, and Individual #362; o 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; o Evidence tab for Presentation Book for Section J of the Settlement Agreement; o Minutes of the monthly Polypharmacy Committee Meetings for the prior six months, as well as the 11/17/11 meeting; o List of individuals who have been administered the Reiss Screening instrument; o 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. o Quality Assurance internal audits that were related to psychiatric services; o Job description for psychiatrists; o List of psychiatrists employed at AUSSLC; o Curriculum Vitae (CVs) of all psychiatrists employed at AUSSLC; o Weekly schedules for psychiatrists; o List of meetings and rounds attended by psychiatrists; o List of individuals receiving anticholinergic medication, with names of medication(s) prescribed, start/stop dates, and duration of use; o Facility-wide data regarding polypharmacy, including intra-class polypharmacy; o Minutes of the Pre-Treatment Sedation Committee for the last six months; o The "Dental Task Analysis," revised 6/8/11, and approved by the Pre-Treatment Sedation Committee on 6/22/11; o List of individuals prescribed psychotropic medication, including medication and psychiatric diagnosis; o List of individuals prescribed intra-class polypharmacy; o 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; o List of individuals with tardive dyskinesia; o List of individuals receiving benzodiazepines, with names of medication(s) prescribed, start/stop dates, and duration(s) of use; o Chemical restraint data for the following individuals: Individual #375, Individual #30, Individual #109, Individual #195, and Individual #325; o Minutes of the newly formed committee to revise the AUSSLC consent process, from 7/14/11 to 9/30/11; o The newly developed protocol for the consent process for psychotropic medication, which was not dated, but was submitted 11/17/11; o Minutes and related materials from the 11/17/11 Pharmacy and Therapeutics (P&T) Committee Meeting; o Minutes and ancillary material distributed at the 11/17/11 Polypharmacy Committee

	Meeting; and o The Pre-Treatment Sedation Policy, revised 7/6/11. ▪ **Interviews with:** (Note: Cheri Grimm, Settlement Agreement Support Specialist attended all of the following interviews.) o Jose Levy, Director of Behavioral Services, on 11/15/11; o Judi Stonedale, M.D., Staff Psychiatrist, on 11/16/11; o Scott Murry, M.D., Lead Psychiatrist, on 11/14/11 and 11/17/11; o Kenda Pittman, Director of Pharmacy Services; and Zach Corbell, Pharm. D., on 11/15/11; o Rhonda Stokley, DDS, Director of Dental Services, on 11/15/11; o Nilima Mehta, M.D., Staff Psychiatrist, on 11/16/11; o Tushar Desai, M.D., Staff Psychiatrist, on 11/17/11; o Mary Gallo, R.N., Psychiatric Specialty Nurse (with Dr. Murry), on 11/17/11; o Frederick Bibus, M.D., Medical Director, on 11/15/11; o Ms. Cheri Grimm, Settlement Agreement Support Specialist, on 11/17/11; o Ms. Joanne Villasana, Human Rights Officer, on 11/16/11; and o Scott Murry, Lead Psychiatrist; Mary Gallo, R.N., Psychiatry Specialty Nurse; Mike Delisle Program Auditor, QA Department; and Lilani Muthali, M.D., Medical Services Coordinator for DADS State Supported Living Centers, on 11/17/11. ▪ **Observations of:** (Note: Cheri Grimm, Settlement Agreement Support Specialist attended all of the following observations.) o Polypharmacy Committee Meeting, on 11/17/11; o Pharmacy and Therapeutics Committee Meeting, on 11/17/11; o Psychiatry Clinic provided by Judi Stonedale, M.D., on 11/16/11; o Psychiatry Clinic provided by Scott Murry, M.D., on 11/15/11; o Psychiatry Clinic provided by Nilima Mehta, M.D., on 11/16/11; o Psychiatry Clinic provided by Tushar Desai, M.D., Consulting Psychiatrist, on 11/17/11; and o Observations of the following individuals: Individual #77, Individual #357, Individual #262, Individual #243, Individual #281, Individual #156, Individual #74, Individual #326, Individual #86, Individual #80, Individual #94, Individual #157, Individual #37, Individual #30, Individual #122, Individual #374, Individual #135, Individual #130, Individual #146, Individual #442, Individual #336, Individual #6, Individual #421, Individual #160, Individual #272, Individual #333, Individual #293, Individual #406, Individual #291, Individual #119, Individual #61, Individual #294, Individual #90, Individual #264, Individual #143, Individual #91, Individual #353, Individual #181, Individual #84, Individual #338, Individual #224, Individual #318 Individual #165, Individual #342, Individual #184, Individual #370, Individual #291, Individual #429, Individual #435, Individual #175, Individual #103, Individual #159, Individual #234, Individual #93, and Individual #220.

	Facility Self-Assessment: On 11/17/11, a member of the Monitoring Team met with relevant AUSSLC staff members to review the Facility's current self-assessment process. The following staff members were present at this meeting: the Lead Psychiatrist, Psychiatric Specialty Nurse, Medical Coordinator for the Department of Developmental Services and Aging (DADS) State Supported Living Centers, and a member of AUSSLC's QA Department. The initial section of this meeting was devoted to a review of the Facility's protocols for assessing their compliance with each of the 15 provisions of Section J of the Settlement Agreement. The Psychiatry Department conducts an internal review that utilizes a different methodology than that employed by the representative of the Quality Assurance Department. It appeared that, prior to this meeting, which a member of the Monitoring Team organized, that each of these entities was unaware of the others' activities in this regard and were utilizing different methodologies. The representative of the QA Department indicated that he reviewed one individual record per month with the standard tool that was used in other Facilities, which assesses for the presence or absence of an item, and does not provide an assessment of the quality of the item. An example that was given during the meeting was that of the appropriate psychiatric diagnosis. The QA review checked for the presence or absence of a psychiatric diagnosis, but not its validity, because someone without specific clinical training could not assess the diagnosis' validity. As might be expected, the QA Department's review was consistent with the Monitoring Team's review for items that required a dichotomous yes/no, or present or absent assessment, such as, "were the members of the Psychiatry Staff certified by the American Board of Psychiatry and Neurology," or, whether the necessary consults had been signed for a specific psychotropic medication. The data from the QA reviews was not considered in the Facility's self-assessment of compliance with the 15 provisions of Section J and, thus, it is not relevant to the following discussion. Over time, however, the QA data should be integrated into the self-assessment process, as appropriate. The AUSSLC's self-assessment, which the Lead Psychiatrist wrote, relied upon the reviews of 20 percent of the records of those individuals who were receiving psychotropic medication during October 2011. The Lead Psychiatrist and Psychiatric Specialty Nurse reviewed this sample of individual records, with each reviewing half of the sample. There was no attempt at dual reviews to assess for inter-rater reliability. In the 11/17/11 meeting, it was pointed out that the items that were scored for each provision were derived from an analysis of the prior monitoring report. For example, if the prior monitoring report primarily discussed the appropriateness of the individual's diagnosis with regard to Section J.13, then the Facility's internal review also scored this information under Section J.13. This is worth noting, because some redundancy exists in the requirements of the provisions of the Settlement Agreement, so that specific topics could be discussed legitimately in relation to more than one provision. This observation is also relevant, because the Facility's decision to follow the format utilized in the prior monitoring report means that this possible source of variance has been mitigated. There was a high degree of agreement between the overall results of Monitoring Team's present review and the Facility's self-assessment that was completed in October of 2011. Specifically, there was agreement on all of the 15 provisions with regard to whether the Facility was in substantial compliance with a specific

	provision. It is important to note that the Facility's POI included relevant data from the internal reviews for a number of the provisions of Section J the Settlement Agreement. Although these efforts should be expanded in the future, this data helped to justify the Facility's findings of compliance or noncompliance with specific provisions. The congruence between the results of the Facility's internal and this external review appears to derive from three inter-related factors, including: 1) AUSSLC had designed their newly formatted Quarterly Psychiatric Review documentation to directly address both the content and quality requirements of many of the provisions of Section J; 2) the Facility's internal review scoring process was also influenced by the content of this Quarterly Review document, which, as noted above, was specifically designed to address the content of specific provisions set forth in the Settlement Agreement; 3) the format for the new CPEs was designed to follow the format and content specified in the Settlement Agreement. Thus, the Facility's internal review would be influenced by whether these documents were present in an individual's record, or had not been completed yet. As will be discussed below, the presence or absence of these documents in the individual records also influenced the findings of this external monitoring review. Given that the Facility had only been able to complete the new quarterly review and CPE documentation for a portion of the individuals who receive psychotropic medication, some variation would be expected by chance differences in the specific individuals chosen for the internal review sample described above and the sample for this review. The composition of the Facility's sample was not specified beyond that it was a 20 percent randomly selected sample of individuals who were receiving psychotropic medication. In the future, the Facility's self-assessment process would benefit from integrating the internal monitoring efforts of the QA Department and the initiatives of the Psychiatry Department. The QA Department representative that attended the 11/17/11 meeting acknowledged his limitations in assessing the quality of certain clinical items. However, it should be possible for collaboration between the two Departments to produce a method that would utilize the resources of both. The Facility had included a number of action plans in its POI related to Section J. These addressed a number of important initiatives, including the allocation of resources to assist in the preparation of CPEs, implementing the new quarterly review format, developing and implementing desensitization plans, improving documentation about the efficacy of polypharmacy, ensuring coordination between psychiatry and neurology, and improving the consent process, including development and implementation of a side effect database. At the time of the review, these action plans were in various stages of implementation.
	Summary of Monitor's Assessment: The Psychiatry Department at AUSSLC had made progress in a number of areas concerning the provisions of the Settlement Agreement that relate to psychiatric services. The primary initiatives had been the formulation and completion of the Comprehensive Psychiatric Evaluations that complied with the content and quality specifications set forth in the Settlement Agreement. This process had begun at the time of the prior review. As noted at that time, the quality of the new CPEs that were reviewed was uniformly consistent, and met the standards set forth in the Settlement Agreement. The completion of these documents was very labor intensive, and the progress in completing these for all of the individuals who received psychotropic medication had been incremental. Currently,

	these CPEs had been completed for 37 (23%) of the 160 individuals who receive psychotropic medication. A complimentary process had been the development of new documentation for the Quarterly Psychiatric Reviews. This format, which averaged ten pages, but could be longer depending on the extent of the clinical information for each individual, was designed to correspond with the provisions of the Settlement Agreement that are specific to the appropriate use of psychotropic medication. These documents were also labor intensive. At the time of the review, the newly formatted Quarterly Psychiatric Review Forms had been completed for 81 of the 160 individuals (51%) who receive psychotropic medication. Collectively, the information contained in the CPEs and the revised Quarterly Psychiatric Review Forms directly related to ten of the 15 provisions in Section J of the Settlement Agreement. Thus, these were extremely important documents, and their completion for all individuals receiving psychotropic medication should be a priority for the Psychiatry Department. At the time of the onsite review, it was noted that the Psychiatric Specialty Nurse had been reassigned within the Medical Department. Thus, since the monitoring process began, the number of Psychiatric Nurses had declined, from five to two, resulting in a 60 percent reduction in nursing support. The three full-time Psychiatrists and one part-time Consulting Psychiatrist also continued to receive support from two Psychiatric Assistants. Although these combined resources should be sufficient, the Psychiatry Department should conduct a review of the psychiatrists' responsibilities and the corresponding time commitments. The planning for the Desensitization Plans for dental and medical procedures had proceeded, but as of yet, no actual plans had been implemented. The MOSES and DISCUS monitoring for the side effects of psychotropic medications had been carried out, as specified, for a relatively high percentage of the sample of individuals who receive psychotropic medication. However, the monitoring of the individuals who receive Reglan (which has side effects similar to those of antipsychotic agents) was significantly deficient. This finding is of greater significance than may at first appear, because the monitoring for the side effects of antipsychotic medication with the DISCUS (which had been performed by the Psychiatric Nurses) was due to transition the Unit RN Case Managers, who currently performed these assessments for those individuals who receive Reglan. Thus, it remained to be seen if the same level of DISCUS completion for the individuals who receive antipsychotic medication would be maintained following this transition. The Psychiatry Department had been actively addressing the issue of adequate risk versus benefit analysis related to the use of psychotropic medication, as well as the implication of this analysis for obtaining consent that was truly "informed." A specific multidisciplinary "Consent Committee" also had been developed to further refine this process, and progress in this area will be monitored in future reviews. In summary, the Psychiatry Department had made noticeable progress in addressing many of the provisions of the Settlement Agreement, but significant challenges remained.

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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-and-a-half years ago, and the Facility subsequently added two additional full-time Psychiatrists: Dr. Judi Stonedale and Dr. Nilima Mehta. Dr. Tushar Desai had also 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 and Adolescent Psychiatry, as well as Adult Psychiatry. All of the Psychiatrists had extensive experience working with individuals with intellectual and developmental disabilities (ID/DD), through their previous employment. 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. Three Psychiatric Nurses and two Psychiatric Assistants supported the Psychiatrists. However, the Psychiatric Specialty Nurse was scheduled to be assigned to a different position within the Facility in the near future. (This issue is discussed in more detail with regard to Section J.5 below.) The finding of substantial compliance with this section of the Settlement Agreement was based on the assessment of the individual psychiatrist's qualifications, which indicated that they were all certified by the American Board of Psychiatry and Neurology, and also had extensive clinical experience in the psychiatric treatment of individuals with ID/DD.	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.	As noted above, at the time of the review, the 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. Although the psychiatric diagnoses appeared in a number of sections of the individuals' records, the clinical justification that supported the validity of the diagnosis primarily appeared in the related sections of the CPEs and the Quarterly Psychiatric Reviews. (The latter documentation is discussed in detail with regard to Section J.13, because it is more pertinent to that provision). At the time of the prior review, the Facility had begun an 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 at that time examples of recent CPEs that adhered to the new	Noncompliance

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		format were only found for only 18 percent of the sample of 34 individuals who were receiving psychotropic medication at that time. The Department of Psychiatry maintained data related to their progress in completing the CPEs for those individuals who received psychotropic medication. Review of this document, which was dated 11/16/11, indicated that, since the initiative had begun, a total of 37 CPEs had been completed (23%) of the 160 of the individuals receiving psychotropic medication, and another 17 (11%) were in process. The latter category included drafts that were near completion, as well as those that had only just been started. Thus, this document indicated that documentation was either in process or had been completed for 54 of the 160 individuals receiving psychotropic medication (34%). The review of the records of 24 individuals who were receiving psychotropic medication indicated that seven contained a CPE that had been completed within the last 12 months, and met the content and quality standards set forth in the Settlement Agreement (29%). The specific records were those of Individual #238, Individual #445, Individual #183, Individual #355, Individual #332, Individual #33, and Individual #353. The records of Individual #291 also contained a CPE that complied with the specifications of the Settlement Agreement, but it was dated 3/30/10 and, thus, had been completed well over a year ago, and would need to be revised and brought up-to-date. Review of the CPE completion status data described above indicated that 10 of those that have been completed were presently over one year old. However, updating these documents should be a relatively simple straightforward process and, thus, it would seem to make more sense to primarily focus for now on completing new CPEs for those who do not yet have such an evaluation. These CPEs were found to be very detailed, ranging in length from 10 to 37 single-spaced pages, with an average of approximately 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 37 had been completed to date, with another 17 in process. In total, 160 individuals were receiving psychotropic medication. Also, as noted above, with regard to Individual #291, some of these that were completed over a year ago now required an annual update. Given the importance of these documents to successfully adhere to the provisions of the Settlement Agreement, their completion for those individuals who were receiving psychotropic medication should be a priority for the Psychiatry Department. In summary, the quality of the CPEs clearly met the standards set forth in the Settlement Agreement. The finding of noncompliance for this section related to the Facility's current	

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		inability to complete these evaluations for all of the individuals who were prescribed psychotropic medication at the AUSSLC.	
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 24 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. 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 Positive Behavior Support Plan (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 other words, they potentially were being used in the absence of adequate behavioral treatments or interventions, which could be construed as being "for the convenience of staff," who were not equipped to respond with the appropriate behavioral interventions. In addition, concerns related to the quality of PBSPs are discussed with regard to Section K.9 of the Settlement Agreement. The use of chemical restraint also could be construed as punishment, because it frequently involves the intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of chemical restraint is extremely important in differentiating between the necessary uses of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further investigate the use of mechanical restraint at AUSSLC, the following sample of chemical restraint data was reviewed: INDIVIDUAL # DATE TIME MEDICATION Individual #374 7/1/11 4:00 p.m. Zyprexa 10 milligrams (mg) and Ativan 2mg* Individual #30 8/2/11 6:25 p.m. Zyprexa 10mg IM Individual #325 8/17/11 4:05 p.m. Zyprexa 10mg IM Individual #109 6/20/11 5:56 p.m. Thorazine 25mg IM Individual #195 7/24/11 4:20 p.m. Zydis 10mg**	Noncompliance

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		*The route of administration was not identified for Individual #374. ** Zydis is a rapidly dissolving sublingual form of Zyprexa. The individual restraint data was reviewed for the presence and quality of six components of the documentation that the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. These sections, and the results of this review are as follows: 1. The information contained in the section of the form following the prompt to: "Describe events leading to behavior that resulted in restraint" was reviewed. This section of the documentation was left blank for Individual #30. The documentation was present for Individual #375, Individual #109, and Individual #195. However, the documentation for these individuals only described the overt behavior that necessitated the restraint, and not the "events" which precipitated this behavior. The corresponding documentation for one of the five individuals (20%), Individual #325, did adequately describe the antecedent events. 2. The section that followed the prompt to describe: "Interventions attempted to avoid restraint" also was reviewed. This section was left blank for Individual #375 and Individual #30. It was completed appropriately for, three individuals (60%), including Individual #109, Individual #195, and Individual #325. **3.** The portion of the documentation in which the physiological post-restraint monitoring was recorded was completed for all of the individuals in this sample (100%). 4. The face-to-face post-restraint debriefing was not present for Individual #375, but was completed for the other four individuals (80%). 5. The Facility had developed a form referred to as "The Administration of Chemical Restraint Consult." This document addressed a number of key steps regarding the administration of the chemical restraint process, but was completed for only two (Individual #30 and Individual #325) of the five individuals (40%). 6. The Chemical Restraint Clinical Review Form was completed for only one individual (20%), Individual #30. Thus, these essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of intramuscular medications was not fully completed for any of the five individuals in this sample. The documentation for Individual #323 contained all of the elements, except the Chemical Restraint Clinical Review Form. Accordingly, it was not possible to definitively reach the conclusion that chemical restraint was not being used for punishment at AUSSLC, and/or for the convenience of staff in responding to a difficult situation.	

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		The Facility was making progress with regard to the differentiation of maladaptive behaviors that were derived from a psychiatric disorder, as opposed to being related to environmental and/or behavioral factors. However more work in this area was needed. As noted above, the chemical restraint documentation was deficient, and without this, it was not possible to conclude that chemical restraint was not being inappropriately used for punishment or for the convenience of staff in some cases. Thus, the overall rating for this provision was that of noncompliance.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	The 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 indicated representatives were present from Psychiatry, Medicine, Pharmacy, Dental Services, and Psychology. The Lead Psychiatrist indicated that the team recently had approved a new format for the assessments upon which the individual Desensitization Plans would be developed. However, the Pre-Treatment Sedation Committee recently had decided that one more additional step was required before the plans could be implemented. This step was a task analysis for tooth brushing. This analysis now had been completed, and both the Lead Psychiatrist and the Director of Behavioral Services indicated during their respective interviews that the actual implementation of the initial plans should begin in the coming weeks. The dental task analysis format, revised on 6/8/11, and approved by the Pre-Treatment Sedation Committee on 6/22/11, outlined 12 steps, which proceeded from (#1) "Told about appointment. Record if became angry, refused, etc." to (#12) "allows a prophy cup (polishing cup) be used on teeth." The 12 steps were to be answered as either "Does (+)" or "Does Not (-)" along with comments. Given the length of time that it had taken to develop these plans, it would seem to make sense to begin the implementation phase, and then make any further modifications based on feedback from this process. 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 prior six months was as follows: MONTHS in 2011 — % APPTS. NO SEDATION REQUIRED — % APPTS. ORAL PRE-TREATMENT SEDATION REQUIRED — % APPTS. IV ANESTHESIA UTILIZED April — 76.5% — 4.7% — 18.8%	Noncompliance

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		May	89%	6.1%	4.9%	
		June	74.7%	9.3%	16%	
		July	69%	14.9%	16.1%	
		August	70.1%	9.1%	20.8%	
		September	67.6%	11.8%	20.6%	
		The Dental Services staff indicated that it was important to note that this data was reported on a per-appointment basis. For example, in May of 2011, 89 percent of dental appointments were accomplished without any pre-treatment sedation, 6.1 percent required oral pre-treatment sedation, and 4.9 percent utilized IV anesthesia. The observation that the data is reported on a per-appointment basis is significant, because 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 review of the Facility orders for pre-treatment sedation from 3/28/11 to 9/28/11 confirmed that during that time period the orders were uniformly for Lorazepam (Ativan) in a range from 0.5 milligrams to 1mg. These were conservative dosages, and during the 11/15/11 interview with the Director of Dental Services, she indicated that if standard conservative dosages of sedative medications were not effective, she would seek consultation with the Psychiatry staff and/or the Pharmacy. The Dental Pre-Treatment Sedation policy that was revised on 7/6/11 discussed the protocol for the interface with the Pharmacy around the ordering of both oral pre-treatment sedation, and the IV anesthesia in those situations where it was utilized. No specific mention was made of the post-administration physiological monitoring. The IV anesthesia monitoring was, naturally, very detailed. The Consultant, who actually administered the anesthesia, carried it out. The monitoring for the physiological effects of the oral pre-treatment sedation took place in three different settings. The medication was administered on the individual's residence approximately one hour before the dental appointment. Thus, the post-administration monitoring took place on the Living Unit and then transitioned to the Dental Office at the time of the appointment. After the work in the Dental Office was completed, each individual was transferred to the Infirmary for further monitoring, and then was released back to their residence at the discretion of the Infirmary Unit Nursing Staff. Therefore, in order to track the physiological monitoring, it was necessary to review data from three different sources: the individual's residence, the Dental Office, and the Infirmary. A more efficient means of monitoring in the post-administration stage would be to create a form that accompanies the individual throughout the whole process,			

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		as is done in some of the other DADS SSLCs. This would decrease the risk of omissions, and should facilitate communication between the different professional staff that interact with the individual during the course of their pre- and post-dental appointment experience. The topic of the physiological monitoring related to the use of pre-treatment sedation for dental appointments is discussed in more detail in Section Q of this report. As noted above, the Facility was devoting a great deal of time and attention to minimizing and monitoring the use of pre-treatment sedation for dental procedures. However, the documentation that detailed the utilization of pre-treatment sedation from 3/28/11 to 9/28/11 indicated that the majority of pre-treatment sedation at AUSSLC was utilized for medical appointments. The manner in which this data was organized made it difficult to actually compare the relative utilization rates of pre-treatment sedation for dental as opposed to medical procedures. For example, there was a discrete six-page listing of individuals who received pre-treatment sedation for dental procedures during this time period. However, orders were included for some dental procedures in the preceding 19 pages, which were primarily devoted to orders for pre-treatment sedation for medical procedures. As with the orders for pre-treatment sedation for dental procedures, the majority of the orders for medical procedures were for Lorazepam in either dosages of 0.5mg or 1mg. There were a few orders for 25mg of Benadryl or Atarax, which were benign dosages of these antihistaminic agents that also have sedative properties. Occasional orders were included for pain medications, such as Hydrocodone, but these were primarily for potentially painful procedures, such as the reapplication of wound dressings. The sedative hypnotic agent Chloral Hydrate was also utilized occasionally in the relatively low dosages of 500mg. Overall, the medications utilized appeared to be appropriate and were prescribed in moderate dosages. The issue of Pre-Treatment Sedation Plans for medical procedures was discussed separately with the Lead Psychiatrist, the Director of Psychological Services, and the Medical Director. No initiative was underway to develop plans for these procedures at this time, because the Facility continued to focus on the development and implementation of these plans for dental procedures. The physiological monitoring related to the administration of pre-treatment sedation for medical procedures was not discussed in the pre-treatment sedation policy, nor could a discussion be found in the minutes of the Pre-Treatment Sedation Committee that were reviewed. In the discussion with the Medical Director, it was noted that the issue of physiological monitoring after the administration of pre-treatment sedation for medical procedures was complicated by the fact that many of these appointments took place at external medical facilities, even though Facility nursing staff administered the medication at AUSSLC.	

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		The development of Pre-Treatment Sedation Plans for medical procedures, as well as the issue of physiological monitoring following the administration of pre-treatment sedation medication for medical procedures, would appear to be topics for the Pre-Treatment Sedation Committee to address in the near future. Thus, although the Facility had devoted a great deal of effort to the development of pre-treatment sedation plans, none of these plans had yet been implemented. In addition the use of pre-treatment sedation for medical procedures had not been reviewed or investigated. Accordingly the Facility was found to be in noncompliance with this provision of the Settlement Agreement.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	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. A total of 160 individuals were 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 submitted on 11/16/11. This indicated that the two full-time Staff Psychiatrists had caseloads of 54 and 63. The Lead Psychiatrist followed 31 individuals, and the Consulting Child Psychiatrist had a caseload of 25 individuals. These numbers totaled 173, but 160 individuals were receiving psychotropic medication. Because the numerical listing of the caseload distribution was received after the completion of the onsite review it was not possible to directly discuss this discrepancy with the Lead Psychiatrist. A number of recent changes had occurred in the composition of the Psychiatrists' caseloads related to changes in the distribution of individuals to different Living Units at AUSSLC, and this might have contributed to the discrepancy. During the remainder of the week, when the Consulting Psychiatrist was not present, the full-time Psychiatrists provided coverage for his caseload. The Consulting Psychiatrist also indicated that his caseload had been reconfigured so that it contained individuals who were relatively stable and, thus, there was less likelihood that the full-time Psychiatrists would have to respond to a crisis situation when he was not present. In addition to the Staff Psychiatrists, the Facility also employed three full-time Psychiatric Nurses and two full-time Psychiatric Assistants to help coordinate the psychiatric care of the 160 individuals who were receiving psychotropic medication. However, the Psychiatric Nurse Specialist position was scheduled to be transferred to the Medical Department to assist with overall compliance issues in the coming weeks. This reduction in staffing would reduce the total number of Psychiatric Nurse positions to two, representing a 60 percent reduction from the five that were in place at the time of	Substantial Compliance

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		the initial review. Thus, the total composition of the Psychiatry Department at AUSSLC would appear to have sufficient resources to meet this requirement of the Settlement Agreement, under normal operating conditions. However, as efforts were being made to achieve compliance with the Settlement Agreement, the Psychiatry Department had some additional responsibilities. Some of these would require increased initial effort that would diminish over time, while others were more ongoing in nature. As noted in the discussion of other provisions, the Psychiatry Department had begun two initiatives that directly related to the 15 provisions of Section J. These initiatives were the completion of CPEs (as discussed with regard to Section J.2), and the newly formatted Psychiatry Quarterly Review Forms (as discussed with regard to Section J.13). The Staff Psychiatrists independently indicated that it required 12 to 15 hours to complete the CPEs in order to meet the specifications of the Settlement Agreement. After reviewing a number of these documents, this appeared to be a reasonable estimate. Thus, completing both of these documents required a significant amount of time. In addition, the Psychiatrists had begun to attend the PST meetings for the individuals on their caseloads (as is discussed with regard to Section J.8). Accordingly, during the onsite review, a member of the Monitoring Team discussed with the Lead Psychiatrist the recommendation that the Department undertake a thorough review of the weekly time allocation of the Psychiatrists. The goal of the review should be to ascertain if there are a sufficient number of Psychiatrists and/or professional support services to meet the increased demands on the Psychiatrists' time allocation, particularly during the months that it will take to implement the important new initiatives described above. The finding of substantial compliance with this section of the Settlement Agreement was continued from prior reviews, because the Facility did employ a sufficient number of skilled psychiatrists to provide appropriate clinical services to the individuals who reside at AUSSLC.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	As indicated above, the Facility had developed an initiative to complete a thorough CPE for each individual receiving psychotropic medication, which they believed would meet the standards set forth in the Settlement Agreement. The review of the medical records of 24 individuals receiving psychotropic medication identified a recently completed CPA for seven of the individuals in the sample (29%). 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 37 individuals (23%) of	Noncompliance

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		the 160 individuals who were prescribed psychotropic medication. Data regarding the Facility's progress in completing the CPEs is discussed in further detail above with regard to Section J.2. The finding of noncompliance for this section of the Settlement Agreement related to the observation that the Facility had not been able to complete these evaluations for all of the individuals who were prescribed psychotropic medication.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The spreadsheet, which was updated on 10/1/11, listed the individuals who had been administered the Reiss Screen for Maladaptive Behavior from 5/13/08 to 9/1/11 (most recent date). Each of the Monitoring Team's past three reports included the results of an analysis of a distinct 20 percent sample of individuals who had been administered the Reiss Screening instrument. This methodology verified the accuracy of the data by comparing the information contained in the spreadsheet to a copy of the actual Reiss scoring sheet for each individual in the sample. Each of these prior reviews confirmed that the information in the spreadsheet was 100 percent accurate and, thus, a similar study was not repeated again this time. The prior review discussed problems with adherence to the portion of this provision that relates to completion of the CPEs for those individuals whose scores on the Reiss Screening instrument were above, or very near, the clinical cut-off score that should have prompted further psychiatric assessment. The current review focused on those individuals for whom the Reiss Screen had been administered since, or shortly before, the prior monitoring review. Since the last review, the Reiss Screen was not administered to individuals who were admitted to AUSSLC who were receiving psychotropic medication, because they were evaluated with a psychiatric evaluation instead of a Reiss Screen for Maladaptive Behavior. Each individual who had been administered the Reiss Screening instrument in the sample identified below also received a detailed Psychological Evaluation, which accompanied the Reiss Screening. The five individuals who had received an updated Psychological Evaluation and Reiss Screening within the timeframe described above were: <u>Individual #206</u>: Psychological Evaluation 5/6/11 Reiss Screen administered 4/22/11 (Total Reiss score = 10.0) CPE completed by Psychiatry Department 7/26/11 <u>Individual #99</u>: Psychological Evaluation 7/28/11 Reiss Screen administered 8/2/11 (Total Reiss score = 22)	Noncompliance

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		CPE completed by Psychiatry Department 9/2/11 Individual #52: Psychological Evaluation 8/3/11 Reiss Screen administered 8/3/11 (Reiss score = 1.0) Individual #153: Psychological Evaluation 10/4/11 Reiss Screen administered 8/25/11 (Reiss score = 4.0) Individual #362: Psychological Evaluation 8/31/11 Reiss Screen administered 8/31/11 (Reiss score = 2) The Psychological Evaluations for these individuals indicated both the Reiss Screen and the related Psychological Evaluation were performed due to a change in their status that raised the question of they would benefit from psychotropic medication. The one exception to this was Individual #153, whose Psychological Evaluation indicated that both the Reiss Screening and Psychological Evaluation were done in preparation for their upcoming "Personal Development Plan." The review of the Reiss spreadsheet dated 10/1/11 indicated that five of the individuals' Reiss Screens dated back to 2008, and a further 11 were performed in 2009. During the interview with the Director of Psychological Services, he indicated that a plan was being developed for each individual to have a complete psychological reassessment every three to five years. The Reiss Screen would be a part of that reassessment for individuals who were not receiving psychotropic medication, because those who were receiving psychotropic medication would have been evaluated by the Psychiatry Department. The specific individual material described above would indicate that the Reiss Screen was being performed for individuals who had a change in status that raised questions about the potential utility of psychotropic medication. Further, those individuals whose scores on the Reiss Screen were above the clinical cut-off score had subsequently received a thorough CPE in a timely manner. Thus, the planned psychological reassessment of individuals who had not been evaluated in a number of years, which will include an updated Reiss Screening evaluation for those who do not receive psychotropic medication, should address this provision in the future. The Facility's status in this regard will be assessed in future monitoring reviews. As noted above, the Facility had been monitoring individuals who had a change in their status that might have required the introduction of psychotropic medication through the	

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		use of the Reiss screening instrument, as well as a psychological evaluation. Those individuals whose scores on the Reiss screen were above the clinical cut-off score did receive a CPE by a Psychiatrist in a timely manner. The Facility had developed a plan to reevaluate all of those individuals who had not been assessed with the Reiss Screening instrument in several years. The finding of noncompliance is related to the lack of progress with that initiative. In addition, although those individuals who were reevaluated with the Reiss screen had experienced a change in their psychiatric status, it was not clear that the Facility had a mechanism in place to identify individuals with a potential change in their psychiatric status in a uniform, systematic manner to ensure that all such individuals would be reevaluated.	
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 of Psychology Services. These interactions also were 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 analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. The observations of the Psychiatry Clinics and the related documents that were produced illustrated the active collaboration between the two disciplines. A persistent deficit in this collaboration, in terms of case formulation, was the co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional 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 delineated clearly. Developing a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision, would provide a mechanism to address this problem. This subject is also relevant to Section J.9 of the Settlement Agreement, where it is discussed in more detail. This provision also contains the terminology "integrate pharmacological treatments with behavioral and other interventions through combined assessments and case formulation." The primary disciplines that attended the Psychiatry Clinics were nursing, psychiatry, psychology, direct support professionals, and the Qualified Developmental Disabilities Professional. Disciplines such as Occupational Therapy and Physical Therapy were, of course, not able to attend the Psychiatry Clinics, because there were several every week. However, these disciplines often did attend the individual PSP meetings. The Psychiatrists (or a member of the Psychiatry Department) also had begun to attend these meetings. The attendance at these meetings, as well as the content, was reviewed for the	Noncompliance

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		24 individuals in this sample. This review indicated that a member of the Psychiatry Department had attended a recent individual PSP meeting for 15 of the 24 individuals (63%). The specific records that contained this documentation were those of: Individual #361, Individual #370, Individual #412, Individual #238, Individual #445, Individual #355, Individual #160, Individual #332, Individual #350, Individual #353, Individual #390, Individual #291, Individual #175, Individual #357, and Individual #406. A Psychiatric Assistant attended six of these reviews, the Attending Psychiatrist attended eight, and a Psychiatric Nurse attended one. Although the Psychiatry Department had begun an initiative to attend the individual PSP meetings, the documentation from these meetings did not fully reflect the psychiatric aspects of the individuals' treatment in any of the records reviewed (0%). There was a discussion of the psychological treatment plan and reference to the individuals' psychotropic medication, but no information was included that reflected the psychiatric aspects of their presentation, nor was any mention made of the contributions to the meeting that were made by the member of the Psychiatry Team that attended the meeting. As a result, integration of psychiatric supports with other supports was not evident in the individuals' PSPs. The rating of noncompliance for this section of the Settlement Agreement relates to this finding, and the observation that although a member of the Psychiatry Department had begun to attend the individual PSP meetings, this still had not been accomplished on a regular basis for the majority of individuals who were prescribed psychotropic medication.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of psychiatric and 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 24 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 related to the degree to which behaviors that were identified as being targets of a psychotropic medication also were 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 behavioral factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested 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.	Noncompliance

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	ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The review of the sample of the records of 24 individuals receiving psychotropic medication identified 15 individuals (62%) 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 #361, Individual #271, Individual #412, Individual #445, Individual #350, Individual #74, Individual #60, Individual #374, Individual #33, Individual #360, Individual #165, Individual #357, Individual #183, Individual #160, and Individual #59. The records of the following nine individuals (38%) contained an adequate differentiation of the behaviors that were present due to biological factors, as opposed to behavioral determinants: Individual #238, Individual #355, Individual #332, Individual #353, Individual #291, Individual #175, Individual #406, Individual #370, and Individual #156. The differentiation of the maladaptive behaviors that the individual presented with was directly related to the concluding requirement of this provision that addresses: "the need to minimize the need for psychotropic medication to the degree possible." The misidentification of behaviors as being linked to a psychiatric disorder that were in reality related to behavioral/environmental factors would increase the risk that the individual would be prescribed psychotropic medication that was not necessary. In addition, the individual might not receive the behavioral supports that would be appropriate to address the problem. The Director of Psychiatric Services had modified the format for the Quarterly Psychiatric Reviews so 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. The newly formatted Quarterly Review documents had now been incorporated into the records of many of the individuals who receive psychotropic medication. While this information addressed this provision, there continued to be a deficit with regard to extent to which this information was incorporated into the psychological sections of the record, such as the PBSP. As noted above with regard to Section J.8, this information also had not been incorporated into the PSP documentation. Accordingly the Facility was found to be in noncompliance with this section of the Settlement Agreement. However, the Psychiatry Department's progress in addressing these issues through the development of the new Quarterly Psychiatric Review documentation was noted.	
J10	Commencing within six months of the Effective Date hereof and with	This provision of the Settlement Agreement addresses the risk versus benefit considerations related to the use of psychotropic medications for a specific individual.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	The discussion of these factors primarily occurred in the Human Rights Committee section of the record, as well as the PBSP. Prior reviews of these sections of the records 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 Director of Psychiatric Services had made extensive revisions to the form that was utilized to document the Quarterly Review of the individuals' clinical status. This initiative was discussed in the Monitoring Team's prior report. The revised format contained a section related to empirical individualized risk versus benefit analysis. This analysis took into account both the potential and realized side effects of the prescribed medication, the morbidity associated with the symptoms of the psychiatric disorder that was being treated with these medications, and the degree to which the prescribed medications had been effective in diminishing the symptoms and maladaptive behaviors that were related to the underlying psychiatric disorder. The composition of the newly formatted Quarterly Reviews, as well as the Facility's status with regard to the completion of this documentation for all individuals who receive psychotropic medication, is discussed with regard to Section J.13. The current review found that there was an adequate discussion of the risk versus benefit analysis in 15 of the 24 individual records contained in the review sample (63%). However, this information was not yet fully reflected in the other sections of the individuals' records that discuss the risk versus benefit analysis. Specifically, the HRC review of the risk-benefit analysis related to the approval of the use of psychotropic medication was not significantly different from that described above for prior monitoring reviews. The Facility had developed a Consent Committee to address these issues and representatives from the Human Rights Department did participate in those meetings. This is also further discussed with regard to Section J.14. Thus, a challenge for the Psychiatry Department will be to complete the risk versus benefit analysis for those individuals who have not yet undergone this analysis, and further, to facilitate the incorporation of this valuable information into the other sections of the individuals' records that rely on these formulations. The finding of noncompliance for this section was related to the continued deficiencies in this area. However, as noted above, progress in reforming the risk-benefit assessment process had begun.	
J11	Commencing within six months of	AUSSLC had continued its policy of reviewing every individual whose psychotropic	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.</td><td>medication regimens met the criteria for polypharmacy on a monthly basis. The "Monthly Psychiatry Polypharmacy Reduction Meeting Notes" were reviewed for the prior six months. The Staff Psychiatrists, Director of Pharmacy Services, Clinical Pharm. D., Psychiatric Specialty Nurse, and the Medical Director attended these meetings, which either a Psychiatric Nurse or Psychiatric Assistant facilitated. The Meeting Notes indicated that the group engaged in a detailed case-by-case discussion of individuals whose medication regimens met the criteria for polypharmacy. A member of the Monitoring Team observed the November meeting of this Committee, which occurred on 11/17/11. 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 11/17/11 meeting provided a summary of the Facility's progress toward minimizing polypharmacy as of 11/9/11. This data indicated that eight individuals (as compared to nine at the time of the prior review) were receiving two or more medications from the same class, and 31 individuals (as compared to 40 at the time of the prior review) were receiving three or more medications, regardless of class. The total number of individuals who met the criteria for polypharmacy was 32, as seven 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 = 1;
▪ Three medications = 24;
▪ Four medications = 7;
▪ Five medications = 0; 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 2010. Tabular representation of that data is as follows:

<table>
<tr><th>DEFINITIONS OF POLYPHARMACY</th><th>JULY 2010</th><th>OCT. 2011</th></tr>
<tr><td>Number of individuals receiving two or more medications from the same class</td><td>13</td><td>8</td></tr>
<tr><td>Number of individuals receiving three or</td><td>49</td><td>31</td></tr>
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more medications regardless of class or indication		
Number of individuals receiving both I & II	12	7
Total number of individuals on polypharmacy	50	32
Total number of individuals receiving psychotropic medication	184	160
Percentage patient population receiving psychotropic medication	27%	20%

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. The discussions of the remaining 32 individuals whose psychotropic medication regimens continued to meet the criteria for polypharmacy, which took place during the 11/17/11 Polypharmacy Committee Meeting, indicated that the psychiatric team believed that many of these medications were essential for the individuals' stability. The 20 percent of individuals receiving polypharmacy also included individuals who have been admitted from the community within the last year while receiving multiple psychotropic medications.

The Facility clearly had made a great deal of progress in reducing unnecessary polypharmacy. This effort also was reflected in the observations of the Psychiatric Clinics that took place during the onsite review, because it was evident that the question of whether all of the individuals' medications were necessary was a topic of discussion at each review that was observed. Recognition of the Facility's efforts to effectively reduce polypharmacy could be enhanced by dividing the individual data on the remaining individuals who receive polypharmacy into the following four categories: 1) those that were admitted from the community on polypharmacy within the last year, with notation of the progress that had been made since their admission in reducing the number of medications they receive; 2) delineation of those individuals who the Psychiatry Department believed were receiving psychotropic medication regimens that met the criteria for polypharmacy, but the continuation of these medications was necessary for their continued stability. This information also should include the empirical evidence that supports these opinions; 3) the individuals who continue to receive polypharmacy, but there is a plan in place to challenge those medications that might not be necessary. This information should include data on current and projected tapering schedules for specific medications that might not be necessary; and 4) those individuals (if any) that do not fit into one of the prior three categories. The compilation of the data in the

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		categorical format described above should provide a more accurate representation of the Facility's progress in reducing polypharmacy. It also would provide the Facility with information it needs to determine if additional action is needed for specific individuals. As noted above, the Psychiatry Department had made substantial progress over a number of years in reducing the use of polypharmacy with psychotropic medication at AUSSLC. The current finding of noncompliance for this provision primarily relates to the lack of empirical documentation that those individuals who continued to receive medication regimens that met the criteria for polypharmacy would experience deterioration in their psychiatric status, if any of their existing medications were removed. In the absence of such justification, plans would need to be included for reducing the polypharmacy, or justifying its efficacy. The recommendations above with regard to the reformatting of the data that the Psychiatry Department maintains for these individuals are directly related to this observation.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	This provision of the Settlement Agreement mandates 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. An important component of this was also the latency between the time that the nurse completed the exam, and subsequently, the prescribing physician reviewed the documentation. The review of the sample of the records of 24 individuals who were prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months, was present for all but the following four individuals (followed by most recent MOSES completion date): Individual #271 (3/16/11), Individual #412 (3/11/11), Individual #355 (3/4/11), and Individual #59 (2/11/11). Thus, the MOSES was completed on schedule for 20 of the 24 individuals (83%). The records of 20 individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for all but four individuals. Those individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #412 (3/11/11 - 3/23/11), Individual #355 (3/4/11 - 3/24/11), Individual #332 (6/29/11 - 7/19/11), and Individual #165 (7/21/11 - 8/5/11). Thus, the MOSES evaluations were reviewed in a timely manner for 20 of the 24 individuals (83%). The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 22 individuals (Individual #353 and Individual #332 were not receiving antipsychotic	Noncompliance

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		medication and, thus, monitoring with the DISCUS was not required) identified documentation that the DISCUS was current, and had been performed quarterly for the past year for all but the following four individuals (date of most recent DISCUS evaluation): Individual #271 (6/24/11), Individual #412 (3/11/11), Individual #355 (6/13/11), and Individual #59 (5/20/11). Thus, the DISCUS had been performed as specified for 18 of the 22 individuals (82%) who required this monitoring. Those individuals whose records documented that there was a significant delay between the date the nurse completed the DISCUS evaluation, and the prescribing physician reviewed and signed it (latency before review) were as follows: Individual #271 (6/24/11 - 7/7/11), Individual #355 (6/13/11 - 7/19/11), Individual #33 (10/8/11 - 11/1/11), and Individual #156 (10/27/11 – 11/18/11). Thus, the prescribing physician reviewed the DISCUS in a timely manner for 18 of the 22 individuals (82%). 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 also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS for those individuals who were receiving antipsychotic medication. Thus, a Psychiatric Nurse would monitor an individual for side effects if they were receiving Reglan as well as an antipsychotic 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 and who were not also prescribed psychotropic medication. The following sample of four individuals (100% of those who fit the above criteria) was selected, and included: Individual #454, Individual #62, Individual #269, and Individual #200. The review of the records of these individuals for documentation related to the MOSES indicated that the examination had been performed as required, and the prescriber had reviewed and signed them in a timely manner for Individual #62, and Individual #269. There was no MOSES contained in the requested documentation for Individual #454, or Individual #200. Thus, these evaluations had been completed and reviewed as expected for 50 percent of the sample.	

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		The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review indicated that these evaluations were completed as specified and reviewed in a timely manner for only one of the four individuals (25%) (i.e., Individual #62). No DISCUS evaluations were included for Individual #269. There was a gap of five months (5/20/11 to 10/19/11) in between DISCUS evaluations for Individual #454, and a gap of over two weeks for the review and signature by the prescribing physician. The most recent evaluation for Individual #200 was dated 5/20/11, and there was a gap of six months between that evaluation and the prior (12/29/10) assessment. The prescriber had not reviewed the 12/19/10 assessment until weeks after the evaluation was completed. The discrepancy between the results on the completion of the MOSES and DISCUS for the individuals receiving psychotropic medications, and those who were prescribed Reglan and no traditional psychotropic medication was significant. As noted above, a Psychiatric Nurse completed the DISCUS for those individuals who received psychotropic medication, whereas the individual's RN Case Manager completed the DISCUS for those who received only Reglan. An RN on the Unit completed the MOSES for both groups of individuals. On 8/1/11, DADS changed this policy, so that on a quarterly basis, the RN Case Managers now would complete the MOSES/DISCUS as part of their Quarterly Nursing Assessments. This could not be delegated to other nursing personnel. A policy to parallel this change in protocol was not available for review, but was documented in an internal DADS e-mail, dated 7/12/11. This policy should be fully implemented by the time of the next monitoring review, and its effects on the timely completion and review of the MOSES and DISCUS evaluations will be assessed at that time. During the prior review, the subject of the latency between the completion of the MOSES and DISCUS and the date the prescribing physician reviewed and signed them was discussed with the Psychiatry Department. At that time, staff 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. 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 may require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. The Facility might want to proactively monitor the degree to which the MOSES and	

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		DISCUS are being carried out as scheduled to assess for any decrease in the frequency of the monitoring following the transition. The Department should also ensure that the RN Case Managers have the necessary training to correctly perform the DISCUS evaluation. The finding of noncompliance for this section of the Settlement Agreement primarily relates to the deficiencies in the completion of these important side effect monitoring tools, prescribing physicians' timely review of information, as well as the lack of a method to document that any sudden significant changes in an individuals' side effect status was immediately reported to the prescribing physician.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	This provision of the Settlement Agreement addresses processes that are essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the records of a sample of 24 individuals (15%) receiving psychotropic medication indicated that a description of the specific symptoms that would support the psychiatric diagnosis of record could be identified for 22 individuals (92%). Those individuals for whom this documentation could be located included the following: Individual #361, Individual #271, Individual #412, Individual #238, Individual #445, Individual #183, Individual #355, Individual #160, Individual #332, Individual #370, Individual #33, Individual #374, Individual #60, Individual #350, Individual #353, Individual #291, Individual #165, Individual #175, Individual #357, Individual #406, Individual #156, and Individual #360. The individual records in which this documentation could not be identified were those of Individual #59 and Individual #74. The records for these individuals did not contain adequate justification for the psychiatric diagnosis. Specifically, the documentation for Individual #59 and Individual #74 did not contain either a recent CPE or the newly formatted Quarterly Review Form, and there was insufficient information in the remainder of the record to justify the diagnosis for Individual #59. Additional documentation in the record was not consistent with the diagnosis for Individual #74. The prior review found that 56 percent of the records contained adequate justification for the psychiatric diagnosis of record. However, at the time of that review, it was noted that documentation of the symptoms that substantiated the psychiatric diagnosis were often found in different sections of the record, and were not present in a coherent manner. The current review found that this documentation could be located in the following two related sources in the record: 1) the newly formatted CPEs, in those records that contained them; and/or 2) in the revised Quarterly Psychiatric Clinic review	Noncompliance

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		forms. The completion list for the Quarterly Review Forms, dated 11/11/11, indicated that the revised Quarterly Review Forms had been completed for 81 of the 160 individuals who receive psychotropic medication (50%). The newly formatted psychiatric Quarterly Review Forms were 11to12 pages in length and contained sections that discussed the diagnosis (including the DSM criteria for that diagnosis), past psychotropic medication trials (including the rationale for any changes in dosages and medication), the non-psychiatric medications that the individual received, pertinent laboratory and/or other medical information, the results of the most recent MOSES and DISCUS side effect monitoring, results of the mental status examination performed by the Attending Psychiatrist at the time of the review, a discussion of the specific symptoms or diagnosis that each psychotropic medication was prescribed to address, and an empirically-based risk versus benefit analysis for each prescribed medication. The tables that reported the frequency of the monitored behaviors were augmented by graphs that the Psychology Department supplied. These graphs provided dose response data for the prescribed psychotropic medication with phase lines to demarcate major environmental or pharmacological changes. In order to adequately complete these newly formatted Quarterly Reviews, the Attending Psychiatrist relied upon three appendices, which the Psychiatry Department produced internally to assist in this process. A copy of this information was requested during the onsite review. The requested documentation was submitted on 11/17/11, and contained the following Appendices: Appendix A "Determining Side Effect Risk," Appendix B "Determining Behavioral Severity," and Appendix C "Determining Efficacy." Thus, the three Appendices primarily related to the risk versus benefit determination for each psychotropic medication. 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 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 persistent problem with the documentation in AUSSLC records was the dual identification of a specific behavior as being both a "target behavior" of the prescribed psychotropic medication, and also as being present on a learned or behavioral basis. This issue is discussed in more detail with regard to Section J.9. This provision also addresses the question of the efficacy of the prescribed psychotropic medication. In 10 of the 24 records reviewed of individuals receiving psychotropic medication (42%), empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. These records were those of the following individuals: Individual #361,	

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		Individual #271, Individual #238, Individual #370, Individual #406, Individual #445, Individual #291, Individual #355, Individual #160, and Individual #353. 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 rationale for these medication changes. This database also would provide additional historical data points with which to make comparisons of current frequencies that would enable the Psychiatric Treatment 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 Psychiatrist reviews individuals who are receiving psychotropic medication. This review of a sample of the medical records of 24 individuals indicated that Quarterly Reviews were performed as specified in this provision on a uniform basis 100 percent of the time. Documentation also was present to show that the Psychiatrist had directly observed the individual in conjunction with this review. The Psychiatry Department had made progress in several of the requirements that are specified in this section of the Settlement Agreement. Much of this progress was related to the completion of the CPEs, and new the newly formatted Quarterly Review documentation for those individuals who were receiving psychotropic medication. As noted elsewhere in this report, this documentation had still not been completed for all of the individuals who were prescribed psychotropic medication.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the	The review of the Rights/Consents sections of the medical records for the sample of 24 individuals who were receiving psychotropic medication indicated that 16 individuals (67%) had a Guardian of the Person. Those individuals who did not have a guardian relied on the Facility Director to review the material concerning risk versus benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The review of the individual records indicated that consents for the use of psychotropic medications had been obtained in a timely manner for all of the individuals in the sample. However, as noted below, there were significant deficiencies related to the consent process that raised concerns about the degree to which these consents were truly "informed." As indicated with regard to Section J.10 of the Settlement Agreement, the risk-benefit	Noncompliance

#	Provision	Assessment of Status	Compliance
	medications or restrictive procedures and shall identify associated risks.	analysis that was contained in the Psychiatry section of the record demonstrated considerable improvement in the description and quantification of both the benefits and side effects of the prescribed psychotropic medication. However, this improvement did not carry over to the documentation contained in the Human Rights section of the record, and/or the information utilized to provide the necessary information to the individual who provides consents on the behalf of the individual. These discussions did not contain any reference to the probability that these beneficial effects of the medication would be actually 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 generic listing of side effects, which did not include a discussion of the frequency with which those side effects occur in the general population, as based on published data. The above-referenced systemic deficits in the risk versus benefit discussion made it difficult, if not impossible, for a guardian or the Facility Director to render a truly informed consent regarding the use of psychotropic medication. The Psychiatry Department was aware of these deficits, and had participated in the formation and ongoing conduct of an inter-departmental committee to address the consent process for psychotropic medication at AUSSLC. The minutes generated from those meetings were requested, and the Facility submitted them on 11/17/11. These minutes corresponded to the meetings of this committee that were held on 7/14/11, 8/8/11, and 9/30/11. Although not all of the members were able to attend every meeting, the attendance section of the minutes indicated that the composition of this committee included the Lead Psychiatrist, two full-time staff Psychiatrists, the Director of Behavioral Services, the Assistant Director of Behavioral Services, the Human Rights Officer, as well as another representative from the Human Rights Office, the QDDP Coordinator. The minutes of these meetings indicated that the Facility was aware of the deficits in the current consent process for psychotropic medication, and quoted excerpts from prior monitoring reports related to Sections J.10 and J.14, which primarily related to this process. An outgrowth of this committee's work had been the development of a new protocol for the consent process for psychotropic medication. This protocol was not dated, but was submitted on 11/17/11. The protocol was formatted as a flow sheet, which began with the recommendation of a new psychotropic medication, and concluded with the initiation of that medication, once the necessary consents were received. The protocol was quite detailed and recognized somewhat different pathways for those individuals who had a Guardian, as opposed to those who did not, although the key elements related to obtaining a truly informed consent were identical for both groups.	

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		The review of the minutes of the meetings of this committee, as well as the proposed protocol described above, indicated that AUSSLC was aware of the deficits that are inherent in the current consent process and was taking steps to eliminate those inadequacies. As described above, the Psychiatry Department had made progress in developing a new format that should greatly enhance the risk-benefit analysis, as it relates to the use of psychotropic medication. However, no mechanism was yet in place to ensure that this information was incorporated into the other aspects of the consent/human rights approval process. A committee had been established to facilitate that integration. As a result of the current deficiencies, a finding of noncompliance has been made. Future reviews will assess the degree of progress that the Facility has made in integrating the information obtained from the new risk-benefit analysis process into the other aspects of the consent process.	
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.	In order to address this provision of the Settlement Agreement, the Psychiatrist began attending the Neurology Clinics so that they could be present to discuss the individual's care with the Neurologist. The Lead Psychiatrist indicated that this interaction was documented via a note in the individual's record. 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 the Psychiatrist had made a corresponding note in the Psychiatry section of the record that made reference to the Neurology Consultation. Neurology Consultation Notes were located in the Consultation section of the record for the following seven individuals: Individual #355, Individual #74, Individual #353, Individual #357, Individual #156, Individual #406, and Individual #370. In order to determine if adequate consultation had occurred between the Consulting Neurologist and the Attending Psychiatrist, the Neurology Notes were assessed for reference to the individual's psychotropic medication, as well as other aspects of the individuals' psychiatric status. The existence of a corresponding reference to the Neurology Consultation in the Psychiatry section of the record also was assessed. The documentation that the Psychiatrist had attended the Neurology Clinic and verified this with a descriptive note in the individual's record was verified for all seven	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		individuals in the sample who had received a Neurological Consultation in the prior year. The Neurology Notes also referenced the psychotropic medications. The Neurology section of the record was not present in the sections of the record that were supplied for Individual #370, although this section was part of the standard record review document request. However, there were detailed notes in both the Psychiatric Progress Notes, and the corresponding Psychiatric Clinic Notes that documented Neurology Consults on 3/7/11 and 6/27/11. During this period, an increase in the individual's seizure frequency was discussed, and changes were made to the individual's anticonvulsant medications. The rating of substantial compliance for this section of the Settlement Agreement is related to the findings that the psychiatrists had begun to regularly attend the neurology clinic appointments for the individuals for whom they were clinically responsible. In addition, the related documentation indicated that that they had engaged in a process to coordinate the use of those medications that were utilized for both neurological and psychiatric purposes.	

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

1. The completion of CPEs that meet the content and quality requirements of the Settlement Agreement should be a priority for the Psychiatry Department. (Sections J.2 and J.6)
2. AUSSLC should complete the documentation that they have developed to justify and monitor the administration of chemical restraint. This documentation should be completed uniformly for all individuals who receive chemical restraint in a timely manner. (Section J.3)
3. The physiological monitoring related to the use of pre-treatment sedation for dental procedures should be more streamlined, which including consolidation of the information within one record that would then follow the individual throughout their dental experience. (Section J.4)
4. The Pre-Treatment Sedation Plans for dental procedures should be implemented, with any future modifications being based on the results of this experience. (Section J.4)
5. The Facility should address the development of Pre-Treatment Sedation Plans for medical procedures, as well as the physiological monitoring following the use of pre-treatment sedation for medical procedures. (Section J.4)
6. In order to ensure compliance with Section J overall, the Psychiatry Department should undertake an analysis of the Psychiatrists' time commitments to ascertain if there are sufficient resources in place in order to provide quality care to the individuals who receive psychotropic medication, and also to complete the additional documentation that is necessary to adhere to all of the provisions of the Settlement Agreement. (Section J.5)
7. The Facility should adhere to the plan developed by the Psychology Department to provide psychological reassessment, including the Reiss Screening instrument for individuals who have not been evaluated with the Reiss Screen in several years. (Section J.7)
8. Individuals' annual PSPs should include a description of the psychiatric aspects of that individual's Treatment Plan, as well as the psychological considerations. (Section J.8)
9. The Psychiatry Department should complete the risk versus benefit assessment tool that was contained in the newly developed Quarterly Review documentation for all individuals who receive psychotropic medication. (Section J.10)
10. The risk versus benefit analysis that is contained in the revised psychiatric quarterly review documents should be incorporated into the Human

Rights review process, as well as the Informed Consent documentation. (Section J.10)

11. In order to clearly identify individuals for whom additional action is needed, the Facility should divide the individual data on the remaining individuals who receive polypharmacy into the following four categories: 1) those that were admitted from the community on polypharmacy within the last year, with notation of the progress that had been made since their admission in reducing the number of medications they receive; 2) delineation of those individuals who the Psychiatry Department believed were receiving psychotropic medication regimens that met the criteria for polypharmacy, but the continuation of these medications was necessary for their continued stability. This information also should include the empirical evidence that supports these opinions; 3) the individuals who continue to receive polypharmacy, but there is a plan in place to challenge those medications that might not be necessary. This information should include data on current and projected tapering schedules for specific medications that might not be necessary; and 4) those individuals (if any) that do not fit into one of the prior three categories. The compilation of the data in the categorical format described above should provide a more accurate representation of the Facility's progress in reducing polypharmacy. (Section J.11)
12. The Facility should proactively monitor the degree to which the MOSES and DISCUS side effect evaluations are being carried out as specified following the transition of the DISCUS monitoring from the Psychiatric Nurses to the RN Case Managers for the individuals who receive antipsychotic medication. (Section J.12)
13. The Facility should ensure that the RN Case Managers have received the necessary training to correctly carry out the DISCUS evaluations. (Section J.12)
14. The Psychiatry Department should devise a reliable method to document that any significant changes in the MOSES and DISCUS evaluations were immediately reported to the Attending Psychiatrist. (Section J.12)
15. The justification for the efficacy of the individuals' psychotropic medication should be accompanied by empirical data, as well as subjective observations. (Section J.13)
16. The effort to complete a Quarterly Psychiatric Review in the newly revised format for every individual who is prescribed psychotropic medication should be a priority for the Psychiatry Department. (Section J.13)
17. The Facility should implement the recommendations of the Consent Committee with regard to the revisions to the consent process for psychotropic medications. (Section J.14)
18. The Psychiatry Department and the QI Department should coordinate their respective internal auditing efforts to utilize the resources of both Departments. (Facility Self-Assessment)
19. The Facility should continue to expand its use of internal monitoring data, as well as data from other sources to identify areas in need of improvement, as well as to substantiate its compliance findings. As this analysis identifies problematic areas, corrective action plans should be developed and implemented, as appropriate. (Facility Self-Assessment)

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: Plan of Improvement, dated 11/2/11; Self-Assessment; Settlement Agreement Cross-Referenced with ICF-MR Standards; Psychology Staff Roster, updated 11/8/11; Copies of staff certifications/licenses; Vita of Director of Behavioral Services; Positive Behavior Support Observation form; Minutes from 6/7/11 and 8/1/11 meetings of Data Collection Work Group; Home Supervisors Meeting Agenda, dated 9/23/11; E-mail correspondence regarding 788 environmental modifications from Malika Pritchett to Vira Benson, dated 11/3/11; AUSSLC Specialty Home Proposal for Individuals Diagnosed with Autism Spectrum Disorder, dated 10/19/11; AUSSLC Psychological Evaluation Template and sample; Psychological Assessment Appendix Guideline for Minimums; AUSSLC Monthly Progress Note – Counseling; PSP Addendum Meeting template; AUSSLC Counseling Treatment Plan sample; Positive Behavior Support Plan, Safety Plan for Crisis Intervention Progress Note and Psychiatry Clinic Monthly Review template; Positive Behavior Support Plan template; Positive Behavior Support Curriculum Outline; Positive Behavior Support Workbook Exercises; Mastery Skills Checklist; Defining Behavior and Charting Behavior Changes outline; Restraint Checklist Activity, Restraint Checklist, Restraint Checklist Instructions, Restraint Checklist Routing Checklist 2011, and Restraint Documentation Guidelines and Responsibilities for Licensed Healthcare Professionals – Condensed Version; Sample Positive Behavior Support Plan, Safety Plan for Crisis Intervention, and ABC Data Sheet; Code Red Assistance Flowchart and Guidelines for Direct Care Staff; Minutes from Competency-Based Training Work Group Meetings, on 6/15/11, 6/22/11, 6/28/11, 6/30/11, 7/1/11, 7/13/11, and 8/2/11; Psychological and Behavioral Services Unit Orientation Training; ABC Data Sheet Exercise #1; Observation Notes Activities #1 and #2; Restraint Checklist Activity #1; Stay Close Role-Play Scenarios; Redirection-Reinforcement-Replacement Behavior; General Prevention Procedures; PBSP Competency Check – In Situ Training; Positive Behavior Support, New Employee Orientation; E-Mail correspondence from Jose Levy to Vira Benson regarding full-time equivalents (FTEs), dated 9/21/11; Section K Action Plan; on AUSSLC SLP Psychology Project Meeting minutes, dated 8/24/11 and 10/19/11; o Psychology Department meeting minutes, including: 5/10/11, 5/17/11, 5/24/11, 5/31/11, 6/7/11, 6/14/11, 6/21/11, 6/28/11, 7/5/11, 7/12/11, 7/19/11, 7/26/11, 8/2/11, 8/16/11, 8/23/11, 8/30/11, 9/6/11, 9/13/11, and 9/27/11; o Human Rights Committee meeting minutes, including: 5/26/11, 6/2/11, 6/9/11, 6/16/11, 6/23/11, 6/30/11, 7/14/11, 7/21/11, 7/28/11, 8/4/11, 8/11/11, 8/18/11, 8/25/11, 9/8/11, 9/15/11, 9/22/11, 9/29/11, and 10/6/11; o External Peer Review Notes [Lubbock SSLC (LBSSLC) and Austin SSLC], including: 7/1/11, 8/5/11, and 9/9/11; o Internal Peer Review Notes, including: 5/3/11, 5/10/11, 5/17/11, 5/24/11, 5/31/11,

	6/7/11, 6/14/11, 6/21/11, 7/1/11, 7/5/11, 7/12/11, 7/26/11, 8/9/11, 8/16/11, 8/23/11, 8/30/11, 9/13/11, 9/20/11, and 9/27/11; o Behavior Therapy Committee meeting minutes, including: 6/6/11, 6/13/11, 6/20/11, 6/27/11, 7/11/11, 7/25/11, 8/1/11, 8/8/11, 8/15/11, 8/22/11, 8/29/11, 9/12/11, and 9/26/11; o Alphabetical List of Individuals with a PBSP, updated 11/14/11; o Antecedent-Behavior-Consequence (ABC) Data Sheets for: Individual #183, Individual #351, Individual #353, Individual #325, Individual #78, Individual #246, Individual #284, Individual #30, Individual #277, Individual #427, Individual #199, Individual #97, Individual #326, Individual #380, Individual #140, Individual #159, Individual #118, Individual #194, Individual #33, Individual #405, Individual #389, Individual #19, and Individual #189; o Replacement Behavior Data Sheets for: Individual #183, Individual #351, Individual #353, Individual #325, Individual #78, Individual #246, Individual #284, Individual #30, Individual #277, Individual #427, Individual #199, Individual #97, Individual #326, Individual #380, Individual #140, Individual #159, Individual #118, Individual #194, Individual #405, Individual #389, Individual #19, and Individual #189; o ABC Data Sheets for the week of the onsite review for: Individual #73, Individual #188, Individual #266, Individual #96, and Individual #219; o Positive Behavior Support Plan, Progress Notes (6/11 to 8/11) for: Individual #351, Individual #353, Individual #78, Individual #246, Individual #284, Individual #199, Individual #326, Individual #140, Individual #159, Individual #118, Individual #194, Individual #33, and Individual #19; o Positive Behavior Support Plan, Progress Notes (7/11 to 9/11) for: Individual #277, Individual #389, and Individual #189; o Positive Behavior Support Plan, Progress Notes (6/11 to 7/11) for: Individual #405; o Positive Behavior Support Plan, Progress Note (6/11) for: Individual #380; o Positive Behavior Support Plan, Progress Note (7/11) for: Individual #30; o Master list of individuals receiving counseling services, dated 9/27/11; o AUSSLC Counseling Treatment Plans for: Individual #175, Individual #160, Individual #154, Individual #424, Individual #158, Individual #320, Individual #11, and Individual #7; o AUSSLC Monthly Progress Notes – Counseling for: Individual #175 (6/11 to 8/11), Individual #160 (5/11 to 8/11), Individual #154 (5/11 to 8/11), Individual #424 (5/11 to 8/11), Individual #77 (7/11 to 9/11), Individual #291 (5/11 to 9/11), Individual #158 (5/11 to 8/11), Individual #320 (5/11 to 8/11), Individual #11 (7/11 to 8/11), and Individual #7 (5/11 to 9/11); o Positive Behavior Support Plans for: Individual #183, Individual #175, Individual #353, Individual #325, Individual #406, Individual #246, Individual #180, Individual #357, Individual #284, Individual #93, Individual #421, Individual #30, Individual #23, Individual #122, Individual #283, Individual #326, Individual #380, Individual #208, Individual #395, Individual #159, Individual #77, Individual #80, Individual #99,

	Individual #60, Individual #296, Individual #194, Individual #33, Individual #350, Individual #202, Individual #19, Individual #74, Individual #344, Individual #444, Individual #195, Individual #219, Individual #56, Individual #370, and Individual #361; o List of individuals with a completed FBA, updated 10/1/11; and o Psychological Evaluations for: Individual #273, Individual #333, Individual #374, Individual #49, Individual #82, Individual #326, Individual #159, Individual #130, Individual #292, Individual #99, Individual #296, Individual #194, Individual #33, Individual #165, Individual #360, and Individual #109. ▪ **Interviews with**: o Jose Levy, Director of Behavioral Services, on 11/17/11; o JoAnn Villasana, Human Rights Officer, on 11/17/11; and o Psychology Staff, including Jamison Maris, Lakisha McKenzie, Malika Pritchett, and Andrea Von Briesen, on 11/17/11. ▪ **Observations of**: o Restraint Reduction Committee meeting, on 11/14/11; o Behavior Therapy Committee meeting, on 11/14/11; o Psychology Department meeting, on 11/15/11; o Clinical Care Committee meeting, on 11/16/11; o Human Rights Committee meeting, on 11/17/11; o Residence 501, Residence 729, Residence 732 Eagle, Residence 772, Residence 779 Hummingbird, Residence 779 Phoenix, Residence 792 Roadrunner, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; o Workshops 503, 527, and 544; o Day Habilitation Centers 510, 512, 533, and 775; o Chapel; o Computer Lab; o Personal Focus Assessment meeting for Individual #73, on 11/15/11; and o Personal Support Plan meeting for Individual #357, on 11/16/11.
	Facility Self-Assessment: A review of the Facility's Plan of Improvement for Section K indicated that there was not consistent agreement between the Monitoring Team's findings and the Facility's self-assessment. In one of 13 areas, both the Facility and the Monitoring Team found that the Facility was in substantial compliance with the Settlement Agreement. Specifically, with regard to Section K.2, the Director of Behavioral Services met the specified qualifications. However, the Facility also found that it was in compliance with Section K.3, which required the implementation of a peer review system. The Monitoring Team did not agree with the Facility's assessment that it was in compliance with this provision. Steps had been taken to address other areas of the Settlement Agreement. The Facility's POI provided some narrative, which described some of these steps. However, the POI included minimal data, and where data was included (e.g., regarding numbers of progress notes completed timely), it largely addressed the

	presence or absence of items as opposed to the quality of supports provided. Based on what was written in the POI, the Facility had not used the data to any great extent to identify problems, and develop and implement solutions. The only example of this for Section K of the Settlement Agreement was with regard to data collection for target and replacement behaviors. For Section K.4, the POI indicated that self-assessment activities had identified a problem with data collection, and a meeting had been held between the Psychology Department and the ADOP. As a result, Home Supervisors were retrained, and they were to retrain their staff using a train-the-trainer model. Few details were provided about the sample used to draw the conclusion, or the training that was done as an attempt to address the issue. However, this was a step in the right direction. Unfortunately, no follow-up was provided in the POI to illustrate if improved outcomes had been attained. As the Facility's self-assessment process evolves, it is essential that a set of data points, which could be gathered through a variety of methods (e.g., data collection, monitoring, etc.), be established and used to identify strengths and weaknesses of the supports provided. The Facility should use this information to identify areas needing attention, and develop and implement plans to address deficiencies. Such plans should include expected outcomes, which if not met, should result in modification to the corrective action plan. Action plans were developed to address external peer review, writing PBSPs so that they can be easily understood and implemented, training direct support professionals, establishing treatment integrity, and improving the competencies and knowledge of Psychology Department staff. At the time of the review, these action plans were in various stages of implementation. All were important priorities for the Psychology Department.
	Summary of Monitor's Assessment: As noted in the Facility's Plan of Improvement, efforts had continued to meet the requirements of the Settlement Agreement. One additional staff member had obtained certification from the Behavior Analyst Certification Board. As a result, in addition to the Director of Behavioral Services, three associate psychologists were Board Certified Behavior Analysts. With the exception of one associate psychologist, all other master- and doctoral-level staff had completed at least one course in pursuit of certification. The Facility had made significant gains in developing both internal and external systems of peer review. Internal peer review continued through the weekly meetings of the Behavior Therapy Committee (BTC). Through affiliation with Lubbock and El Paso State Supported Living Centers, monthly external peer review had been established. The Facility had begun completing updated assessments of cognitive abilities and adaptive behavior skills. Other areas remained seriously out of compliance with the provisions of the Settlement Agreement. Data collection remained an area with significant problems. In spite of efforts to train home supervisors who would then train direct support professionals, analysis of data reflected errors, missing data, and poor compliance with data collection guidelines. As noted following each visit, this is particularly concerning, because clinical decisions are made based upon this inaccurate and unreliable data.

	Very few functional behavior assessments had been completed since the last visit. This assessment provides the foundation for a strong behavior support plan, and should be a priority for any individual who displays problem behavior. This is particularly true for individuals whose behavior has worsened or for those who have displayed a poor response to treatment. As noted in the past, behavior support plans continued to lack comprehensive preventative and antecedent strategies, reflected ineffective teaching strategies to develop functionally equivalent replacement behaviors, and identified poorly designed reinforcement systems. When new behavior support plans were developed or revisions were made to current plans, the timeline for necessary consents was inefficient and resulted in delays to plan implementation. Lastly, limited progress had been made with regard to competency-based training of staff on all components of individual behavior support plans. Changes had been made to New Employee Orientation. Additionally, psychology staff had met several times to address the development of a competency-based training model. A revised template for providing on-the-job feedback was created. However, this had been an exceptionally slow development process.

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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.	An updated roster of Psychology Department staff was provided for review. As of 11/8/11, there were a total of 12 master's level associate psychologists. Ten of these 12 were assigned individual caseloads, one was providing counseling services, and one was identified as the department educator. In addition to the Director of Behavioral Services, three of these associate psychologists were Board Certified Behavior Analysts. Six of the nine remaining associate psychologists and the doctoral level Assistant Director of Behavioral Services had completed at least one of the required courses in Applied Behavior Analysis offered through the University of North Texas. Two other associate psychologists were enrolled in the first course. Seven psychology assistants supported these associate psychologists. Additional information included on the roster indicated that there were four vacancies (i.e., one administrative psychology assistant, one psychology assistant, and two associate psychologists). Staff are commended for their continued efforts in obtaining certification. The Facility and State are also commended for the support provided to these individuals. Consideration is again encouraged for support for bachelor level psychology assistants who are interested in pursuing credentialing as a Board Certified Assistant Behavior Analyst. This is particularly relevant as these are the individuals whose jobs require them to spend time in the residences, training and assisting direct support professional staff. The Facility was rated as being in noncompliance with this provision, because the	Noncompliance

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		professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	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. Mr. Levy continued to develop guidelines for required assessments and resulting plans in an effort to ensure consistency among all members of the Psychology Department. The feedback he provided, as evidenced by peer review activities, encouraged quality work from his staff. During the onsite, staff interactions that the Monitoring Team observed were positive and mutually respectful. Because he met the qualifications outlined in the Settlement Agreement, the Facility was found to be in substantial compliance with this requirement.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Since the last visit, the Facility had continued to provide internal peer review with regard to Structural and Functional Assessment Reports (SFAR), Positive Behavior Support Plans (PBSP), and Safety Plans for Crisis Intervention (SPCI). Staff continued to use the rubrics that had been developed to provide structured feedback on all elements of the SFAR, PBSP, and SPCI. However, staff should include specific written feedback so that staff are reinforced for components of the assessment or plan that were completed skillfully, and are provided specific suggestions for revisions to the assessment or plan as necessary. Every effort should be made to not only evaluate the level of compliance to identified standards, but also to use this review as an opportunity for continued training of all staff involved. In addition to the completed scoring rubrics, there was evidence of written feedback on draft documents. This written feedback revealed thoughtful and constructive peer review. Since the last visit (effective 10/3/11), the responsibility of internal peer review has been returned to the Behavior Therapy Committee. This resulted in the dissolving of the Peer Review Committee, allowing for a better use of staff time. The Behavior Therapy Committee continued to meet weekly. The Facility had provided a list of individuals with behavior support plans (updated 11/14/11). Information provided included the individual's annual PSP date, date(s) of revisions to the plan, and BTC date(s). This information was completed for 206 individuals, 193 of whom had annual PSP dates in 2011. While all had BTC dates identified, the data for 76 of these individuals suggested that BTC had reviewed their behavior support plans prior to the annual PSP date. Fifty-nine of the 76 had BTC review dates from 2010, 15 had review dates from 2009, and two had review dates from 2008. This information suggested that behavior support plan review was not current. While	Noncompliance

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		the tracking of BTC review is important and useful information, particularly as it pertains to timeliness of plan approval and implementation, staff should ensure that information provided is accurate and current. The Facility also had succeeded in establishing an external peer review through affiliations with both Lubbock and El Paso State Supported Living Centers. Since July, AUSSLC and LUSSLC had conducted peer review each month via teleconference. The written feedback provided by staff from LUSSLC proved to be comprehensive and appropriate to the peer review process. Additionally, the Facility reported that beginning in September, monthly external peer review had taken place with El Paso SSLC via e-mail. This is a very promising practice. The staff at the Facility are encouraged to present cases in which the individual has experienced regression or has been very resistant to the interventions applied thus far. This should prove to be the most beneficial use of external peer review. With ongoing evidence of regularly scheduled internal and external peer review, and the development of a Facility-specific policy, substantial compliance with this component of the Settlement Agreement will be achieved.	
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.	According to the Facility's Plan of Improvement, psychology staff completed training and implemented a new data sheet in June. This ABC data sheet was designed so that staff could record the following information: a) date; b) start and end time of the behavioral episode; c) the number of times the behavior occurred; d) the location where the behavior occurred; e) the activity in which the individual was engaged just before the behavior occurred; f) the events one minute before the behavior occurred; and g) the staff behavior following the behavioral incident. A review of completed ABC data sheets for 23 individuals was conducted. Problems were noted throughout. First, the month and year was consistently recorded on the data sheets for only 14 of 23 individuals (61%). As one reviews data sheets, it is essential that this information be provided. Next, although the Director of Behavioral Services indicated that staff were to record antecedents and consequences for each behavioral episode, the documents reviewed consistently revealed data recorded across an eight hour shift. This resulted in the ABC data having little utility, because one cannot determine the location, activity, immediate antecedent, or immediate consequence for any particular behavioral occurrence. Lastly, staff notes, where provided, were not always dated. A review of accompanying replacement behavior data sheets for 22 individuals revealed missing data for all individuals in the sample. The missing data could indicate that replacement behavior training did not occur, or that data was not recorded following	Noncompliance

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		training. During the onsite review, on multiple occasions, individuals were observed engaging in problem behavior. ABC data sheets were requested to determine whether these incidents were documented. The findings are reviewed below: ▪ During his Personal Focus Assessment meeting held on 11/15/11, Individual #73 was observed displaying repeated slaps to his face. The member of the Monitoring Team recorded 53 occurrences of this behavior over a 17-minute period. When the ABC data were reviewed, there was no recording of this behavior on this date. ▪ On 11/14/11, Individual #188 was observed in his day habilitation setting. Between 11:30 a.m. and 11:35 a.m., he was observed hitting his head 14 times. There was no record of this self-injurious behavior on this day on his ABC data sheet. ▪ At 8:07 a.m. on 11/15/11, Individual #266 was observed hitting her head five times. A review of her ABC data sheet reflected no record of this behavior. ▪ On 11/15/11, Individual #96 was observed in her residence. At 4:25 p.m., she repeatedly slapped her face. She was told not to do this, and then was given a hand held massager. There was no record of this behavior on her ABC data sheet. ▪ While in his residence, on 11/17/11, Individual #219 was observed hitting his head at 11:40 a.m. Self-injury was not an identified target behavior included on his ABC data sheet. ▪ During the onsite review, Individual #172 and Individual #137 were observed engaging in self-injurious behavior. However, when copies of their behavior support plans and ABC data sheets were requested, the Monitoring Team was informed that neither had a Positive Behavior Support Plan and therefore, there were no data recorded on problem behavior. Additional concerns were raised for Individual #137 as a staff member told her "No, let's not do that," and then asked her whether she wanted her graham cracker. By providing food contingent upon self-injury, the staff member could be strengthening this response. A total of 52 monthly progress notes related to the Positive Behavior Support Plan were reviewed for 19 individuals. For 16 individuals, progress reports for three consecutive months were provided. For two individuals, one progress report was provided, and for one individual, two reports were provided. The following summarizes the findings from this review: ▪ Progress reports for 15 of the 19 (79%) individuals were signed. This represented a marked improvement since the last review. ▪ Reports for 18 of the 19 individuals (95%) included a review of the individual's	

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		progress or lack thereof. The one exception was Individual #33 who had recently been admitted to the Facility. Of these 18 reports in which progress was assessed, 15 reports included comparison numbers in the narrative. This provided the reader with a clear understanding of the rationale for a designation of progression, regression, or stable. In all of the reports, graphs included a table with monthly totals for identified target behaviors. ▪ Although data was reported in all notes in which progress was assessed, either through graphic display and/or narrative reporting, problems with data collection were noted for 11 of the 19 individuals (58%). This clearly raises concerns regarding the accuracy and reliability of the data that was being used not only to assess progress, but also to guide clinical decisions. ▪ A total of 28 graphs were presented across the sample of 19 individuals. The number of measures presented in one graph ranged from a low of two to a high of 11. The mean number of measures presented in the same graph was 5.86. Only seven of the 28 graphs (25%) depicted three or fewer measures. This resulted in graphs that were very difficult to read. Medications were presented in bar graph format, and target problem behaviors and replacement behaviors were presented in line graph format. With so much information presented in most of the graphs, it was difficult to discern improvement or worsening in any particular target behavior. As noted in the past, graphic presentation by the month prohibits an analysis of response to intervention. ▪ For 16 of the 19 individuals (84%), recommendations were made to continue with the current behavior support plan or behavioral services. This recommendation was made even when behavior improvement was not observed, or when contributing factors were identified that could have been addressed in the PBSP. ▪ Finally, the monthly reports for 13 of 19 individuals (68%) included a header regarding emergency medication, and those for 15 of 19 (79%) individuals included a header regarding programmed restraint. It should be noted that Individual #33 had this information included in the first two months of reporting, but this was deleted by the third month. Therefore, she was identified as an individual for whom this information was not included. As noted previously, 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. Additional concerns specific to individual reports are addressed below: ▪ Under Quality of Implementation, Individual #353 was noted to continue to	

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		greet staff, spell words, and "make animal sounds congruent to prompts." As the first two behaviors listed were appropriate, it appeared that the third behavior was also considered acceptable. It is not appropriate for a 51 year-old to be making animal sounds. ▪ The July review for Individual #78 noted "progression" for mouthing and "stable" for pica. However, the numbers reported indicated worsening of both behaviors. This same report noted that increased occurrences of both self-injury and mouthing might have been due to louder environmental conditions in her residence. There were no corresponding recommendations made regarding antecedent management when environmental noise levels increase. ▪ The progress notes for Individual #246 revealed areas of concern. In June, a recommendation was made to consider the role of pain as it related to problem behavior. There was no indication that this matter had been addressed two months later. In June, active treatment services were noted to be poor. Two months later, the recommendations included the following statement: "Engagement would greatly improve the quality of (individual's) life." While both these variables are appropriate considerations, corresponding action should be taken in a timely manner. ▪ One report for Individual #33 noted "implementation of the BSP occurs intermittently at best." While training of staff was recommended, it appeared that problems with plan implementation continued. Based upon document review, observation, and staff interviews, it was clear that data collection remained a problem. As noted in the previous report, the ABC data sheet allowed for the recording of potentially helpful information, however, it remained a cumbersome tool to use. Again, staff should consider a simple recording of behavioral occurrences by direct support professionals. Professional staff could gather information on antecedents and consequences during direct observation in the home, work, and/or leisure environments frequented by the individual. Data accuracy and reliability remained compromised. As psychology staff continue their efforts to design data collection systems that are manageable and valid, they are encouraged to recruit the assistance of direct support professionals. These individuals are far more familiar with environmental factors that might impede the recording of target behaviors as they occur. 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 outlined in the Settlement Agreement. It is imperative that this issue be addressed, because clinical decisions continue to be made based upon the data that is reported. Unless this data is accurate, changes might be made that are not warranted and/or potentially harmful, and ineffective treatment, behavioral and/or psychopharmacological, might continue.	

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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 16 Psychological Evaluations were reviewed. Fourteen of the 16 evaluations (88%) followed a standard format that included the following elements: a) reason for referral; b) sources of information; c) relevant background information; d) medical information; e) psychiatric information; f) results of current and previous evaluations; g) structural functional behavior assessment; h) diagnostic impression; i) findings and discussion; and j) recommendations. A summary of the findings from this review of 16 evaluations is provided below: ▪ Fifteen of the 16 evaluations (94%) reviewed biological, psychiatric, and learned behaviors. The exception was the report for Individual #360, which did not follow the format described above. ▪ Fifteen of the 16 evaluations (94%) reflected current (within three years) measures of adaptive behavior. The exception was Individual #296, whose Inventory for Client and Agency Planning (ICAP) was completed in 2007. The psychologist had recommended that an updated ICAP be completed. ▪ Recent (2011) assessment of psychopathology was identified in the reports for eight individuals (50%), and current (2011) dementia screenings were identified in the reports for two individuals (13%). ▪ In nine of the 16 evaluations (56%), the specific indirect and direct methods used in determining behavior function were identified. These included the Questions About Behavioral Function (QABF), the Functional Assessment Screening Tool (FAST), the Functional Assessment Interview Form (FAIF), and direct observation. ▪ In these nine evaluations where functional behavior assessment tools were identified, summaries of results were provided in six reports (67%). ▪ All of the evaluations (100%) noted medical and psychiatric conditions that might impact and contribute to problem behaviors. ▪ All of the evaluations (100%) included information relating to setting events and motivating operations, all addressed antecedent and consequent conditions, all identified suggested behavioral function, and all provided recommendations for replacement behaviors. ▪ The quality of the information gained through Functional Behavior Assessment (FBA) varied across reports. The evaluations for Individual #273 and Individual #296 offered good examples of FBAs that included indirect and direct assessment, reviewed setting events associated with both appropriate responding and targeted problem behaviors, and provided a clear summary of the antecedents and consequences to problem behavior. Again, staff should ensure that careful assessment of conditions related to problem behaviors and other psychological needs is completed for identified individuals. Assessment should be ongoing to ensure that current variables are identified and addressed. As changes in the rate and/or severity of problem behaviors are observed,	Noncompliance

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		additional assessment should be conducted to ensure that current variables are identified and addressed.	
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.	Since the last visit, the Facility had introduced a new data sheet designed to gather information regarding the antecedents and consequences within a behavioral episode. While staff are commended for these efforts, it was clear from both observation and document review that data collection continued to be a challenge. Data were not recorded accurately and many occurrences of problem behavior went unrecorded. The accuracy and reliability of the data collected and used to guide treatment decisions was considerably compromised. Specific problems are identified and reviewed in detail in Section K.4 of this report. Staff are again encouraged to work with the direct support professionals to design data collection systems that will capture needed information and be manageable within the context of other job responsibilities. Until a system is developed that will ensure the collection of accurate and reliable data, the Facility will remain out of compliance with this requirement of the Settlement Agreement.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	The Facility provided a spreadsheet listing the individuals served and information regarding the most recent psychological assessment and the date on which the assessment was revised and reviewed. A total of 349 individuals were listed. A review of this information was conducted. The results are outlined below: ▪ A comprehensive assessment was noted for 274 of the 349 individuals listed (79%). This assessment was identified as "NA" for 30 of the 75 individuals for whom this information was not provided. It was unclear why an assessment would be not applicable or not appropriate for the identified individuals. ▪ An Inventory for Client and Agency Planning or some other measure of adaptive behavior was listed for 339 individuals (97%). All had been completed within the previous three years, with the exception of assessments for Individual # 296 and Individual #288. ▪ An assessment of cognitive abilities was identified for 53 of the 349 individuals (15%). Of these 53, the date of assessment was current (i.e., within the previous five years) for only 12 individuals (23%). ▪ A Functional Behavior Assessment had been completed for 91 of the 349 individuals. With 207 individuals identified with Positive Behavior Support Plans, this suggested that assessment of possible behavior function was completed for only 44% of the individuals. Further concerns were raised, because many of these assessments were quite dated (e.g., 40 had been completed three or more three years earlier), and the variables related to problem behavior had quite possibly changed. A note was included in the document the Facility provided indicating that the exact number of assessments could not be provided, because the new Comprehensive	Noncompliance

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		Psychological Assessment might include measures of cognitive abilities, information related to functional behavior assessment, etc. It will be essential for the Facility to track all assessments to ensure that the individuals served have current evaluations to help guide their habilitation and support. Since the last onsite review, two individuals were admitted to the Facility. The psychological assessments completed for one of these individuals was reviewed. Within 30 days of her admission, a report was written for Individual #33 in which historical information was summarized, including a review of past standardized assessments. Targeted problem behaviors were identified and defined, observations since admission were reviewed, hypotheses regarding behavioral function were proposed, and recommendations for further action were provided. Just over two months following admission, a more in-depth psychological evaluation was completed for Individual #33. Standardized assessments completed included a screening and comprehensive measure of cognitive ability, a measure of psychopathology, and an adaptive behavior scale. Although indirect and direct assessments were identified as components of a functional behavior assessment, the results of these assessments were not reviewed in detail. Much of the information related to setting events, antecedents, consequences, proposed functions, functionally equivalent behavior, and preferences was similar to that included in the first report. A more in-depth review of information gained through the FBA would have strengthened the report and the resulting behavior support plan.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	The Facility continued to employ one psychologist, a licensed professional counselor, to provide individual counseling services to identified individuals. As of 9/27/11, ten individuals were scheduled to receive individual counseling once per week from either the counselor and/or her practicum student. Six of the 10 (60%) were also scheduled to have weekly "check-ins" in the residence regarding homework assignments. Documents provided for review included the Counseling Treatment Plan for eight individuals These plans included the intake date, the reason for referral, diagnostic information, and identified goals and objectives. 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. As noted in the previous report, objectives were not described in observable and measurable terms, making it difficult to determine how an individual's progress would be objectively assessed (e.g., Individual #175 was to "remain awake and present" in her therapy session; Individual #77 was learning to "complete	Noncompliance

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		assigned homework promoting self-awareness, self-soothe skills, and self-care;" and for Individual #320, criteria for mastery was identified as "60% or higher"). Monthly Progress Notes for all 10 individuals were also reviewed. Each progress 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. While an individual's progress or lack thereof was noted using a variety of terms (e.g., progression, limited progress, regression, no progress, or maintenance), it was unclear how this was determined. In the process summary, comments related to an individual's attendance, timely arrival to appointments, completion of homework assignments, and general affect/behavioral presentation were provided. With the exception of occasional reference to the number of diary entries or homework assignments completed (e.g., Individual #160, Individual #291, and Individual #158), data specific to identified objectives was not provided or reviewed. For Individual #424 and Individual #320, there were occasional statements regarding the improvement or worsening of behaviors targeted for reduction in the individual's PBSP. Overall, progress notes did not provide an objective analysis of the individual's response to therapy. Additional concerns are reviewed below: ▪ Concerns noted in the counseling progress notes included problems related to transportation, staff forgetting appointments, or noncompliance with homework assignments. For Individual #160, the last problem was solved when the psychology intern was assigned to help her with her homework. The intern had also addressed confusion regarding counseling sessions by establishing an appointment calendar. Staff are commended for these specific steps they took to address problems as they arose. It might also be helpful to provide reminders 24 hours in advance, and to re-arrange the location of appointments when transportation problems arise. ▪ Staff also had not provided rationales for the discontinuation of services whenever this was recommended (e.g., Individual #291, and Individual #160). In addition, other strategies were not attempted prior to discharging individuals from counseling, when current methods were not effective (e.g., assigning another counselor, identifying additional motivational factors, etc.). ▪ At times, the approaches used were not flexible enough to meet the needs of the individuals. For example, Individual #291 was expected to make diary entries for homework. The progress note for May indicated that he and the counselor disagreed on the best format to use for this activity. Rather than solving the problem by working together to create a new format, the note indicated that the counselor preferred to continue with the current format. Some negotiation and compromise is recommended. Additional feedback is provided below regarding the draft revision of the counseling	

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		treatment plan for Individual #7 that was included in the Section K Presentation Book: ▪ Under baseline presentation, the individual was described as "pushy, annoying, manipulating, and willful in his interactions with staff and his peers." Staff should avoid language that reflects negative connotations. Rather, the individual's behavior should be described in observable and measurable terms. ▪ The counseling objectives were unclear. In one, the individual was expected to "one-mindfully participate" for 15 minutes. While a definition of this behavior was later provided, the objective measure to determine progress remained unclear. Further, he was to engage in deep breathing exercises once a week, but the behavior was not defined, nor was there an identified duration of deep breathing. Similarly, he was to "construct 'I' statements," but the required number of statements and their frequency was not identified. Lastly, reference was made to "coping skills of distraction, self-soothe, relaxation, and acceptance." Each of these should be defined in observable and measurable terms so that objective assessment of progress can take place. 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 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.	Positive Behavior Support Plans for 39 individuals were reviewed. The format was consistent across all plans and remained as described in previous reports. Review of these plans resulted in similar findings as previously reported. Therefore, each section will be addressed briefly below: ▪ All but three plans (92%) indicated development or revision within the previous 12 months. The plans for Individual #183, Individual #283, and Individual #99 were dated 9/8/09, 9/8/10, and 5/25/10, respectively. Additionally, the plan for Individual #183 and Individual #344 were incomplete. ▪ The plan for Individual #296 and Individual #370 were both identified as drafts, even though they had been developed on 6/2/11 and 7/27/11, respectively. As documents were prepared for review at the end of October, it is concerning that these plans had not yet been approved. ▪ All of the plans (100%) included a rationale for the plan within the text of the document. ▪ Historical information was included in all 39 of the PBSPs. This information often included birth history and a summary of educational and placement services prior to admission to the Facility. Staff should carefully review plans to ensure that only relevant information is included. In several cases, extensive review of medication trials was included. Examples included the plans for Individual #23, Individual #180, Individual #326, and Individual #204. As noted previously, this information is not relevant to the current behavior support plan,	Noncompliance

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		increases the length of a document that staff are expected to read, and detracts from the action guidelines that staff are to implement to help improve behavior. This information is likely in the clinical record should a review of medication be necessary. ▪ Operational definitions of all or most targeted problem behaviors were included in every PBSP. An exception was found in the PBSP for Individual #370 as one of her target behaviors, vocalizations/tic behavior, lacked a definition of the behavior in observable and measurable terms. "Continuous vocalizing behavior" provided no parameters regarding the beginning or end of a behavioral episode, types of sounds included, voice volume, or observable tics. ▪ All but one of the PBSPs (97%) included treatment expectations written in objective and measurable terms. The behavioral objectives provided for Individual #246 were not clear. In three of four targeted problem behaviors, the measure was intervals, but the length and number of possible intervals was not identified in the objective. ▪ While all of the plans included hypothesized behavioral function, only 22 (56%) referenced a completed Functional Behavior Assessment. The PBSP for Individual #296 included a description of conditions associated with appropriate behavior. This is helpful when outlining preventative strategies in the PBSP. Staff should ensure that each individual with targeted problem behavior has a current FBA. ▪ The completion of a systematic preference assessment was noted in only one of the 39 PBSPs (3%). Identification of potential reinforcers is critical in promoting positive behavior change. ▪ The plans for six individuals (15%) included guidelines for staff to provide attention regularly for the absence of problem behavior (e.g., Individual #325, Individual #421, Individual #93, Individual #380, and Individual #202), or a token contingent upon the absence of problem behavior (e.g., Individual #194). The remaining 33 PBSPs (85%) did not identify sufficient schedules of reinforcement. ▪ While all of the plans noted setting events, motivating operations, and antecedent conditions that contributed to the occurrence of problem behavior, the quality of the resulting preventative strategies varied across plans. Some plans (e.g., Individual #180, Individual #23, and Individual #296) included simple preventative strategies, such as consistent schedules, warnings of changes in routine, avoidance of loud and crowded environments, and limited physical contact. An example where prevention was not addressed was found in the plan for Individual #444 who engaged in fecal smearing after defecating. There was no recommended schedule for frequent check and change. ▪ Although replacement behaviors were identified in 38 of 39 PBSPs (97%), the degree to which these were functionally equivalent to the targeted problem	

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		behavior varied from plan to plan. An example where the identified replacement behavior (i.e., waiting calmly) did not meet the hypothesized function of the targeted behavior (i.e., access to tangibles and escape) was found in the plan for Individual #56. An example where the identified replacement behavior referenced staff behavior (i.e., provide activities to keep the individual busy) was found in the plan for Individual #60. Replacement behaviors should often involve an appropriate form of communication that the individual uses to obtain the same outcome as the targeted behavior. Staff should review these for each individual with a PBSP. ▪ Guidelines for training replacement behaviors were found in 35 of the 39 PBSPs reviewed (90%). Again, the quality of these training guidelines varied widely across plans. Many plans included training schedules that resulted in one learning opportunity per shift or per day (e.g., Individual #122, Individual #380, and Individual #361). Others had even less frequent training opportunities (e.g., Individual #175, Individual #77, and Individual #56). Individual #353 was given the opportunity to demonstrate her replacement behavior only after staff asked her if she wanted a break, and once she had become upset. This would likely reinforce the targeted behavior that staff were attempting to eliminate. The same reinforcer was to be applied for prompted and unprompted replacement behaviors exhibited by Individual #208 and Individual #219. Without differential reinforcement applied to independent choice-making versus prompted choice-making, these individuals will likely not learn to spontaneously display the behavior. ▪ Strategies applied when targeted problem behavior occurred were very similar across all 39 documents. In 25 of the 39 staff instruction guidelines (64%), 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 PBSP, consequences should be individualized to ensure an outcome of positive behavior change. ▪ Staff directions were included in all of the plans (100%). These provided a summary of the identified problem behaviors, preventative strategies, and steps to take when the problem behavior occurred. ▪ Ten of the 39 plans (26%) were signed. This was an improvement over the last review. It is recommended that all plans be signed, indicating the author and any supervisory staff who provided review. A review was conducted of the minutes from the Human Rights Committee meetings held between 5/26/11 and 10/6/11. A listing of members present revealed that for eight of	

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		18 meetings, a psychologist was not in attendance. These meetings included discussion regarding PBSPs, sedation and/or restraint for dental procedures, restrictive devices, safety plans, level of supervision due to problem behaviors, or questions regarding behavioral function. As issues addressed at the HRC meeting often relate to behavior support and/or safety plan consents and restrictive procedures, it is important that the individual's psychologist be present. The Facility also should ensure that a health care or medical provider is in attendance to address medication-related questions. At the time of the onsite visit, the HRC Officer explained that meetings are held as long as three members are present, one of whom must be a non-affiliate member. The minutes provided reflected active participation by the members. On multiple occasions, members requested clarification or follow-up on specific matters. Examples are provided below: ▪ At the 5/26/11 meeting, the committee suggested that a functional analysis be completed for Individual #78 to better understand the function of her pica behavior, and to determine whether there was an ongoing need for her restrictive body suit. ▪ Following a discussion regarding the level of supervision for Individual #119 on 6/2/11, the members made several recommendations, one of which was to explore counseling for this individual. ▪ On 6/16/11, the members recommended that Individual #30 be allowed to take headphones with him to the dental clinic, so that he could listen to music during procedures. ▪ Individual #92 received chemical sedation prior to certain medical exams. At the meeting held on 7/21/11, the members asked the staff to report back to the committee with further details on the restraints and plans to reduce this practice. ▪ At the 7/28/11 meeting, members voiced concerns with the dental desensitization plan for Individual #100, noting it was "weak" as staff have always brushed her teeth. ▪ Approval was denied for the use of a body suit with Individual #165 on 8/18/11. A request was made for additional information regarding the function of the individual's disrobing behavior. ▪ At this same meeting, the members approved (with recommendations) placement of an alarm on the windows in the bedroom of Individual #109. The team was asked to gain a better understanding of the function of her unauthorized departures with strategies to address this behavior in her PBSP. ▪ On 9/8/11, the team for Individual #73 was asked to follow-up in 30 days with a plan to develop a replacement behavior for pica. Although these and other appropriate suggestions were made to the members of	

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		individuals' teams, no evidence was provided that staff ever provided follow-up. This was discussed with the Human Rights Officer who concurred that there was no mechanism to ensure compliance with the committee's recommendations. Without ensuring that the concerns raised by the HRC are addressed, the utility and effectiveness of this oversight process are compromised. As noted in the past, concerns remained regarding obtaining consents and approvals in a timely manner. The Director of Behavioral Services provided a spreadsheet that contained data regarding dates of PBSP development and corresponding HRC review and consent. Data was reviewed for 92 individuals who had a date identified for both PBSP development and HRC review. Four of these 92 individuals (Individual #429, Individual #435, Individual #249, and Individual #103) were excluded from further analysis, because the dates recorded suggested that HRC consent was provided 10 months to one year before the PBSP was developed. Of the remaining 88 individuals, 50 (57%) had their PBSPs reviewed and approved by HRC within one month of the development date. For the others, HRC consent was obtained over one month after plan development. In some cases, consent took several months. The Director of Behavioral Services provided a second spreadsheet designed to track Personal Support Team approval, Behavior Therapy Review, parent/guardian consent, HRC consent, and plan implementation date. While this information would be very useful, the tracking tool revealed incomplete data, and, therefore, it was not used to analyze consent time frames. The Facility should develop a clear and simple spreadsheet that can be used to track all necessary consents. At the same time, procedures should be developed to ensure that these consents are obtained in a timely manner to minimize the delay in implementation of new and revised PBSPs. The Facility provided documentation regarding efforts that had been made to create a home environment specifically for individuals who had been diagnosed with autism. Feedback on Specialty Residence Proposal for Individuals Diagnosed with Autism Spectrum Disorders, dated 10/19/11, and environmental modifications made to Residence 788 is provided below: ▪ In the first step of the proposal, recruitment of staff interested in specific content areas was recommended. It is important to note that the efficacy of sensory integration and music therapy, two of the listed content areas, has not been documented in the research literature. Caution is advised, because only evidence-based practices should be recognized when providing positive behavior support. ▪ Further in the proposal, consideration is given to identifying specific attire (e.g., scrubs) to be worn by direct support professionals. As the proposal relates to the individuals' home, uniforms that are associated with hospital environments	

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		are not appropriate. ▪ Included in the list of environmental modifications was the addition of a sand pit. Unless this area is to be used to teach individuals to play horseshoes, bocce, or some other age-appropriate leisure skill, the addition of a sand pit is not appropriate. Staff are reminded that individuals who share a diagnosis of autism continue to have individual strengths, needs, and interests. Environments and programs should be designed for the individual, not for the group.	
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.	Graphs continued to display monthly occurrences of targeted behaviors, which generally was not adequate to allow adequate analysis. Axes were labeled, and data points and paths were displayed. Condition change lines or arrows were used to depict changes in medication, change of residential placement, missing data, and the introduction of new data collection systems. As noted with regard to Section K.4, graphs often depicted multiple measures. The graph included in the monthly progress report for Individual #30 provided an example of a visual display of data that was very difficult to interpret. This graph included information on four medications, three targeted problem behaviors, two replacement behaviors, restraint, and VPA [Valproic Acid] levels. With 11 measures included in one graph, it was not possible to interpret the individual's response to intervention. As each graph depicted total frequency of the target behavior per month, it was difficult to ascertain the individual's response to medication or environmental changes. No graphs included condition lines reflecting changes to behavior support plan strategies. Measures of inter-observer agreement or treatment integrity were also not depicted on any of the graphs. Monthly data display can mask critical changes in behavior that result from changes in intervention, changes in medication, including subtle changes to dosing, and changes related to health issues. Staff should provided graphic display of targeted behaviors in a manner that will allow analysis of the effects of planned (e.g., changes to the PBSP, changes in medication, etc.), and unplanned changes (e.g., sudden move in home, health problems, etc.). Although monthly review of progress was evident, there was no indication that assessment and intervention were re-evaluated and revised in a timely manner. Inter-observer agreement procedures were in the initial stages of implementation, and data remained inaccurate. In addition, graphing conventions did not allow adequate review of the data. Therefore, the Facility remained out of compliance with this provision.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one	The Director of Behavioral Services had made an effort to ensure that the section of the PBSP entitled "Staff Directions" was written in language at the ninth grade level of education. A review of these sections reflected written guidelines that were clear and	Noncompliance

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	year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	understandable. Direct support professionals who were asked about PBSPs reported that they understood the components of the plans, and if there were questions, psychology staff were quick to respond. As evidence to support efforts to ensure treatment integrity, the Facility provided lists of dates on which monitoring of PBSPs had occurred. This same information was provided to reflect the training that had taken place on PBSPs and skill acquisition programming. However, no data was provided to indicate the degree to which PBSPs were implemented as written. Without a clear explanation regarding the steps taken to ensure a high degree of treatment integrity, and corresponding data to reflect the success of these efforts, the Facility will remain out of compliance with this component of the Settlement Agreement.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	Since the Monitoring Team's last visit, the Psychology Department had developed a Competency-Based Training Work Group. Minutes from the meetings of this group were provided for review. Between 6/15/11 and 8/2/11, this group met seven times. The group agreed that competency training would occur in two ways. First, direct support professionals would demonstrate competency through completion of quizzes, role-play, and response to written scenarios. Second, in-situ training would need to occur in the residences and day programming sites. At the first meeting, two pilot residences were identified. By the third meeting, two new pilot residences were identified. During the fourth meeting, the group agreed that the Director of Behavioral Services should be involved to address administrative-related questions. By the fifth meeting, it was agreed that only one residence would be piloted for training. At the sixth meeting, committee members agreed to conduct observations in the pilot residence, while inviting the residence's psychologist to participate. By the last meeting, the team decided that the competency check form, which had first been proposed at the 6/28/11 meeting, would be changed to focus on global intervention strategies rather than interventions specific to individual PBSPs. The development of a new Facility based On-the-Job Training Committee also raised questions about the continued function of this committee. Lastly, the group discussed problems with conducting observations in the previously identified pilot residence. In sum, it appeared that this group had met repeatedly over a month and a half with very little accomplished. Psychology staff should develop competency-based training that can be conducted in the environments in which the individuals live, work, and recreate. The psychologist assigned to the individual should provide training specific to the individual's plan. Identifying one pilot residence is a good strategy to test a tool and training implementation. As problems are identified, changes can be made before disseminating the training campus-wide. Discussion and problem solving can continue for long periods of time. However, to meet the requirements of the Settlement Agreement, plans must be developed and put into action in a timely manner.	Noncompliance

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		The Monitoring Team was provided with a copy of the PBSP Competency Check – In Situ Training document. This monitoring tool allowed psychology staff to give feedback to direct service professionals regarding the correct implementation of the following PBSP components: a) preventative procedures; b) intervention and/or protective procedures; c) replacement behaviors; d) reinforcement strategies; and e) correct recording of target behaviors. Competency was evaluated either through in situ demonstration or role-play. Immediate feedback and training was then provided. This tool was a good start to ensuring competency-based training for all direct support professionals. Psychology staff should provide specific written feedback so that direct support professionals have a clear understanding of what skills they performed well, and also are given specific recommendations for what they could have done differently. One issue related to treatment integrity was the staff-to-individual ratio provided in the residential environments. Several staff, both professional and direct support professionals, reported that the minimum number of staff per shift had been reduced in residential environments. Mandatory holdover, i.e., requiring staff to continue to provide coverage past their already completed eight-hour shift, also was reported to be occurring on a regular basis. Staff from the State and the Facility should ensure that staff-to-individual ratios are adequate to ensure high rates of treatment integrity and habilitation services. Until a system of competency-based training is developed and implemented with the staff that work directly with the individuals served, the Facility will remain out of compliance with this component of the Settlement Agreement.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	Based on information provided in the staff roster, dated 11/8/11, and the Plan of Improvement, dated 11/2/11, there were a total of 14 psychologists on staff. The Director and Assistant Director of Behavioral Services provided supervision. One associate psychologist provided counseling services to individuals who resided at AUSSLC, and a second associate psychologist was identified as the department educator. This resulted in a total of 10 Associate Psychologists providing direct professional services to the 351 individuals in residence. Although the Plan of Improvement indicated that the Director and Assistant Director had assumed small caseloads effective 10/1/11, the level of professional support provided to the individuals was unclear. Therefore, only the 10 associate psychologists with full-time responsibility to the individuals were considered when determining the staff to individual ratio. With a ratio of 1:35, there was not a sufficient number of staff to meet the identified criterion of 1:30. The Facility had two vacancies for unit psychologists, for	Noncompliance

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		which applicants were being interviewed. Further, 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. The requirement of one psychology assistant for every two psychologists was met, because there were seven assistants at the time of the visit.	

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

1. As vacancies arise, individuals who are Board Certified Behavior Analysts should be recruited for these positions. As noted previously, consideration should be given to providing support to Psychology Assistants who have completed an undergraduate degree and who have expressed an interest in pursuing certification as Board Certified Assistant Behavior Analysts (BCABAs). (Section K.1).
2. The Facility should develop a policy related to internal and external peer review. (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. Identified problem behavior(s) should be graphed in a manner that will allow analysis of the effects of planned and unplanned events. 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 revise the plan. (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. When individuals present poor response to treatment or when their behavior problems reveal consistent worsening, staff should take steps to update or complete a functional behavior assessment. Staff should also refer these individuals for external peer review. (Section K.5 and Section K.4)
9. 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)
10. Psychology staff should update psychological assessment for all individuals. Assessments should be used to help identify an individual's strengths and needs, and efforts should be made to ensure that assessment redundancy is avoided. (Section K.7)
11. 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)
12. 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, 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)
13. Preference assessments should be completed on a regular basis. (Section K.9)
14. 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)
15. 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)
16. 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)
17. The Human Rights Officer should develop a system for ensuring timely follow up to recommendations made by the Human Rights Committee. (Section K.9)
18. All documents should be dated and signed. (Section K.9)
19. Inter-observer agreement should be assessed regularly, but no less than once each month. (Section K.10)
20. Measures of treatment integrity should be collected on a regular basis with samples taken on a variety of plans across shifts. (Section K.11)
21. 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)

22. Staff from the State and the Facility should ensure that staff-to-individual ratios are adequate to ensure high rates of treatment integrity and habilitation services. (Section K.12)
23. As the Facility's self-assessment process evolves, it is essential that a set of data points, which could be gathered through a variety of methods (e.g., data collection, monitoring, etc.), be established and used to identify strengths and weaknesses of the supports provided. The Facility should use this information to identify areas needing attention, and develop and implement plans to address deficiencies. Such plans should include expected outcomes, which if not met, should result in modification to the corrective action plan. (Facility Self-Assessment)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of all staff who work in the Medical Department, including names and titles, undated; o Physician caseloads, dated 10/1/11; o Medical staff Cardiopulmonary Resuscitation (CPR) certification; o In-service training for International Statistical Classification of Diseases and Related Health Problems (ICD)/ Diagnostic and Statistical Manual (DSM) criteria; o Primary Care Practitioner (PCP) Continuing Medical Education (CME) in last six months; o DADS SSLC Preventive Health Care Guidelines, implemented 8/30/11; o Minutes of Infection Control Committee meetings for the last six months, dated 5/24/11, and 9/1/11; o Minutes of the Skin Integrity Committee meetings, during the prior six months; o Most recent results/reports of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken; o For any medical staff meetings (e.g., morning medical meetings, etc.), copy of all minutes, handouts, logs from Infirmary admissions, hospitalizations, and 24-hour reports discussed for 15 days prior to Monitoring Team's visit; o Results of the last two external medical peer reviews (i.e., Round 2 from 7/18/11 to 7/19/11, and Round 3 from 10/31/11 to 11/1/11); QA follow-up audits for Round 2; Medical Provider QA audit – follow up results and action plans Round 2; 7/11 Medical Services Audit Corrective Action Plan; Compliance by question category (Round 2, Round 3); Medical Provider QA Audit Meeting minutes, dated 8/25/11; Medical Provider QA Audit meeting minutes, dated 10/18/11; External Medical Provider Audit Exit meeting Round 3, dated 11/1/11; o Records related to individuals' deaths since last visit, including active problem list at time of death, and for seven days prior to death or hospitalization: IPNs; all diagnostic studies, including radiologic and laboratory test results; hospital liaison reports, if applicable; whether autopsy was done, and if so, copy of autopsy report; and Certificate of death for the following individuals: Individual #54, Individual #111, Individual #396, and Individual #121; o Table: Statistics on Deaths Year 2011; o Corrective actions related to mortality reviews; o Progress notes for individuals with Do Not Resuscitate (DNR) orders; o DNR list with reason/criteria: resuscitation status list, undated); o List of death reports (clinical/administrative) that remain incomplete/outstanding; o The 20 most recent annual medical assessments and physical examinations, and the previously completed annual medical assessments and physical examinations, including the following: Individual #307 (annual medical assessments, dated 10/15/10, 9/30/11; annual physical examinations, dated 10/15/10, 9/30/11), Individual #108 (annual medical assessments, dated 11/17/10, 9/26/11; annual physical examinations, dated

	11/17/10, 9/26/11), Individual #429 (annual medical assessments, dated 9/3/10, 9/19/11; annual physical examinations, dated 9/3/10, 9/19/11), Individual #357 (annual medical assessments, dated 9/28/10, 10/15/11; annual physical examinations, dated 9/30/10, 9/17/11), Individual #403 (annual medical assessments, dated 10/3/10, 10/14/11; annual physical examinations, dated 11/4/10, 10/14/11), Individual #137 (annual medical assessments, dated 9/9/10, 9/23/11; annual physical examinations, dated 9/9/10, 9/23/11), Individual #89 (annual medical assessments, dated 11/4/10, 9/29/11; annual physical examinations, dated 11/4/10, 9/29/11), Individual #216 (annual medical assessments, dated 9/25/10, 9/8/11; annual physical examinations, dated 9/25/10, 9/8/11), Individual #159 (annual medical assessments, dated 10/28/10, 9/27/11; annual physical examinations, dated 10/29/10, 9/27/11), Individual #80 (annual medical assessments, dated 8/23/10, 9/15/11; annual physical examinations, dated 8/23/10, 9/15/11), Individual #458 (annual medical assessments, dated 11/10/10, 10/6/11; annual physical examinations, dated 11/12/10, 10/6/11), Individual #157 (annual medical assessments, dated 9/111/10, 9/20/11; annual physical examinations, dated 9/11/10, 9/20/11), Individual #83 (annual medical assessments, dated 11/1/10, 9/9/11; annual physical examinations, dated 11/2/10, 9/9/11), Individual #26 (annual medical assessments, dated 8/18/10, 9/14/11; annual physical examinations, dated 8/18/10, 9/14/11), Individual #19 (annual medical assessments, dated 10/8/10, 9/23/11; annual physical examinations, dated 10/8/10, 9/22/11), Individual #281 (annual medical assessments, dated 10/19/10, 9/13/11; annual physical examinations, dated 10/19/10, 9/13/11), Individual #442 (annual medical assessments, dated 9/23/10, 9/20/11; annual physical examinations, dated 9/23/10, 9/20/11), Individual #98 (annual medical assessments, dated 9/16/10, 9/20/11; annual physical examinations, dated 9/16/10, 9/20/11), Individual #439 (annual medical assessments, dated 9/21/10, 9/18/11; annual physical examinations, dated 3/26/10); o Specialty clinic schedule per month for the past six months (i.e., May, June, July, August, September, October 2011); o List of all outside consultations for medical purposes for the past six months, categorized by specialty; o List of individuals with tracheotomies; o List of individuals with vagal nerve stimulators (VNS), date of VNS placement, and, if applicable, replacement dates; o List of individuals with fractures, dates of fracture, type of fracture, and bone fractured; o List of individuals with injuries requiring Emergency Room (ER) visit or hospitalization, since the last onsite review; o List of individuals with pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the last on site review; o Policies for medical screening and routine evaluations: includes Health Care Guidelines, dated May 2009; o For those over 50, date of last colonoscopy, and list reason for colonoscopy (i.e., preventative, versus evaluation of active problem) with reason, if not up-to-date;

	o For those women over 40, date of last mammogram, and reason listed, if not up-to-date (e.g., guardian refusal, etc.); o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person (include calcium, Vitamin D, IV bisphosphonate, etc.), date of last Dual-energy x-ray absorptiometry (DEXA) scan or state if none completed, and copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o Last thyroid test for individuals with Down syndrome; o For the 10 individuals most recently seen in the ER, copies of IPNs from start of signs/symptoms to transfer to ER, and the ER report, including for: Individual #204 (ER visit 10/11/11), Individual #358 (ER visit 10/7/11), Individual #358 (ER visit 10/11/11), Individual #146 (ER visit 10/11/11), Individual #153 (ER visit 10/12/11), Individual #65 (ER visit 9/30/11), Individual #403 (ER visit 9/23/11), Individual #216 (ER visit 10/2/11), Individual #402 (ER visit 9/28/11), and Individual #124 (ER visit 10/11/11); o For the 10 individuals going to the ER and not hospitalized at least 30 days prior to Monitoring Team's visit, copy of discharge orders from ER, and copy of Facility record orders, integrated progress notes/Infirmary progress notes, follow-up to any recommendations, including for: Individual #204 (ER visit 10/11/11), Individual #358 (ER visit 10/7/11), Individual #358 (ER visit 10/11/11), Individual #146 (ER visit 10/11/11), Individual #153 (ER visit 10/12/11), Individual #65 (ER visit 9/25/11), Individual #65 (ER visit 9/29/11), Individual #403 (ER visit 9/23/11), Individual #216 (ER visit 10/2/11), Individual #402 (ER visit 9/28/11), Individual #124 (ER visit 10/11/11); o For the 10 individuals with the most recent hospitalizations that have returned for at least 30 days (in order to allow completion of recommendations), 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, including for: Individual #65 (date of hospitalization 9/30/11), Individual #65 (date of hospitalization 10/11/11), Individual #65 (date of hospitalization 10/18/11), Individual #81 (date of hospitalization 10/1/11), Individual #97 (date of hospitalization 10/10/11), Individual #165 (date of hospitalization 10/15/11), Individual #260 (date of hospitalization 10/12/11), Individual #260 (date of hospitalization 10/18/11), Individual #62 (date of hospitalization 10/14/11), Individual #316 (date of hospitalization 10/11/11), Individual #309 (date of hospitalization 10/8/11); o Hospital liaison nurse documentation for ten most recent hospitalizations; o Length of stay for Infirmary admissions for past six months; o Infectious disease data per quarter by category of infection for the last two quarters; o Summary report/trend analysis of infectious disease/communicable disease for the last two quarters; o Avatar pneumonia tracking forms completed for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth,

	type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases of pneumonia for past year, by month; o Absolute numbers of new cases over last year by month of decubitus ulcers; o Absolute numbers of new cases over last year by month for urinary tract infections (UTIs); o New cases of bowel obstruction; o Individuals with specific diagnoses over last year; o List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o Policies and procedures related to seizure management, including: State of Texas Nursing Education Workgroup presentation, undated; DADS SSLC Nursing Protocol: Seizure Management Guidelines, dated February 2011; nursing educational document: Prolonged seizures, undated; DADS SSLC Seizure management attachment: nursing protocol: vagal nerve stimulator, dated February 2011; o List of individuals being treated for seizure disorder; o Documentation of seizure management for five individuals, including: Individual #356 (7/11/11), Individual #261 (8/29/11), Individual #96 (7/11/11), Individual #336 (1/10/11), Individual #336 (7/11/11), Individual #336 (9/12/11), Individual #264 (7/25/11), and Individual #264 (9/12/11); o List of individuals seen by neurologist with dates seen, and reason, since the Monitoring Team's last visit; o List of cases of status epilepticus, since the Monitoring Team's last visit; o List of seizure medications per individual for diagnosis of seizure disorder; o List of individuals going to ER for uncontrolled/prolonged/new onset seizure since Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o Individuals with refractory seizures referred for VNS; o List of individuals on one, two, three, four, and five antiepileptic drugs; o Percentage of persons on older anti-epileptic drugs (i.e., Phenobarbital, Dilantin, Mysoline); o Any tracking of data for individuals who have transitioned to community in past one year, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided; o Alphabetical list of individuals residing at AUSSLC, dated 11/9/11; o Antibiogram for last six months; o Medication history for individuals with jejunostomy tube (J-tube) or gastrojejunostomy tube (GJ-tube) for Individual #65 and Individual #402, and drug regimen review profile from 5/1/11 to 10/21/11; o PCP orders from 11/1/10 to the present, PCP IPNs from 11/10 to the present, most recent annual medical assessment/physical examination with active problem list, radiographs for past one year, and other x-ray and scan reports (e.g., routine scans, ultrasound, CT scan,

	etc.), consult reports for past one year, operative and procedure reports for past year, most recent PSP and subsequent addendums, preventive care flow sheet, DG-1 form, ER reports for past year, hospital admission history and physicals and discharge summaries for past year, most recent nursing assessment, most recent annual BSP and subsequent addendums, and out-of-hospital DNR form/resuscitation status for the following: Individual #175, Individual #366, Individual #390, Individual #64, Individual #277, Individual #41, Individual #115, Individual #173, Individual #107, Individual #389, Individual #338, and Individual #109; o For individuals that moved between buildings, list of individual's name, prior building, and most recent building (name/number); o For those with methicillin-resistant staphylococcus aureus (MRSA) from 5/1/11 through 10/31/11, culture report positive for MRSA, and report indicating resolution - negative MRSA from same; o Attendance roster for Infection Control Committee meeting on 11/14/11; o For Individual #404, all documentation, such as hospital liaison notes, Ethics Committee notes, Human Rights Committee (HRC) meeting notes, progress notes, family contact and any other documents concerning the individual's status/condition and treatment decisions; o Recommendations of administrative and clinical death reviews; o For Individual #210, IPNs from 11/10/11 to 11/16/11; o For Individual #327, most recent BSP and addendums since then, and psychiatry IPN notes past two months; o For Individual #98, IPNs from 11/11/11 to present, and psychiatry notes for past two months; o For Individual #74, IPNs from 11/11/11 to present; o For Individual #291, IPNs from 11/11/11 to present, most recent BSP and subsequent addendums, and psychiatry notes for past two months; o For Individual #152, IPNs from 11/11/11 to present; o For Individual #65, nursing training roster for care of his GJ-tube, dates of GJ-tube clogs, ER visits, and replacements over the last six months; o For Individual #239, IPNs from 10/20/11 to present, any lab/x-rays, or other studies during same time; o For Individual #108, IPNs from 11/1/11 to present, any transition discussions with him, and any training of staff on how to approach topic of transition with him; o For Individual #199, Physical and Nutritional Management Team (PNMT) monitoring documents of positions for the past 30 days, gastrointestinal (GI)/Gastroesophageal Reflux Disease (GERD) work-up since 10/1/11, and PNMT notes on him since 10/1/11; o For Individual #358, IPN, including nursing assessment on readmission from hospital on 11/15/11; o For Individual #100, IPN from 11/1/11, and intake and output (I and O), during that time, and any lab results, since 11/1/11; o For transitions in the past year, technical expertise provided, including name, date of

	issuance, department providing expertise, and brief description of guidance; o Individuals referred to the ER and/or admitted to the hospital over the last year; o Infection Control Committee handouts for meeting on 11/14/11, including: influenza season resident and employee vaccination data, organisms identified – MRSA/ *vancomycin-resistant enterococci* (VRE)/multi-drug resistant organism (MDRO) from 5/1/11 to 10/31/11, infection control monitoring schedule for hand hygiene spot checks, and hand hygiene compliance rate campus-wide from January to September 2011; o Individuals admitted to the Infirmary over the last year; and o Presentation Book for Section L. ▪ **Interviews with**: o Fred Bibus, MD, Medical Director; o Jae Yang, MD, Staff Physician; o Archie Smith, MD, Staff Physician; o Alfredo Cisneros, MD, Staff Physician; o Jodie Friedrich, NP, Nurse Practitioner; o Kay Cowan, RN-FNP-BC, Infection Control Nurse; o Mary Birdsong, Admissions Placement Coordinator; o Sherrie Scarbrough, Post-Move Monitor; and o Holly Lindsey, QDDP Coordinator/previous Post-Move Monitor. ▪ **Observations of**: o Individual #351, Individual #113, Individual #366, Individual #450, Individual #347, Individual #269, Individual #381, Individual #398, Individual #268, Individual #434, Individual #174, Individual #22, Individual #182, Individual #422, Individual #196, Individual #31, Individual #299, Individual #323, Individual #107, Individual #405, Individual #265, Individual #310, Individual #212, Individual #260, Individual #51, Individual #62, Individual #50, Individual #18, Individual #188, and Individual #363; o Morning medical rounds report, on 11/15/11, 11/16/11, and 11/17/11; and o Infection Control Pandemic Planning Committee, on 11/14/11.
	Facility Self-Assessment: The Facility's self-assessment for Section L provided minimal information, and no data to support the Facility's findings. In addition, the Facility found itself in compliance with Section L. This was inconsistent with the Monitoring Team's findings, which is discussed in further detail below. The POI for this section indicated the only step undertaken to move towards compliance with Section L.1 was that a medical care policy had been revised. For Section L2, the Facility determined it was compliant, because external reviewers had now completed three rounds of reviews at the Facility. There was a process to follow up on the findings of these reviews through the implementation of action plans. However, as is discussed in further detail with regard to Section L.2, no information was provided to establish inter-rater reliability between external reviewers. No information was submitted that any of the original questions had been revised to reduce variability in reviews, or regarding any additional training of the reviewers to overcome variability concerns. There

	remained no formal report from the reviewers after they completed the review. For Section L.3, the Facility indicated that an action plan had been developed. However, the action plan for Section L.3 that was submitted included 13 action steps, but none had been started. With regard to Section L.4, the Facility indicated: "No action steps or initiatives have been initiated during the last six months. Based on the lack of any data for this section of the POI, no attempt had been made in the past two years to complete any internal review process.
	Summary of Monitor's Assessment: Overall, the Facility had made very little progress with regard to Section L. It was not clear that the Facility had a clear understanding of the intent or the urgency of compliance with the provisions in this section of the Settlement Agreement. The Facility remained out of compliance with all sub-sections of Section L. One of the few areas in which limited progress had been made was in the development and role of the morning report. Attendance was interdisciplinary, and an efficient format for minutes had been developed. The group was beginning to ask critical questions, but there was little evidence of closure, and the breadth of critical questions and follow-up was inadequate to ensure quality care across the campus. Although in the weeks immediately preceding the Monitoring Team's review, the minutes reflected the need to develop a system for closure of issues raised in the meetings, several months of these meetings had occurred without the resolution of this necessary step. This reflected the lack of administrative action/leadership, and a significant delay in responding to this essential area of clinical administrative oversight. There appeared to be no review of databases created for preventive tests, such as colonoscopies, mammograms, pap smears, etc. There was no evidence of data tracking, analysis, and meeting with PCPs to review findings and develop action steps to address issues related to appropriate care and treatment. The Monitoring Team identified a number of problems with the completion of these essential tests. In addition, insufficient data was available to determine the adequacy of treatment for osteoporosis. Given the large numbers of individuals at AUSSLC with this serious condition, it was concerning that the Facility did not have a rigorous system to allow internal review. The external review process should include review of 20 percent of the records per year for compliance, and this had not yet occurred. Concerns related to the reviews included the lack of establishment of inter-rater reliability, and the lack of formal documentation for each review. However, results of the peer reviews had had a positive impact on clinical practice. No initiatives were in place for internal review. To date, the Medical Department had had two years to develop internal tracking systems. The Medical Department appeared to consider Section L.3 an option rather than a requirement. If lack of knowledge on medical QI/QA systems was a problem, the Medical Department did not appear to have made any attempt to gain outside assistance or consultation in

	developing an internal program. At this point in time, none of the necessary infrastructure existed. This should have included providing guidance and collaborating with the Information Technology Department in creating systems that would be helpful to the Medical Department by providing information for trend analysis and ongoing QA monitoring. The current databases appeared to have been developed only for the purposes of providing information for the Monitoring Team's visits. The Medical Department was not using them for self-monitoring and improvement.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Given that this Section of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, and Do Not Resuscitate Orders. <u>Staffing and Administration</u> The Medical Director, three staff physicians, one nurse practitioner, and two medical secretaries staffed the Medical Department. On the organizational chart, the Psychiatry Department was also listed under the Medical Department, and included four psychiatrists, three psychiatric RNs, and two psychiatric assistants. From a physician caseload table, dated 10/1/11, the Medical Director had a caseload of 34 individuals, the nurse practitioner had a caseload of 43, and the three staff physicians had caseloads from 90 to 92 individuals. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated 11/7/11 (i.e., DADTX Course Due/Delinquent, Basic CPR). Of the primary care providers in the department, five out of five (100%) were current in CPR. Psychiatry was also listed for CPR training. Four out of four psychiatrists (100%) were current in CPR certification. A separate CPR database was submitted, from 10/27/11, entitled Employee Compliance Report. From this information, although five PCPs were current, one physician was due for renewal by 11/17/11 (during the Monitoring Team's visit). However, no information was provided indicating a renewal had been completed in a timely manner by the time of the Monitoring Team's exit meeting. A list of CME credits was submitted for the five PCPs in the Medical Department (i.e., four physicians and one nurse practitioner). For the time period from May 2011 through October 2011, this varied from zero to nine hours. The topics that were covered included many important areas related to the care of individuals at AUSSLC, including: treatment	Noncompliance

#	Provision	Assessment of Status	Compliance
		of lipids, evaluation of dysphagia, treatment of osteoporosis in men, updates in infectious disease, MRSA skin infections, risk factors and protective factors for colorectal cancer, gastric outlet obstruction, dementia, tuberous sclerosis, ankle sprain, hepatitis B, hyperammonemia, tube feeding in the elderly, herpes zoster, shingles vaccine, and treatment of limb spasticity. During interviews, all of the PCPs noted considerable improvement in the filing of medical information in the active records. Since the Monitoring Team's last review, the system was changed, and currently the Client Records Department picked up the lab and consult reports directly from the Medical Department for filing in the active record. This change occurred on 9/1/11. The new system appeared to be successful in meeting the needs of the medical staff in providing care to the individuals. <u>Physician Participation In Team Process</u> Since the Monitoring Team's previous review, the morning medical rounds expanded membership to include several other disciplines, including: psychology, habilitation therapies, PNMT, chaplaincy, human rights, administration, and a QDDP. They continued to include the Medical Director and PCPs, and several members of the Nursing Department (i.e., the hospital liaison nurse, Infirmary nurse manager, and nursing administration). At the meetings, attendance was recorded, followed by the hospital nurse liaison reviewing medical concerns that had been reported since the prior meeting, as well as hospitalizations, and Infirmary admissions. The structure of the minutes was in table format, and a column was included that identified those concerns needing follow-up. Space was left at the end of the minutes for recording progress towards the closure of follow-up items. On 11/15/11, 11/16/11, and 11/17/11, a member of the Monitoring Team attended the meetings. Earlier notes from the Section L Presentation Book documented follow-up until closure. However, during the week of the observations, no documentation of follow-up was included in the minutes, even though for several individuals, the questions and concerns indicated the need for follow-up. The group had begun to ask a number of critical questions, including for example, questions about the signs and symptoms preceding illness leading to hospitalization. However, there was no follow-up or minutes that reflected any documentation of follow-up. In a number of instances, the member of the Monitoring Team had to ask questions in order to obtain information related to closure (e.g., for Individual #98, Individual #210, Individual #327, Individual #74, Individual #291, Individual #152, Individual #108, Individual #199, Individual #358, and Individual #404). Topics needing closure varied. However, they routinely should include whether lacerations and bites had healed with or without complications, whether preceding events leading to injury were reviewed and preventive steps taken, whether further work-up was needed for an illness leading to an Infirmary admission or	

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		hospitalization, etc. One of the Monitoring Team's question concerning GERD had to be asked a second day, because the group did not recognize the need to ask it. Some questions remained unanswered. No system appeared to be in place for the chair of the meeting to appoint someone routinely to gather information and determine a date for bringing that information back to the meeting. Of note, when reviewing specific issues of behavioral or psychiatric focus, the psychiatrists appeared to be fully knowledgeable of those cases, including details of behaviors, medications, doses, and timelines. They were able to provide important background information, and rationale for choice of medications and changing of regimens. The contribution of the PCPs to the committee review varied, some with full knowledge of a case listed for discussion, and others having little knowledge of the listed concern. Separately, the minutes of the morning medical meetings were provided for the 15 days prior to the Monitoring Team's visit. The minutes for each day included a section for attendance with name and title, which was completed. The concerns reviewed and discussed were categorized into medical review (usually acute care or new issues arising in the residences), hospital admissions, and Infirmary admissions. For each of the individuals listed, a concise medical review was included, providing the important clinical information in a few phrases. For the medical reviews, one column was entitled "incident." This column was left blank for all concerns, and the purpose was not clear. The last column, marked "follow-up," was completed with a "yes" or "no." Few follow-ups were noted during the two-week time period. However, several of the concerns would have benefited from critical questions being asked and answered, such as exploring the reason for the ER visit and discussing approaches to prevent recurrent ER visits for the individual. When there was a fall, no follow-up was noted discussing reasons for the fall and methods to prevent another fall, or whether the fall risk plan was amended. Items needing follow up were tracked at the end of the minutes. Three examples were provided, but all had open unresolved issues, and none demonstrated closure. From the areas earmarked as needing closure, one could not determine what steps were actually taken, and/or the timelines for these steps. Closure documentation required additional clarity. For the hospital admission section of the morning minutes, scant documentation was provided of next steps. The recommendations/plan section was usually left blank, as well as the responsible person section. Many had no entries. For instance, despite the problem of a GJ-tube being clogged and needing replacement, no discussion was recorded as to how to prevent clogging of GJ-tubes, use of alternate J-tubes, review of nursing procedure/practices and training, or the need for monitoring those with GJ-	

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		tubes to ensure optimal care in positioning, administration of medications and formula, and adequacy and frequency of flushes. The morning medical minutes for Infirmary admissions also had a section for issues discussed, but little to no documentation was included in the recommendation/plan section, the person responsible. Documentation was not adequate to show that issues were discussed for each individual. During the two weeks of submitted material, one item was listed under "other significant issues." It continued with no apparent closure. The concern was dated 11/2/11, and was stated as: "who does follow up from morning medical rounds," and this continued for the two weeks unresolved. A recommendation/plan was included for a work group to provide the answer, with the person responsible appointed. However, no date was included at which time an initial report back to the committee was expected. The topic indicated that this aspect of the morning meeting had not been determined, and no system was in place. This explained the lack of follow-up for many issues brought to the morning medical meeting. However, given that this concern was initially documented on 11/2/11, indicated that several months of these meetings had occurred without the resolution of this necessary step. This reflected the lack of administrative action/leadership, and a several-month delay in responding to this essential area of clinical administrative oversight. On 10/18/11, the P&T Committee indicated that all medication errors/variances should be discussed at the morning medical meeting. However, during the three days of morning meetings, no discussion occurred of any medication error. Since the Monitoring Team's last visit, the positive aspects of the morning meeting included the initiation of documentation of attendance, the interdepartmental participation by members of several departments, the creation of a succinct format for the minutes, and a form to document when an item required closure with adequate space to describe the closure. Areas needing attention included focus on closure, with defined time periods in which an item is to be resolved or report brought back to the committee, and improvement in the critical questions asked, leading to recognition of the many clinical areas needing closure. <u>Routine Care</u> For 20 individuals, a copy of the most recent annual medical assessment (AMA) and physical examination evaluation, as well as the prior AMA and physical examination (PE) evaluation were requested. One individual was listed for whom no information was submitted (i.e., Individual #358). A total of 19 current AMAs were submitted with the previous AMA, and 18 current PEs were submitted with 19 the previous PEs. The table of information also had three dates that were inaccurate, when comparing to the actual AMA and PE documents. This suggested the need for the Facility to review	

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		documentation before submitting it to the Monitoring Team for review. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For the 19 individuals for whom information was received, compliance for timely AMA completion was 11 out of 19 (58%). Compliance for timely completion of the physical examination was 12 out 18 (67%). As part of the monitoring review process, the Monitoring Team selected the medical records of 12 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. Every 29th name listed on the census list was selected, after the first name was chosen by random selection. Documents reviewed included preventive care flow sheet, physician orders from 11/1/10 to the present, integrated progress notes from 11/1/10 to the present, most recent annual BSP and subsequent addendums, last annual PSP and subsequent addendums, labs, radiographic studies (x-rays, ultrasound tests, etc.) from 11/14/10 to the present, consult reports from 11/14/10 to the present, operation/procedure reports from 11/14/10 to the present, the most recent annual medical assessment and physical exam, the DG-1, the most recent nursing assessment, any hospital admission history and physical report and any hospital discharge summary for the past year, ER visits for the past year, and any out-of-hospital DNR forms/resuscitation status forms. Each aspect is discussed below as the relevant preventive or routine care topic is discussed. From the information submitted for 12 medical records that were reviewed: ▪ Ten (83%) annual medical assessments had been completed in a timely manner. ▪ Active problem lists appeared to be thorough in 11 (92%). ▪ Four (33%) had information about smoking history. ▪ One (8%) had information discussing requirements for transition. ▪ The DG-1 forms were reviewed. Four (33%) had updated diagnoses. The 12 medical records also were reviewed to determine whether the physician IPN note used the SOAP format. In 10 out of 10 records with IPNs written by physicians (100%), the SOAP format was used, and included date and time on the IPN. Two records had no IPNs written by physicians for the year reviewed. Given the daily presence of PCPs on campus, and the complex challenges of this population, the sample indicated that two out of 12 (17%) only saw the PCP once in a year, at the time of the annual examination. None (0%) had a PCP quarterly review of medical progress during any quarter in the prior year. Except in documented circumstances of prolonged time away from campus [e.g., prolonged hospitalization or admission to a long term acute care (LTAC) facility, etc.], or for individuals with certain behavioral conditions, such as extreme tactile defensiveness, a quarterly review with updated lab and test information, review of	

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		weights, medications, seizure data if applicable, etc., along with a focused physical exam, would allow closer and consistent on-going evaluation of the individuals. As the individuals become familiar with the PCPs, there also would be the potential benefit of improved cooperation and compliance with need for less restrictive measures (i.e., physical, mechanical, chemical restraint) for completion of a PCP visit. <u>Access to Specialists</u> On site, several specialty clinics were held to meet the needs of the individuals. The clinic calendars submitted included no June or August 2011 schedules. Additionally, two schedules for July and September were submitted, both with the same revised date, but with conflicting information in some instances. The following clinics appeared to have taken place at AUSSLC on the following dates: ▪ Orthopedics – 5/2/11, 5/16/11, 7/11/11, 7/25/11, 9/19/11, 10/3/11, and 10/17/11. Other clinic dates listed in July and September were inconsistently documented (i.e., 7/18/11, 9/5/11 – a holiday). ▪ Neurology - 5/2/11, 5/23/11, 7/11/11, 7/25/11, 10/3/11, and 10/10/11. Other clinics held in September were inconsistently documented (i.e., 9/5/11, 9/12/11, 9/25/11). ▪ Gynecology - 5/6/11. A potential clinic in September (i.e., 9/16/11) was not consistently documented. ▪ Surgery - 5/9/11, 5/23/11, 7/18/11, 9/12/11, 9/26/11, 10/10/11, and 10/24/11. A potential surgery clinic (i.e., 9/5/11) was not consistently documented. ▪ ENT clinic - 5/12/11, 5/26/11, 7/7/11, 7/28/11, 9/1/11, 9/15/11, 10/13/11, and 10/27/11. A potential clinic in September (i.e., 9/29/11) was not consistently documented. ▪ Optometry – 5/18/11, 7/20/11, and 10/12/11. Clinics for 9/21/11, and 9/14/11 were not consistently documented. ▪ Podiatry - 5/18/11, 7/20/11, and 10/19/11. Clinics on 9/21/11, and 9/14/11 were not consistently documented. ▪ Gastroenterology screening - 5/27/11. ▪ Gastroenterology - 10/11/11. A potential clinic on 9/6/11 was not consistently documented. ▪ Eye clinic - 7/8/11, 9/9/11, and 10/14/11. When the gaps and discrepancies were communicated to the Medical Director, corrected information was presented. The following is additional and corrected information: ▪ Orthopedics - 6/6/11, 6/20/11, there was no 7/18/11 clinic, 8/8/11, 8/22/11, and there was no 9/5/11 clinic. ▪ Neurology - 6/13/11, 6/27/11, 8/1/11, 8/29/11, and neurology clinic was held 9/12/11.	

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		▪ Gynecology - 8/19/11, and there was no 9/16/11 clinic. ▪ Surgery – 8/1/11, 8/15/11, 8/29/11, and there was no 9/5/11 clinic. ▪ ENT – 6/9/11, 6/23/11, 7/21/11, 8/4/11, 8/18/11, and a 9/29/11 clinic did occur. ▪ Optometry – 6/15/11, 8/17/11, the 9/14/11 clinic did not occur, and the 9/21/11 clinic did occur. ▪ Podiatry - 6/15/11, 8/17/11, the 9/21/11 clinic did occur, and the 9/14/11 clinic did not occur. ▪ GI screening – no changes indicated; ▪ GI clinic - 6/14/11, and 8/9/11. ▪ Eye clinic – 6/10/11, and 8/12/11. Clear and accurate documentation should be maintained of specialty clinics, including written documentation of periodic reviews, focusing on completeness and resolution of discrepancies. Given the number of errors in this submitted information, the inference was that no one looked at the quality of the information that was submitted. This is problematic, as the intention of the information is for the department to use this data for trend analysis and future goal setting, with corrective plans when needed. Additionally, a number of appointments were documented with consultants and for special procedures in the community. The following was a breakdown of these appointments for each specialty and special procedure, according to the raw data submitted: EEG - 11, ENT/otolaryngology – 16, radiology - 72, retinal/glaucoma/eye specialists - 16, sleep study - one, cardiology - eight, cardiothoracic surgery - two, dermatology - eight, endocrinology - three, dental specialties (endodontist - one, orthodontist - four, periodontist - one), gastroenterology - 18, gynecology - four, nephrology - six, hematology/oncology - 19, orthopedics - 11, plastic surgery – four, physical medicine – four, podiatry - six, rheumatology - one, surgery – two, dialysis – two, urology – 10, vascular surgery - one, special procedures – four, and Reclast therapy – 15. From the list of on-campus specialty clinics and the off –campus appointment rosters, it appeared there was access to all specialties in caring for the individuals at AUSSLC. <u>Preventive Care</u> Of the 12 medical records reviewed, eight out of 12 (67%) had an updated preventive care flow sheet. Current vision screening was documented in 11 out of 12 of the records reviewed, and one had a defined reason for not providing routine vision screening. All 12, therefore, had vision screening, or a contraindication for vision screening listed (100%). Audiological screening was current in 11 out of 12 records reviewed (92%).	

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		Audiological screening was overdue in one record. The influenza vaccination had been given to 12 individuals (100%) in a timely manner. Whether the individual needed to receive varicella vaccine (depending on birth date and immunity status), and whether it was given if indicated, was recorded in 12 of the 12 active records reviewed (100%). Of the 12 medical records reviewed, eight out of 12 were women. One was over the age of 65, and one had a contraindication for a pap and pelvic procedure documented. Of the remaining six, four (67%)were up-to-date with pap smears. A list was submitted identifying women residing at AUSSLC who were over the age of 40, along with the date of last mammogram, and the reason, if it was not done or outdated. A total of 134 women were identified as being over the age of 40. The American Cancer Society recommendations were to be followed, according to a DADS SSLC Policy #009.1, dated 2/16/11. Additionally, the SSLC Preventive Health Care Guidelines issued on 8/30/11 recommended annual screening mammography for women ages 40 to 70. Of these 134 women, 31 had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for the test, age over 70, etc.). Of the remaining 101 women, 70 had mammograms within the prior year. This was a compliance rate of 70 out of 101 (70%). From the sample of 12 medical records reviewed, there were six females over the age of 40. Of these, six (100%) were up-to-date on mammogram testing, or had a contraindication documented for the procedure. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, and the reason for the colonoscopy. A total of 227 names were submitted. Of these, 17 were over the age of 75. Based on the State Office preventive care policy, this upper age limit was one of the guidelines, after which routine screening was not recommended. There were four others that had reasons not to order a colonoscopy. Of the 227, two had died. Therefore, the eligible population was 204 individuals. Of these, 107 completed a colonoscopy within the last ten years, and no alternate testing considered acceptable as clinical equivalents was submitted for the other individuals for whom screening was recommended. Of the 204 individuals for whom a colonoscopy or clinical alternative was indicated between the ages of 50 and 75, 107 had completed an appropriate procedure (52%). From the sample of 12 medical records reviewed, nine individuals were 50 years of age or older. Of these, there was one individual beyond the age of 75. Of the remaining eight	

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		individuals, six (75%) had colonoscopies completed within the past 10 years. A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T score, treatment would be ordered to optimally treat the individual. The following information was based on the submitted information: ▪ A total of 140 individuals with a diagnosis of osteopenia or osteoporosis had a DEXA scan submitted. A total of 39 individuals were listed with a diagnosis of osteoporosis or osteopenia without a DEXA scan submitted. The 140 individuals with a DEXA scan were reviewed. ▪ Of the 140 DEXA scan results reviewed, 105 out of 140 (75%) were within the past three years. ▪ Of the 140 individuals reviewed, for both osteoporosis and osteopenia, additional calcium and vitamin supplements per individual were submitted through the pharmacy database. For the 140 individuals with a T score confirming osteopenia or osteoporosis 78 (56%) had calcium supplementation, and 79 (56%) had Vitamin D supplementation. ▪ There were 43 individuals with osteopenia and 97 with osteoporosis. Of those with osteoporosis, 25 of the 97 (26%) only had vitamin D and or calcium supplementation, without additional treatment (e.g., bisphosphonate, Miacalcin, etc.). According to national guidelines, osteoporosis treatment generally includes treatment in addition to Vitamin D and calcium (there are several options). A total of 72 out of 97 (74%) had recommended treatment of Vitamin D, calcium, and an additional medication for osteoporosis (e.g., bisphosphonate, Miacalcin, etc.). The Medical Department should create a system for tracking individuals with osteopenia/osteoporosis, including T scores, frequency of DEXA scans, and types of medication prescribed. It is recommended the QA Department independently monitor the work-up for osteopenia/osteoporosis, periodicity of DEXA scan testing, and adequacy of treatment. From the sample of 12 medical records reviewed, six had a diagnosis of osteoporosis or osteopenia. Of these, six (100%) had supplemental calcium and vitamin D prescribed, as well as other medication ordered (i.e., bisphosphonate or Miacalcin) specific for osteoporosis. Treatment for these six was appropriate. There was one additional individual for whom a DEXA was requested on 6/3/10. However, according to submitted	

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		information, this test had not been completed. A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 22 individuals were identified with a diagnosis of Down syndrome. All 22 (100%) had a current thyroid test. Of the testing submitted, 19 out of 22 values were within normal limits. Three were out of range, but information was not submitted regarding follow-up evaluation and treatment. <u>Acute and Emergency Care</u> The information submitted for this section was considered incomplete. Pages that were double-sided copy were only copied on one side; blank pages were copied, suggesting the wrong side of the paper was copied; sections of requested information were missing for some records, which contributed to poor compliance scores; some pages were copied two and three times, and other pages not copied; and some pages, especially IPNs, had no name on the page for identification. The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room, whether or not the ER visit resulted in a hospitalization. These individuals are listed in the documents reviewed section. All 10 had gone to the ER from their residence. None had gone from the Infirmary to the ER. The following summarizes the results of this review: ▪ Information was submitted documenting that the ER was notified of the arrival of the individual with appropriate medical background information provided verbally for none (0%). ▪ Prior to the transfer to the ER, a PCP was on site for two of these transfers. In two records (100%), the PCP had written an IPN that included the date, time, and reason for the transfer. Vital signs were recorded in one of the two records (50%). In two of the two (100%), the SOAP format was utilized. ▪ When the individual returned to the Facility after evaluation at the ER, 10 of the 10 active records (100%) had an IPN. Of these 10, 10 (100%) utilized a SOAP format. ▪ These notes included the date, time, and summary of ER information and findings in 10 IPN notes (100%). Six of 10 IPN notes (60%) included vital signs. ▪ When returning to the Facility, eight returned to the Infirmary. The record was unclear whether the individual returned to the residence or was admitted to the Infirmary in two records. The Medical Records Department should consider providing a unique identification for Infirmary charting (e.g., colored pages, heading of page indicating Infirmary location, etc.) to clarify the location of the individual and where treatment/monitoring is provided. ▪ Seven of the 10 records (70%) had additional PCP notes as follow-up to the original concern. The reasons for transfer were as follows: trauma - five ER	

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		visits, gastrointestinal problems – two, infection – two, and hyperthermia – one. ▪ For eight out of 10 transfers to the ER (80%), treatment was considered timely. There was insufficient documentation submitted for two records to determine whether referral was timely. Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review: ▪ For the 10 active records, there was documentation indicating 11 hospitalizations. ▪ A PCP wrote a pre-hospital evaluation/transfer note in two of the 11 hospitalizations. For five of these, the transfer occurred after hours or on weekends. For one hospitalization, the submitted documents did not include the time prior to transfer to the hospital. ▪ All individuals returned to the Facility. None died while in the hospital. Of the 11 hospitalizations, within 24 hours of return to the Facility, six of the 11 individuals (55%) had IPNs post hospitalization. For four hospitalizations, no post-hospital information was submitted. ▪ Of the six post-hospital IPNs submitted, six (100%) included vital signs. ▪ All six (100%) included date, time, and an adequate summary of hospital events and findings. ▪ All six (100%) active records used the SOAP format. ▪ Ten of the 11 records of the hospitalizations (91%) included a copy of the hospital admission history and physical. ▪ Seven of the 11 (64%) included a copy of the hospital discharge summary. ▪ Ten of the 11 (91%%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ One of the 11 (9%) included hospital liaison nurse notes for the individuals. ▪ For three of the 11 hospitalizations (27%), adequate PCP notes were included as part of the follow-up. As already mentioned, four records did not include post-hospital information. ▪ Of the 11 hospitalizations, diagnoses included seizures (one), fever (three), infection (four), and Gastrointestinal diagnosis (three). Additionally, 10 active records were reviewed for those individuals treated in the ER and returned to AUSSLC without hospitalization. The following provide the results of this review: ▪ For the 10 individuals for whom active records were submitted, there were 11 ER visits. ▪ For six of the 11 ER visits, there was documentation that the individual returned, and was admitted to the Infirmary. For five, there was insufficient information to determine if they were admitted to the Infirmary or returned to their home.	

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		▪ For three out of six (50%), there was a completed Infirmary discharge form. ▪ For 10 out of 11 (91%) ER visits, there was a follow up PCP IPN note. Each was in SOAP format, and included date and time of the IPN. ▪ Of these 10 post-ER IPN notes by the PCP, nine out of 10 (90%) included a summary of the ER visit. Five out of 10 (50%) included vitals signs. ▪ Additional follow-up notes were submitted for 10 of the 11 ER visits, ranging from one to four additional IPN entries by the PCP. AUSSLC had an Infirmary. Individuals were admitted to the Infirmary for several reasons, usually involving instances requiring increased nursing monitoring, such as after sedation for a medical or dental procedure, or after discharge from a hospital. The Facility submitted data concerning Infirmary use. The following number of admissions per month to the Infirmary was based on raw data submitted: April 2011 – 69, May 2011 – 33, June 2011 – 77, July 2011 – 67, August 2011 – 66, and September 2011 – 65. Lengths of stay varied, depending on the medical and nursing needs of the individual. From April through September 2011, the length of stay based on raw data was tabulated as follows: one day (length of stay) - 84 admissions, two days - 113 admissions, three days - 54 admissions, four to 10 days - 87 admissions, 11 to 20 days - 25 admissions, and over 20 days - eight admissions. <u>Pneumonia</u> Information from four databases was submitted for pneumonias. In most cases, the Facility spreadsheet appeared to match the details concerning type of pneumonia (i.e., community acquired, aspiration pneumonia, pneumonia not associated with aspiration), and the date of diagnosis listed in the Avatar system. The Avatar system listed two additional pneumonias. A third list with details regarding feeding route and last video swallow test included one additional case of pneumonia. A fourth list (April to August 2011) did not include names, but listed 16 pneumonias, more than the other databases (the Avatar system listed 13 pneumonias for the time period May to August 2011). Continued review of the data is recommended in order to ensure consistency across the databases. Since 5/11, there had been 15 aspiration pneumonias (based on information tabulated from the three databases). Information was available for 13 of the individuals who had experienced these pneumonias from 5/2011 through 8/2011. Eleven out of 13 individuals had completed a video swallow study in the past. Eight individuals had gastrostomy tubes, and all of these had an intermittent feeding schedule (versus continuous or bolus). No information was submitted that documented any GERD work-up for the individuals with aspiration pneumonia. Additionally, for those with feeding tubes and aspiration pneumonia, it was not clear the reason for not considering continuous feeding. Five individuals were on pureed texture foods.	

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		Infection Control From the May 24, 2011 Infection Control/Pandemic Planning Committee meeting, there was approval to target disease entities including pneumonias, with emphasis on decreasing this morbidity. The specifics were not identified in the minutes, although there was information indicating action steps were taken. The number of influenza vaccinations for employees was tracked per year, and had increased from about 240 employees in 2009 to about 320 employees in 2011. Additionally, a program was in place for spot-checking hand hygiene campus-wide, emphasizing the role of good hand washing techniques in preventing spread of pathogens. A calendar of monitoring hand washing was submitted. It included twice yearly observations in all campus areas, including residences, food service, workshops, dental services, physician services, maintenance, housekeeping, habilitation therapies, and the beauty/barber shop. Analysis of the findings to determine any areas needing in-service education was not submitted, nor was an indication provided as to whether or not the calendar was being followed or the goal of the initiative was being accomplished. The high rate of 100% compliance with hand washing suggested either a Hawthorne effect (i.e., when people are observed, compliance increases), the tool was too insensitive to measure good hand washing technique, or the raters were not trained. An AUSSLC "MDRO" policy also was drafted, undated, focusing on use of contact precautions, hand washing and personal protective equipment. A separate draft policy, undated, was entitled "Multi-drug resistant infections (MRSA and VRE)." It provided guidance on contact and isolation precautions. As advances in infection control are frequent, timely approval of draft policies is essential, and is often followed by frequent revisions. There was ongoing in-service training by the infection control nurse for a variety of infection control topics in the prior six months. Topics included ringworm, influenza information and use of declination form for influenza, bed bugs, gastrointestinal concerns, infection prevention in practice (standard precautions/personal protective equipment, proper hand washing technique/use of antiseptic hand gel, MRSA/tuberculosis/blood borne pathogens, and linen handling/cough etiquette, care of suction canisters/tubing/and yankauers, and MRSA prevention.) There were 13 cases of MRSA infection reported in the prior six months. Most were cultured from wound infections. All were reported to be resolved, but no follow-up cultures were available to verify lack of carrier state or colonization. It was indicated that the MRSA infections appeared to originate at AUSSLC, and not after an ER visit or hospitalization. The Facility's draft policy provided guidance concerning follow-up cultures of MRSA wounds and healed wounds with a prior positive culture for MRSA. However, the policy did not appear to provide guidance about what should happen when the number of cases	

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		of MRSA/MRDO exceeded the threshold level identified by infection control. Without further recommendations regarding added surveillance and proactive steps (e.g., for hand washing, additional instruction in use of personal protective equipment, consideration of decolonization protocols, steps that the PCP needed to order, review of environmental cleaning practices, etc.) in the congregate living setting at AUSSLC, it was not clear the purpose of identification of the threshold level. The number of MRSA cases did exceed this level in the third quarter of FY 2011, but there was no information concerning additional steps taken to reduce the increased numbers in the congregate living environment at AUSSLC. Infection control did not appear to increase monitoring or intensified infection control oversight for the MRSA positive infections during this time period. No follow-up culture reports were completed for any of the MRSA infections (i.e., skin. respiratory, eye) reported during that time period. Additionally, the Facility policy for MRSA/MDRO that was currently in place was not submitted, only an undated draft policy. The infection control nurse should provide current reference material or consult with area authorities (e.g., hospital infection control department or local health department) to ensure the Facility is using the appropriately aggressive approach in preventing the spread of MRSA in the congregate living environment on campus, and to ensure the policies reflect current practice. This is a specialized area that might require consultant expertise. <u>Chronic Conditions and Specific Diagnostic Categories</u> As part of the review of 12 records, GERD was reviewed. Of the 12, nine were diagnosed with GERD. Of these nine, eight had appropriate evaluation and treatment (89%). Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. In October 2010, one individual was newly diagnosed with diabetes mellitus, type II. Three individuals were newly diagnosed with cardiovascular disease. One case of a newly diagnosed cancer was reported in the past year. There were three cases of bowel obstruction in the past year (dates of illness 9/15/10, 11/28/10, and 8/22/11). From a separate list, there were two new cases of bowel obstruction (i.e., 9/22/11 and 8/22/11). The Facility had no Skin Integrity Committee for the six months prior to the Monitoring Team's review. However, a subcommittee for skin integrity recently had been created as part of the Clinical Care Committee. The Facility submitted a list of new cases of decubiti per month for the prior year. The document did not indicate if the decubitus ulcer originated at the time of hospitalization or other off campus site, or occurred while individuals were residing at AUSSLC. Since April 2011, two new decubitus ulcers were documented in June 2011, and no other new decubiti were documented in 4/11, 5/11, 7/11, 8/11, 9/11, or 10/11. More remotely,	

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		four new decubiti were documented in March 2011, two in February 2011, four in January 2011, and two in November 2010. A list was submitted indicating that as of 10/4/11, approximately 120 individuals had a diagnosis of a seizure disorder. The Facility submitted information concerning antiepileptic medication usage, as well as other information related to individuals with seizure disorders. The following summarizes this information: ▪ As of October 4, 2011, 119 individuals were prescribed routine antiepileptic medication for a seizure disorder. There was one individual prescribed a pro re nata (prn, or "as needed") antiepileptic medication only. ▪ Of the individuals prescribed a routine antiepileptic medication, 55% were prescribed one antiepileptic medication, 26% were prescribed two antiepileptic medications, 15% were prescribed three antiepileptic medications, 2% were prescribed four antiepileptic medications, and 2% were prescribed five antiepileptic medications. ▪ A total of 24 individuals were considered to have a refractory seizure disorder. Eleven of these had a VNS implant. In the prior six months, no referrals were made for VNS implant for refractory seizures. ▪ In the prior six months, four individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure. The Facility reported that there were no cases of status epilepticus since the Monitoring Team's last visit. ▪ A list was submitted indicating the percentage of individuals with a seizure disorder that were prescribed older antiepileptic medications. A total of 22.5% of individuals with seizures were prescribed Dilantin, 2.5% were prescribed Primidone, 13% were prescribed Phenobarbital, and zero percent was prescribed Felbamate. ▪ Additionally, 28 individuals had a VNS implant. The Facility submitted neurology consultation notes documenting seizure management for five individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records: ▪ For five individuals (100%), the notes indicated a description of the seizures. ▪ For five (100%), the notes included a review of current medications for seizures and dosages. ▪ For none (0%), the notes included recent blood levels of antiepileptic medications. The lab for blood levels might have been available at the time of the neurology visit, but were not submitted, nor written in the consult report. ▪ For five (100%), a focused physical exam was recorded. ▪ All five (100%) included recommendations. Separately, a list of individuals seen by the neurologist from 4/18/11 through 9/12/11	

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		was submitted. The following indicates per month, the number of individuals seen in the neurology clinic: April 2011 – 10 individuals, May 2011 - 11 individuals, June 2011 – 24 individuals, July 2011 – 21 individuals, August 2011 – 24 individuals, and September 2011 - 11 individuals. A roster of individuals on enteral feeding from 5/1/11 through 10/21/11 was submitted. Names of 48 individuals on feeding tubes were included. Of these one had a GJ-tube and one had a J-tube. A medication history list was submitted for each of these, dating back at least one year. Medication choices appeared to be compatible with the route of administration. However, for one individual (i.e., Individual #65), oral medication was prescribed on 5/14/11, 9/23/11 to 10/5/11, and on 7/22/11. All other medications were given by tube. It was not indicated if the individual could tolerate medication by mouth (PO) or was supposed to receive nothing by mouth (NPO). The individual received all other medication through the feeding tube. Similarly, Individual #402 was prescribed oral medication from 5/16/11 through 6/29/11, from 9/7/11 to 9/12/11, and from 9/24/11 to 10/10/11. It was not indicated if the individual could tolerate medication PO or was NPO. That both individuals had all other enteral medications administered through a feeding tube inferred that this was a prescribing documentation error. However, if the individual was to take all enteral medication through a feeding tube, then the pharmacy also should have discovered the inconsistency, and clarified/corrected the route of administration at the time of new order entry, rather than allowing the order to be written for one to sixteen days. Both the pharmacy and the PCPs should review all individuals with enteral feeding tubes to determine which medications are to be administered through the tube, and ensure that the orders reflect that information. The individual with GJ-tube had original placement on 7/8/11. There were several episodes of clogged GJ-tubes necessitating ER trips with GJ-tube replacement. This occurred on 8/17/11, 9/9/11, 9/25/11, 9/29/11, 10/29/11, and 11/11/11. Four nursing in-service trainings on GJ-tube management were held (i.e., 7/14/11, 8/4/11, 8/25/11, and 11/15/11). Varying numbers of nurses attended the training. It is recommended that the Facility collaborate with hospital nursing for further insight into the frequent clogging, as well as with the manufacturer to determine additional factors that need to be addressed. GJ-tubes are associated with clogging, and other options (such as a J-tube) should be considered if nursing is not able to resolve the frequent clogging. <u>Do Not Resuscitate Orders</u> A total of 16 individuals at the Facility had DNR orders in place. For nine (56%), adequate clinical justification was provided for the DNR. Justification included diagnoses of dementia, congestive heart failure, and restrictive lung disease. For all 16, resuscitative orders were reviewed within the prior one-year period, as required on the	

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		out-of-hospital do not resuscitate order. For those orders for which adequate justification was not provided, the following issues were noted with regard to the justification: ▪ Four individuals had DNRs ordered for "multiple chronic medical problems." Diagnoses used to provide justification for DNR should be precise, and reflect the terminal state of the individual. Vague terminology does communicate the reason for the DNR status. Likewise, two individuals were diagnosed with cancer, but the status of the disease was not known (e.g., with metastases, on hospice, or whether the individual was being aggressively treated suggesting the individual was not terminal). ▪ It was also noted that the length of the DNRs varied. Four DNR orders were initiated in 2011. The remainder indicated longer time spans from 1999 to 2010, suggesting the need to review whether or not the individuals with remote orders for DNRs continued to meet the criteria for terminal condition. ▪ The Facility Ethics Committee appeared to conduct no routine review of all of the changes in DNR status from Resuscitation level I to II or III. The Ethics Committee should review all DNR status changes. ▪ No information was submitted to indicate if any of the 16 DNRs had been rescinded, or if consideration had been given that any should be rescinded. Of the 12 medical records reviewed, all were considered Resuscitation Status 1 (full code). <u>Ethics Committee</u> Several meetings of the Ethics Committee were held in the two months prior to the Monitoring Team's visit. Current members included a chaplain/clergy as chair, Medical Director, psychiatrist, occupational therapist, attorney, Facility social worker, hospital liaison nurse, Human Rights Officer, and two family representatives. At the 9/15/11 meeting, minutes indicated the need to develop a better relationship with the local medical center. The reason stated was that consulting physicians and guardians might make decisions, especially during weekends, that might not be in the best interest of the individuals. Such decisions were considered to be due partly to not understanding accurately the health conditions of the individuals admitted to the hospital. No follow-up had been documented with regard to this important concern. Minutes should include decisions/action steps, and timelines that are followed through to closure. At the 10/20/11 meeting, the discussion focused on Individual #404 and the current critical health condition that required the individual's mother to make decisions regarding further life sustaining treatments or palliative care. The mother requested more information to make an informed decision. The Committee decided to call an ethics	

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		consult as soon as possible, which was scheduled for 10/26/11. The mother attended by conference call, an also participated in an 11/16/11 hospital discharge planning meeting. The committee's goal was to ensure that all pertinent information was communicated and discussed. The nephrologist at the dialysis center was to be on speakerphone, as well as the mother. On 10/21/11, a staff psychiatrist visited the dialysis center for observation of Individual #404, and to interview dialysis nurses, direct support professionals, the individual's suitemate, and the nephrologist. The psychiatrist provided a lengthy descriptive note. On 10/21/11, the PCP provided a detailed IPN summarizing the individual's medical status. During a morning medical meeting that a member of the Monitoring Team observed, it was noted the individual had progressed to terminal status, and an Ethics Committee meeting was held urgently. The State Office was unaware of this individual's terminal status, complicated health status, and decision for DNR. It is recommended that all such cases have State Office involvement. Specifically, the Medical Director should ensure the State Office is aware of individuals who have resuscitation status changed to level III. As noted above, an ongoing role of the Ethics Committee also should be to review all changes in resuscitation status. On 8/26/11, the PST made Individual #81 a Resuscitation Status II. However, no notification appeared to have been made to the Ethics Committee, nor was there evidence of review by the Ethics Committee. To ensure there is appropriate and standardized review of resuscitation changes, the Ethics Committee should be involved in the review of each case to ensure it meets requirements of the Facility, State Office, and State Regulations. <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Non-facility Physician Case Reviews</u> For Round 2 of the non-facility physician review (July 18 to 19, 2011), reviewers completed 19 record reviews and used a 30-question auditing tool. Reviewers completed reviews of 20 records for Round 3 (October 31 to November 1, 2011). No information was submitted concerning inter-rater reliability between the two non-facility physicians, or the inter-rater reliability between the two non-facility physicians compared and the external peer review auditors at other SSLCs. Additionally, no summary report from the State Office or from the external auditors was submitted. It appeared that the SSLC Medical Department or QA Department had recorded the information that was submitted. The following represents a synopsis of the information the Facility provided related to	Noncompliance

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		the Round 2 and Round 3 reviews: ▪ For Round 2, for the 19 external peer record reviews, PCP compliance in essential areas ranged from 68% to 94%. For areas considered non-essential, compliance ranged from 53% to 84%. ▪ Areas that appeared to need improvement included: the active problem list (i.e., dating and signing when it was last reviewed, updating the list as new problems occurred or when problems were resolved); appropriate documentation of drug and/or food allergies, intolerances and reactions; documentation concerning tobacco product use, and whether counseling was provided if there was tobacco use; documentation of appropriate/timely immunization administration; IPNs reflecting the PCPs' interpretation and follow-through of abnormal lab; IPNs reflecting the PCPs' review and follow through regarding medical and/or surgical recommendations; timely completion of the IPNs within five days of receipt of the recommendations; and the inclusion in the 180-day physician orders of indication and duration for each medication. ▪ The Medical Department submitted follow-up documentation for Round 2. An undated and incomplete corrective action plan grid was submitted defining 10 noncompliant areas based on Round 2. Also submitted were two Medical Provider QA audit meeting minutes. The attendance section of the minutes of the 8/25/11 meeting only indicated "physicians." Specific names should be included. The meeting included an in-service training to address the Round 2 action plans on several topics, including: SOAP format, treatments ordered for acute illness, abnormal tests/studies/labs and the plan for follow-up, consult recommendation follow-up and timeliness of follow-up, notes within 24 hours of readmission from the hospital or Long Term Acute Care facility, and legibility. Additional topics included consultations (i.e., ensuring referrals contained essential current and past history), physician orders (i.e., including indication and duration of treatment for acute medical problems), and ensuring pertinent information was included in the annual medical assessment. At this time, the specific audits were distributed to the PCPs, and need for review as soon as possible, because the QA department monitored the progress of action plans. No information was provided concerning the delay in addressing the external audit findings (i.e., audit of July 18 to 19, 2011, and distribution of the audit findings on 8/25/11). It is recommended that discussion of the findings and approach to resolution occur as soon as the QA Department distributes the corrective action plans. Corrective action plans should be available to the Medical Department within five business days, or as determined by Facility Administration. ▪ A second follow-up medical provider QA audit meeting occurred on 10/18/11. At that time, the QA Department provided findings of their follow-up audit of the corrective action plans distributed to the PCPs. Areas of improvement were noted, as well as continuing areas of concern. A new concern also was identified.	

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		Verbal/telephone orders usually did not include the indications for the ordered medication. At this meeting, the Medical Director provided an overview of the external review process, focusing on questions from the audit tool with the lowest compliance scores. The QA Department explained the breakdown into essential and non-essential components of the audit, as well as the threshold compliance scores. Reasons were not included for not sharing this information with the PCPs at the start of the external peer review process. There was discussion about regularly scheduled meetings to discuss medical QA/external audit findings, but no decision was reflected in the minutes. Several steps to be completed were included as recommended corrective action plans, including collaboration with nursing to define the process for timely signing of verbal orders, as well as including indications on the verbal orders; review of the Preventive Health Care Guidelines for SSLCs, dated 8/11; and collaboration with nursing to determine the process for documenting resident allergies on the physician order sheets. During the Monitoring Team's visit, no information was submitted to determine progress in closure of these corrective action plans. It is recommended that regular monthly meetings be scheduled for the PCPs to discuss the QA Department's ongoing audits. It is also recommended that the QA Department conduct reviews and complete monthly QA corrective action progress reports that are then discussed at these meetings. Ideally, three QA reviews/updates should occur between external peer reviews to ensure the PCPs' timely completion of these plans. The 10/18/11 meeting was held approximately two weeks before Round 3 of the external audits, and listed several areas that needing further action. It is recommended that within the first month after the external review, the Facility address the corrective action plans, as well as systemic application of these action plans. Evidence of progress should be seen in the incorporation of the various improvements in the annual medical assessments, progress notes, active problem list, etc. Subsequent external audits should indicate improvement as random records are reviewed. Leaving corrective actions to the final days before the next audit minimizes the impact of the prior audit results on any improvement process. ▪ Round 3 was completed as scheduled, and 20 records were reviewed, a five percent sample of the individuals AUSSLC served. For Round 3, PCP compliance for the essential areas ranged from 93 to 100%. For areas considered non-essential, compliance ranged from 88 to 92%. The Facility took notes at the exit conference on 11/1/11. The external reviewers submitted no formal summary. The minutes indicated progress in several areas of documentation, including IPN content of those returning from hospital admissions, indications for ordered medication, and timely follow-up of consult reports and recommendations. Concern was noted that verbal orders did not include indications for the medication, and that unsigned telephone orders were found. Six	

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		recommendations were made involving such areas as documentation of resuscitation status; ensuring the beginning of the annual assessment summary included specific items, such as the active problem list, medications, diet and resuscitation status; documentation of contacts and attempts to contact family; tobacco usage documentation in the annual medical assessment; and clarification of tobacco use in the active medical problem list. Although the reviewers noted improvement in several areas, a meaningful trend toward improvement will require several serial visits and lengthy reviews to determine permanency of impact. ▪ A table and graph were submitted that reviewed compliance for each PCP across the three Rounds of audit results. For the essential components, each PCP improved over the three reviews. Two PCPs attained 100% compliance for the essential components for Round 3. For the non-essential components, each PCP also improved over the three audits. All PCPs attained compliance. It appeared that the external audit process had improved the quality of the PCPs' documentation. It appeared to be a dynamic process in that additional areas needing review of documentation were identified. It is recommended that future audits begin to incorporate these new areas of concern, internally, if specific to an SSLC, or into the statewide audit tool, if the documentation concern is identified at several SSLCs. ▪ On 11/8/11, a medical provider QA audit meeting was held, which all physicians and the QA nurse attended. At that time, the PCP results for Round 3 of the external review were distributed. The QA Department provided a due date of 12/8/11 (i.e., one month) for resolution and completion of the corrective action plans provided to each PCP. The State Office also had a scan call with the PCPs, and discussed the new external and internal audit process and the audit schedule. As part of this conference, the State Office developed medical management questions for external and internal medical provider audits. These included clinical indicators and questions for aspiration, constipation, diabetes mellitus, osteoporosis, seizures, and urinary tract infections. These documents provided succinct guidance in completing internal and external quality reviews. ▪ A follow-up system was implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. This was accomplished through the QA nurse/QI Department. However, delays appeared to have occurred in distributing action plans and following up after the external reviews were completed. It is recommended that corrective action plans be distributed within the week following completion of the external peer review, and a monthly meeting be conducted each calendar month of the year at which the status of unresolved action plans are discussed. Additionally, attendance rosters should state names and titles, not simply "all physicians," because one of the PCPs was a nurse practitioner.	

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		Mortality Reviews At the time of the review, the Facility had no outstanding clinical death reviews. Since the start of the Monitoring Team's last visit, four deaths had occurred: ▪ The average age was 69.5 (varied from 55 to 94). ▪ The causes of death were: restrictive lung disease, aspiration pneumonia, colon carcinoma, and heart disease. ▪ An autopsy was performed in none of the four. ▪ Three of the individuals had a resuscitation level of III. One individual had a resuscitation level of II. ▪ Three had hospice services. Two died at a hospice facility. ▪ None died in a hospital setting. ▪ Three had a G-tube. ▪ All were appropriately treated. Since the Monitoring Team's last visit, four death review investigations were completed. ▪ Of these, one had two administrative recommendations, and one had an additional clinical recommendation. ▪ The nursing QA reviews included 15 recommendations for three of the four deaths. ▪ The two administrative recommendations had some level of follow-up. A workgroup was developed for one of the recommendations, but no information was submitted to indicate whether the recommendation was carried out or the conclusions of the work group. The other recommendation included an action step that appeared to be contradictory with the findings. There was no information concerning the one additional clinical recommendation. ▪ No data was available for the 15 QA nursing recommendations. ▪ It appeared that only the administrative recommendations had action steps taken. It was not clear if the other clinical and nursing recommendations were accepted and acted upon or not. It is recommended that a clear policy for these different levels of recommendations be created to provide guidance in follow-up. If only administrative recommendations are to be followed up, then this should be stated clearly in a policy and procedure.	
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;	Medical Department Internal Reviews The Medical Department had not initiated an internal medical review process. At the time of the Monitoring Team's visit, a medical compliance nurse recently had been hired. Any internal reviews using the same tools as the external peer reviewers will require demonstration of inter-rater reliability. On 10/7/11, the State Office released a draft of the "Internal Medical Review" process.	Noncompliance

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	assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	On 11/8/11, there was a follow up in-service provided to the Medical Director and primary care providers. February 1, 2012 was the anticipated implementation date. The 10/7/11 State Office document provided a framework for both the external and internal medical provider quality assurance audits. It provided the structure for the interface between the two. The internal audits were scheduled for the months in which the external audits did not occur, and required review of two percent of each provider's caseload to be reviewed each month, with a minimum of two records per provider each audit. Additionally, audits with disease/diagnosis specific focus were an additional sample to be completed monthly. Until the new process began on February 1, 2012, the internal audits were to continue to be Facility-specific. The Facility will need to monitor the progress of the internal review system, because it is ambitious and includes monthly record reviews by potentially overextended PCPs, as well as an additional medical audit each month. The Facility and State Office will need to create a monitoring schedule to ensure the internal audits adhere to the expected timeline, and develop criteria for quality of the review. Several concerns were noted at AUSSLC with regard to internal medical reviews. In the two years since Settlement Agreement implementation began, the Facility had initiated no QI/QA program or pilot. The Medical Department appeared to consider Section L.3 an option rather than a requirement. If lack of knowledge on medical QI/QA systems was a problem, the Medical Department did not appear to have made any attempt to gain outside assistance or consultation in developing an internal program. At this point in time, there was potential for two years of experience in developing the necessary infrastructure, but none existed. The information technology database systems for medical needs and monitoring appeared to be undeveloped, or developed only for the needs of the Monitoring Team, rather than as an ongoing source of information regularly analyzed for self-improvement. Although the State Office responsibility included providing support to each SSLC and standardizing expectations at all SSLCs, the Medical Department appeared to have misinterpreted this as there was no requirement to begin internal monitoring immediately. The Settlement Agreement indicates that QI/QA activities were expected to commence within six months, and be fully operational in two years. Reasons and excuses for not beginning implementation within six months were not valid. Two years into the Settlement Agreement, when the expectation was full implementation, AUSSLC had no activity and no data related to QA monitoring. Data obtained for the Monitoring Team was specific to the Monitoring Team's requests, and the Facility was not using it for any other purpose. However, no system appeared to be in place to check the quality of the information provided to the Monitoring Team. For example, a member of the Monitoring Team reviewed and analyzed the list of dates for	

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		completion of the annual medical assessments and annual physical examinations that was provided. When considerable noncompliance was determined based on the information provided, and the Monitoring Team discussed these findings with the Medical Director, it was determined the data was inaccurate and a second report was submitted. However, it was apparent that no one looked at the second run of data, because it was identical to the first. If there were any updates, they were not included in the resubmitted document. The accuracy of the information remained unclear, but this information was used to determine compliance. This example suggested no one reviewed data even when it was available. The process of developing a credible and complete information management system to assist the Facility in discovering areas needing improvement is a major goal of the Settlement Agreement, but at AUSSLC, the Medical Department's administration did not "own" it. Many opportunities existed to track information, develop and improve information systems, and fine tune database management over the past two years, but this has not occurred. In the upcoming months, this should be a priority area of improvement for the Medical Department. A first step should be the development of a list of areas requiring monitoring, and collaboration with the Information Technology Department in developing information systems that incorporate the major diagnoses seen at AUSSLC, as well as clinical indicators to provide evidence of attainment of measurable goals in the quality of medical care.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility revised the AUSSLC Medical Care policy, dated 4/1/11, and revised 8/22/11. A new policy also was created entitled "AUSSLC: Medical Services Policy: Management of Consultation Reports," dated 8/16/11, with training provided to the medical staff on 9/1/11. During the prior six months, the Facility implemented one State Office medical policy entitled "SSLC: Preventive Health Care Guidelines: SSLCs," dated 8/30/11. This provided important guidance to the Medical Department, especially with the many recent changes in preventive guideline recommendations from various professional organizations. This document provided the expectations across the SSLC system concerning preventive medical care. On 9/7/11, the SSLC statewide Policy and Procedure #044.2 Emergency Response was effective, requiring the training of CPR to all staff providing direct services to the individuals. The Medical Emergency Response Committee held several meetings to address the responsibilities of the committee. At these meetings held on 8/9/11, 8/24/11, 9/15/11, 9/29/11, and 10/18/11, the group discussed the topics of drill schedules across campus, tracking drill results, retraining of staff if necessary, training	Noncompliance

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		for staff conducting drills, stocking of required emergency equipment, daily inventory of equipment, routine equipment checks to ensure functionality, and review of emergency drills. Additionally, in October 2011, the State Office finalized and released several clinical guidelines. These included Constipation Management, Seizure Management, Enteral Feeding, and Aspiration Pneumonia. From the documents submitted, no indication was found that an in-service had been provided to the PCPs concerning the content of these clinical guidelines. In addition, the Facility provided no information indicating that a future meeting had been scheduled to discuss strategies for implementing these clinical guidelines. A number of policies involving medical services were in various stages of completion. A draft of a policy on Infirmary/hospital transition, dated November 2011, was submitted. It provided guidance concerning communication, transport of equipment with the individual, expectations of steps to be taken for a hospital admission, resuscitative status of hospitalized individuals, and the role of the IDT. This draft policy outlined requirements requiring collaboration between a variety of departments, as well as the individuals' IDTs. It is recommended that this policy include QA monitoring to ensure each aspect of this diverse policy is implemented. A nursing policy entitled "SSLCs Nursing Protocol: Hospitalizations, Transfers, and Discharges," dated June 2011, provided guidance for hospital transfers and discharges. In reviewing the IPNs for acute care transfers to the ER, whether the RN or PCP contacted the ER personnel, and to whom the RN or PCP spoke was not documented. It is recommended that this be recorded in the IPN at the time of transfer. According to the policy, this information was written on the transfer sheet. Although a copy of the transfer form was to be placed in the IPN section of the active record, no IPNs submitted included this transfer form. It is recommended that the completion of the transfer form and filing be reviewed and monitored to ensure that the policy is followed, or the transfer contact person is recorded in the nursing/PCP IPN. A "Physician Client Record Request Procedure," undated was submitted. The intent was to assist the PCPs in obtaining active records in a timely manner. It was unclear if this procedure was implemented, and if so, the success of the procedure, because it required interdepartmental cooperation. The Facility had difficulty locating some of the medical records when the external medical peer reviewers were on campus. To ensure the medical records were available, a new system was created. AUSSLC implemented an Active Records Check-out Process,	

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		revised 7/25/11. Training was mandatory and occurred between 8/8/11 and 9/16/11. Discussion included both the active records and the Individual Notebooks (I-Books). This initiative is discussed in further detail with regard to Section V.1 of the Settlement Agreement.	

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

1. For the morning medical meeting, the PCPs should be fully informed and knowledgeable about the individuals on their caseloads that will be discussed at the morning meeting. Clinical staff that are uninformed should not limit discussion. (Section L.1)
2. For the morning medical meeting, the minutes should provide clarity regarding areas identified as needing closure. (Section L.1)
3. The areas needing documentation of closure should be expanded to include issues such as healing of wounds with or without complications, and review of events leading to behaviors and analysis of that information with changes recommended as appropriate to the ISP/BSP or other relevant document (e.g., change in environment, active treatment program, community activity choice, diet, etc.). (Section L.1)
4. The table used for the minutes of the morning medical meeting should be completed as intended, including the recommendations/plan section, and responsible person. (Section L.1)
5. Medical Department administration should conduct frequent review of areas identified as needing closure at the morning medical meetings to ensure timely progress and resolution of the concerns. (Section L.1)
6. Medical Department administration should determine if medication errors/variances are part of the daily agenda of the morning medical meeting, and if so, documentation should be included of the type and severity of the medication error, the reason for its occurrence, and the steps to prevent recurrence. (Section L.1)
7. Given that no physician quarterly assessments had been done, this should be an area of priority, with timelines set for implementation and discussion of content to ensure all PCPs are documenting the same information at each quarterly visit. (Section L.1)
8. Clear and accurate documentation should be maintained of specialty clinics, including written documentation of periodic reviews, focusing on completeness and resolution of discrepancies. The Medical Department should use this data for trend analysis and future goal setting, with corrective plans when needed. (Section L.1)
9. The Medical Department should create a system for tracking individuals with osteopenia/osteoporosis, including T scores, frequency of DEXA scans, and types of medication prescribed with dosages. The Medical Department should use this information to identify potential gaps in evaluation or treatment, and take appropriate action to correct any issues identified. (Section L.1)
10. The QA Department should independently monitor the work-up for osteopenia/osteoporosis, periodicity of DEXA scan testing, and adequacy of treatment. (Section L.1)
11. The Medical Records Department should consider providing a unique identification for Infirmary charting (e.g., colored pages, heading of page, indication of Infirmary location, etc.) to clarify location of the individual and where treatment/monitoring is provided. (Section L.1)
12. The Facility should review the pneumonia data in order to ensure consistency across the databases. (Section L.1)
13. For infection control topics, timely approval of draft policies is essential. (Section L.1)
14. The infection control nurse should provide current reference material or consult with area authorities to ensure the Facility is using the appropriately aggressive approach in preventing the spread of MRSA in the congregate living environment on campus, and to ensure the policies reflect current practice. (Section L.1)
15. Both the pharmacy and the PCPs should review all individuals with enteral feeding tubes to determine which medications are to be administered through the tube, and ensure that the orders reflect that information. (Section L.1)
16. The Facility should collaborate with hospital nursing staff for further insight into the frequent clogging of GJ-tubes, as well as with the

manufacturer to determine additional factors that need to be addressed. If nursing is not able to resolve the frequent clogging, other options (such as a J-tube) should be considered. (Section L.1)

17. Diagnoses that provide justification for DNR orders should be precise, and reflect the terminal state of the individual. (Section L.1)
18. For those individuals for whom DNR orders were put into place more than a year ago, the DNR should be reviewed to ensure the individual continues to meet the criteria of a terminal condition. (Section L.1)
19. The Ethics Committee should review all DNR status changes to ensure there is appropriate and standardized review of resuscitation changes, and to ensure the decision meets the requirement of the Facility, State Office, and State regulations. (Section L.1)
20. Minutes of the Ethics Committee should include action steps to implement the decisions that are made, including timelines for completion. These should be followed in the minutes until closure is achieved. (Section L.1)
21. All cases of new DNR orders should be communicated to an appointed contact in the State Office. (Section L.1)
22. The State Office should establish and provide data concerning inter-rater reliability of the external non-facility physician reviewers in completing the auditing tool. (Section L.2)
23. The State Office should ensure the external review process includes a summary report in writing from the non-facility physician reviewers that is then is forwarded expeditiously to the Facility. (Section L.2)
24. For all minutes in the Medical and QA Departments, attendance should include name and title. (Section L.2)
25. Discussion of the external review findings and any discussions concerning approach to resolution should occur in an expeditious manner (within five business days or as determined by Facility administration policy), and the QA Department's distribution of corrective action plans should occur at that time. (Section L.2)
26. The Medical Department and QA Department should encourage completion of the corrective action plans within the first month after the external review, as well as systemic application of these action plans. (Section L.2)
27. Minutes of the medical QA meetings should include action plans and closure documentation, with defined timelines. (Section L.2)
28. Regular monthly meetings should occur with the PCPs and the QA Department to review status and progress toward resolution of identified issues. (Section L.2)
29. Future audits should begin to incorporate new areas of concern. (Section L.2)
30. With regard to mortality reviews, a clear policy for the different levels of recommendation should be created (especially clinical and nursing) to provide guidance concerning follow-up. (Section L.2)
31. The Facility should monitor the progress of the internal review system, because it is ambitious and includes monthly record review by potentially overextended PCPs, as well as an additional medical audit each month. The Facility and State Office should create a monitoring schedule to ensure the internal audit adhere to the expected timelines, and develop criteria for the quality of the reviews. (Section L.3)
32. As an area of priority focus, the Medical Department's administration should develop a list of areas requiring monitoring, and collaborate with the Information Technology Department in developing information management systems that incorporate the major diagnoses seen at AUSSLC, as well as clinical indicators to provide evidence of attainment of measurable goals in quality of medical care. It is essential that the Medical Department regularly reviews the accuracy of the data collected, and uses the information to identify areas requiring improvement. As areas requiring improvement are identified, the Medical Department should identify and implement appropriate corrective actions or action plans. Documentation should be maintained on the completion of correction actions as well as the expected outcomes, and the corrective actions should be modified should it be determined that clearly identified outcomes are not achieved. (Section L.3)
33. For the draft policy concerning Infirmary/hospital transition, it should include QA monitoring to ensure that each aspect of this diverse policy is implemented. (Section L.4)
34. Completion of the ER transfer form and filing of the copy should be reviewed and monitored to ensure the policy is followed, or alternately, that the transfer contact person is recorded in the nursing/PCP IPN. (Section L.4)

SECTION M: Nursing Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC's POI; o AUSSLC's Nursing Department Presentation Book; o AUSSLC's Monitoring Tools for Nursing; o AUSSLC's minimum staffing numbers for nursing; o Infection Control Quarterly Rounds audit data; o AUSSLC's Infection Control Monitoring Tool data; o State Office's training curriculum addressing Documentation, and Physical Assessment; o Laminated cards for nursing protocols, addressing head injuries, antibiotic therapy, diarrhea, temperature elevations, respiratory distress/aspiration, constipation, and vomiting; o State Office Quality Assurance policy (draft); o State Office Minimum & Integrated Clinical Services policy, undated; o Draft Case Manager Responsibilities, dated 11/1/11; o AUSSLC's Corrective Action Plans for Nursing; o AUSSLC's nursing staffing information; o Resume and job description for Quality Assurance Nurse; o AUSSLC Nursing Monitoring tools with instructions; o Program Compliance Nurse's monitoring data; o AUSSLC's lists of individuals who were seen in the emergency room, and hospital; o Infection Control Monitoring data; o Medical records for the following individuals: Individual #269, Individual #398, Individual #117, Individual #100, Individual #87, Individual #57, Individual #195, Individual #74, Individual #212, Individual #421, Individual #262, Individual #309, Individual #90, Individual #274, Individual #62, Individual #147, Individual #442, Individual #239, Individual #353, Individual #43, Individual #382, Individual #186, Individual #426, Individual #82, Individual #72, Individual #3, Individual #309, Individual #289, Individual #290, Individual #454, Individual #147, Individual #310, Individual #306, Individual #204, Individual #73, Individual #137, Individual #117, Individual #118, Individual #296, Individual #188, Individual #186, Individual #53, and Individual #395; 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 Risk lists for health indicators; o Nursing Advisory Committee meeting minutes, dated 6/6/11, and 6/17/11; o Infection Control Committee meeting minutes, for May and September 2011; o Infection Control Monitoring Schedule for Hand Hygiene Spot Checks; o Infection Types Report for Pneumonia;

	○ AUSSLC Nursing training rosters; ○ Infectious Outbreak Timelines; ○ Medication Administration Observation tracking schedule, and data; ○ Medication Variance Committee meetings minutes, dated 10/17/11, and 11/14/11; ○ AUSSLC Medication Variance Reports; ○ AUSSLC Medication Variance data; ○ Infection Control Quality Improvement Report; ○ Infection Control Monitoring Tools, for June, and October 2011; ○ Housekeeping Quality Checklists; ○ Medical Emergency Response Drill training outline; ○ State Office Emergency Response policy, dated 9/7/11; ○ Emails from Pharmacy to Nursing, dated 9/9/11, 9/14/11, 9/15/11, 10/12/11, 10/14/11, 10/27/11, and 11/8/11; ○ AUSSLC Corrective Action Plans for Nursing; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 10/18/11; ○ Medication Administration Observation audit data, for May through October 2011; ○ Medication Administration Observation audit, dated 11/15/11; ○ Emergency Medical Drills and tracking sheets; ○ Emergency Medical Equipment Checklists, for August and September 2011; ○ Medical Emergency Response Committee minutes, dated 8/9/11, 8/24/11, 9/15/11, 9/29/11, 10/18/11, and 11/15/11; and ○ Mock Drill Remediation reports. ▪ **Interviews with**: ○ Priscilla R. Hackett, MSN, MPH, RN, CCM, Chief Nurse Executive (CNE); ○ Jolene Harvey, RN, Nurse Operations Officer (NOO); ○ Tammy Snyder, QA Director; ○ Kay Cowan, RN, MSN, FNP, BC, Infection Control Nurse IV; ○ Jennifer Mears, Competency Training and Development (CTD) Director; ○ Soledad Reyes-Hernandez, CTD Training Specialist II; ○ Michele Head-Blalack, RN, Nursing Operations Officer; ○ Pam Mathie, RN IV, Infirmary Nurse Manager; ○ Jose Levy, MA, LPA, BC, BA, Behavioral Services Director; ○ Minnie Stephen, Director of Housekeeping; ○ Byron Swor, Director of Facility Supports Services; ○ Connie Horton, FNP, State Consultant; ○ Valerie Kipfer, RN, MSN, State Office Nursing Services Coordinator; ○ Barbara Unger, QDDP, Physical Nutritional Management Team; ○ Linda Lothringer, Settlement Agreement Coordinator (SAC) Unit Director; ○ Valerie Ditta, Assistant Director of Administration; ○ Jennifer Russell, Assistant Director of Programs; ○ Vira Benson, Facility Director; ○ Holly Lindsey, QDDP Coordinator;

	○ Karen Hardwick, Ph.D, State Office Consultant; ○ Chris Strickling, OT, Ph.D, Physical Nutritional Management Team; ○ Coindy Bean, RN, Hospital Liaison; ○ Brenda Starr, RN, Nurse Manager; ○ Michael Maynard, RN, Nurse Manager; ○ Chris Brock, Respiratory Therapist; ○ Kim Montgomery, RN, Case Manager; ○ Ana Saenz, RN, Case Manager; ○ Mary Le Febvre, RN, Nurse Manager; ○ Susan Chmiel, PT, Physical Nutritional Management Team; ○ Shelly Conroy, MA, CCC/SLP; Physical Nutritional Management Team; ○ Kim Ingram, MA, CCC/SLP Habilitation Therapies Director; ○ Abigail Collins, QDDP; ○ Donna Jesse, State Office SSLC Operations Director; and ○ Jim Todd, Attorney, State Attorney General's Office. ▪ **Observations of**: ○ Medication Administration in the Infirmary; ○ Medical Emergency Response Committee meeting, on 11/15/11; and ○ Use of emergency equipment at the Infirmary, Residence 797, and Residence 793.
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section M of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings. Although the Facility self-assessment of noncompliance was in alignment with the findings of the Monitoring Team, no indication was provided regarding on what information, observations, or data the Facility had based its findings. Thus, no relevant data was presented to substantiate its findings of noncompliance, or to assist the Facility in identifying areas requiring attention. In addition, for many of the areas in Section M, the POI included information that did not pertain to the specific requirement of the Settlement Agreement for that particular section. Due to the few monitoring audits conducted for nursing during this review period, the Facility was not able to provide data indicating the status of the different areas of nursing practices. Although the Facility had developed and implemented Action Steps/Plans for sections M.1, M.2, M.3, M.4, M.5, and M.6, most of the steps listed in the plans had not yet been implemented. In addition, few of the Action Steps that were included in the Action Plans addressed the priority clinical issues found as being deficient during the past reviews. For example, most of the Action Steps included in the Plans addressed issues related to implementing monitoring systems to audit for the quality of Nursing documentation. However, there were essentially no Action Steps addressing how to achieve quality in the documentation. In addition, no indication was included regarding what actions and interventions the Facility planned to implement and accomplish by the next review.

	Summary of Monitor's Assessment: Since the last review, AUSSLC had made a number of changes regarding the Nursing Department and nursing positions, some which included filling the positions for the Nursing Operations Officer (NOO), the Hospital Liaison, the Nurse Manager positions for Castner Estates and the Infirmary, and the Quality Enhancement Nurse position. In addition, since May 2011, AUSSLC had not used the services of any agency nurses, and had established a Licensed Vocational Nurse 16-hour work schedule pool to cover weekends and other staffing issues. At the time of the review, the Nursing Department had a total of 143.6 allotted positions for Nursing, including 80.1 RN positions and 63.5 LVN positions. Overall, the total nursing vacancies included 12 RN positions, and eight LVN positions. These positive staffing advancements should assist the Facility in moving forward in achieving positive clinical outcomes for the individuals residing at AUSSLC. Similar to the last review, at the time of this review, the restructuring process of the Nursing Department was still underway with other interventions yet to be implemented. The Nursing Department and the Program Compliance Nurse had implemented few Heath Monitoring Tools due to a variety of staffing issues. However, a review of the Nursing Department's limited audits and data for some of the Nursing Health Monitoring tools found that with better consistency, there was promising potential to be able generate relevant data regarding nursing practices. However, due to the problematic issues regarding the lack of clear and specific instructions for the monitoring tools, lack of establishment of the clinical competence of the auditors in the areas they were are reviewing, and the lack of inter-rater reliability established for the monitoring tools, the current data generated were unreliable. Some of the Facility's positive steps forward included initiating the attendance of the Chief Nurse Executive, the Nursing Operations Officer, the Infection Control Nurse, the Hospital Liaison, the Infirmary Nurse Manager, and the Nurse Educator at the daily morning medical meetings. This was a positive step forward in facilitating communication between disciplines regarding acute events, and updates on individuals who were in the hospital. In addition, a procedure had been developed to address data reliability for Infection Control, which was a crucial element in being able to accurately identify the Facility's trends related to infectious and communicable issues. Also, a very promising database was developed and implemented to track, analyze, and trend infectious diseases. The Facility also established the Medical Emergency Response Committee to review the Facility systems related to emergencies. However, consistent with the findings from the past reviews, there was no appreciable progress made in the critical areas addressing nursing Health Management Plans, nursing assessment and documentation in response to changes in status, the quality and timeliness of the quarterly and annual nursing assessments, issues related to the Medical Emergency Response System, and/or nursing medication practices and the medication variance system. The Facility's inability to address these issues directly related to inadequate care provided to individuals, and, in some cases, placed individuals at increased risk of harm.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of	Given that this paragraph of the Settlement Agreement includes a number of	Noncompliance

#	Provision	Assessment of Status	Compliance
	the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	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 medical emergency systems. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the Settlement Agreement. Information and recommendations addressing nursing documentation regarding restraints is included above with regard to Section C. In assessing its progress, AUSSLC indicated in the Facility's POI that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ *"05/01/2011 - Management of Acute Illness and Injury Protocol and Documentation Guidelines fully implemented.* ▪ *08/01/2011 -Hired additional nurses into dedicated positions to the weekend resource team (float pool).* ▪ *08/09/2011 - Medical Emergency Response Committee established. Committee membership reviewed and established to include Competency Training and Development (CTD), Medical, Nursing, Risk Management, Support Services, and Quality Assurance (QA). Reviewed DADS Emergency Response Policy. Identified areas that need to be improved in order to be in compliance with policy.* ▪ *08/24/2011 - Medical Emergency Response Committee meeting held. Discussed need to determine who can conduct drills in addition to the current Competency Training and Development (CTD) CPR instructors (3 staff) and the need to identify more staff from other areas to conduct drills. Discussed corrective action for anyone who fails a drill and the retry.* ▪ *08/25/2011 - Nurse managers held hiring event.* ▪ *09/13/2011- 09/16/2011 State mandated RN physical assessment and documentation class taught by Advanced Practice Nurses - total of 45 nurses participated to date.* ▪ *09/26/2011 LVN Fill Rat e= 94.32% (year to date through August 2011) RN Fill Rat e= 97.4% (year to date through August 2011)* ▪ *09/29/2011 -Medical Emergency Response Committee to review the DADS Medical Emergency Response policy revised 09/07/0211 and discuss key changes related to definitions added, emergency equipment, drills, immediate plan of action and Quality Assurance. The number of additional staff from Nursing, Risk Management/Support Services, Medical and Residential Services was identified.* ▪ *10/01/2011 Nursing regularly attends daily morning medical meeting: includes CNE, NOO, Infection Control Nurse, Hospital Liaison, Infirmary Nurse Manager and Nurse Educator.*	

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		▪ *10/17/2011 - Implemented Hospital, Transfer, Discharge Nursing Protocol. The information obtained from hospital visits is now documented on the Hospital Liaison Report.* ▪ *10/18/2011 - Identified areas needing improvement regarding Emergency Equipment section of Medical Emergency Response policy. Discussed need to identify locations on campus such as vocational areas that need emergency equipment. Continued review of DADS Medical Emergency Response Policy to identify continued need for areas that need to meet compliance.* ▪ *11/2/2011 - Not currently trending or analyzing data."* Also, AUSSLC's POI indicated that these additional steps were initiated as mentioned below with regard to Section M.5, but apply as well to areas noted in this particular section: ▪ *"10/17/2011 Continuing hand-washing spot checks. Two incidents of homes with bed bugs identified within past two months with timeline of handling of incidents by infection control nurse.* ▪ *Supervision of all nurse case managers (who perform the quarterly and annual nursing assessments) has been moved from the unit nurse manager to the Nursing Operations Officer (NOO).* ▪ *10/21/2011 Infection Control Nurse beginning certification process with Certification Board of Infection Control and Epidemiology, Inc., (CBIC). This was reviewed with Infection Control Nurse during performance plan review and will be incorporated into annual performance evaluation.* ▪ *11/1/2011 - Draft version completed of formalized system (procedures) for reporting infections to Infection Control Nurse and system of identifying discrepancies including how reconciled and tracked."* The impact that these steps had on progress and outcomes are addressed in the associated sub-sections below. <u>Staffing</u> At the time of the review, AUSSLC had a census of 351 individuals. Since the last review, AUSSLC had a number of changes regarding the Nursing Department and nursing positions, which included: ▪ In September 2011, the Nursing Operations Officer (NOO) position was filled; ▪ In October 2011, the Hospital Liaison position was filled; ▪ In September 2011, the Nurse Managers positions for Castner Estates and the Infirmary were filled; ▪ The Nurse Manager for Sunrise and a Nurse Educator position were vacant; ▪ Two nursing positions, including the Nurse Recruiter/Schedule Coordinator and a Nurse Educator position were converted to Licensed Vocational Nurse (LVN)	

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		III 16-hour weekend positions; ▪ The supervision of the Nurse Case Managers was moved from the Nurse Manager of the units to the NOO; ▪ In August 2011, the Quality Enhancement Nurse position was filled; ▪ Since May 2011, AUSSLC had not used the services of any agency nurses; ▪ The role of the Case Managers was reviewed, and included job duty changes, such as not administering medications, and working Monday through Friday to facilitate availability to attend meetings for individuals on their caseloads; ▪ In August 2011, a LVN 16-hour work schedule pool was initiated to cover weekends and other staffing issues; ▪ The Program Compliance Nurse had been on leave, and thus, since that last review, few nursing audits had been conducted; ▪ The full-time position for the Physical Nutritional Management Registered Nurse was vacant; ▪ The supervision of the two full-time Respiratory Therapists was moved from Nursing Department to Medical Services; and ▪ A number of Administrative/Managerial nurses attended a Team Building/Communication workshop. At the time of the review, the Nursing Department had a total of 143.6 allotted positions for Nursing. This included 80.1 RN positions and 63.5 LVN positions. Overall, the total nursing vacancies included 12 RN positions, and eight LVN positions. As noted above, the Chief Nurse Executive reported that since May 2011, the Facility had not used the services of any agencies to cover nursing positions. To assist with coverage, the Facility had developed a pool of LVNs who worked 16-hour shifts to cover weekends, and was using overtime for situations when the Facility needed to augment nursing coverage. These positive staffing advancements should assist the Facility in moving forward in achieving positive clinical outcomes for the individuals residing at AUSSLC. Since the previous review, the Nursing Department had continued to focus a significant amount of effort in restructuring the roles and responsibilities of the Facility's nursing positions, and the Nursing Department. From discussions with the CNE, this restructuring process was still underway with additional interventions yet to be implemented. In addition, due to an unforeseen leave of absence of the Program Compliance Nurse, along with the restructuring of the Nursing Department, few of the nursing monitoring tools addressing most of the areas of the Settlement Agreement had been implemented. However, the data from any nursing audits that had been completed had not been analyzed or trended, as noted from the Facility's POI and interviews with the CNE. As mentioned in the previous report, 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.	

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		However, the lack of interventions for problematic issues related solely to nursing was very troubling. Nevertheless, 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> In August 2011, as noted previously, the QA Nurse position had been filled. From discussions with the QA Nurse, since she was assigned the QA position, her main duty had been the monitoring and follow-up for a specific nursing Plan of Correction regarding Diastat, a medication used for seizure activity. At the time of the review, she had not implemented any of the State Office monitoring tools for nursing. However, when the Monitoring Team asked if she had received any type of training for her QA position, she reported that she had not had any type of orientation to her role in the QA Department or her duties as the QA Nurse. In addition, with the Program Compliance Nurse being on a leave of absence, she had not had the opportunity to collaborate with her regarding the monitoring process. Consequently, AUSSLC had very little monitoring data available at the time of the review. By the next review, the QA Nurse and the Program Compliance Nurse or designee should determine a plan for the implementation of the nursing auditing tools based on priority, including a plan for dividing the responsibilities for monitoring between the two positions. In addition, the Facility should consider providing orientation and training to the QA Nurse, with opportunities for collaboration with the other QA Nurses throughout the SSLCs. From discussions with the CNE and the QA Nurse, it was clear that AUSSLC was committed to moving forward in meeting the requirements of the Settlement Agreement despite the acknowledged lack of overall progress made thus far. Building on this commitment, and the positive steps taken in restructuring the Nursing Department, in order for the Facility to move into a position of sustainable substantial compliance, a number of foundational systems should be constructed first before additional systems are implemented. The integrity of the foundational framework will affect the determination of substantial compliance in most, if not all, clinical and nonclinical areas. To adequately and consistently monitor all of the areas of the Settlement Agreement, the Facility should ensure the following systems are adequately implemented: ▪ Although the Facility had developed some initial instructions for the Nursing Health Monitoring tools, overall, the instructions were not clear and specific. They did not outline exactly where the required documentation should be found, and specifically what should be included to meet compliance. In addition, in determining compliance, items addressing the quality of nursing documentation should be compared to quality standards, such as nursing protocols. Without clear and specific instructions, compliance will be determined according to each	

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		auditor's judgment, which should not be the case, and produces unreliable data. The Facility and the State should collaborate on developing specific instructions for the Health Monitoring tools. ▪ The auditors scoring the Health Monitoring tools must be clinically competent in the areas they are reviewing in order for the data generated to be an accurate reflection of the current practices. For example, a discussion with the Director of Behavioral Services regarding the nursing section addressing restraints found that the current auditor for this section, not being a nurse, was not auditing the documentation in alignment with Nursing Standards of Practice. Thus, the auditing results only reflected the completion of the section, rather than the quality of the documentation from nursing. As a result, the monitoring yielded inaccurate results. ▪ Inter-rater reliability should be established for each of the Health Monitoring tools to ensure that all auditors are consistently determining compliance using the same process and criteria. The lack of clear and specific instructions for the monitoring tools will negatively affect inter-rater reliability. Based on discussions with the CNE, no consistent and adequate method was used to establish inter-rater reliability. The Facility and the State should collaborate on developing a specific procedure regarding the establishment of inter-rater reliability to ensure consistency of the process throughout the SSLCs. ▪ Regarding the presentation of data, as noted in previous reports, it should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample, indicating the relevance of the compliance scores. A review of the Nursing Department's limited audits and data for some of the Nursing Health Monitoring tools found that with better consistency, there was promising potential to be able generate relevant data regarding nursing practices. However, due to the problematic issues listed above, the current data generated were unreliable. Implementing the structures listed above should facilitate the accuracy and reliability of the data, as well as bring the Facility's findings more into alignment with the findings of the Monitoring Team. The Facility should implement the remaining essential pieces of the monitoring system listed above to generate credible data going forward, and give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring audit tools based on the significant problematic areas that affect the health and safely of the individuals at AUSSLC. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility' POI indicated that the following steps had been implemented to address the assessment and documentation of individuals with acute changes in health status:	

#	Provision	Assessment of Status	Compliance
		▪ In May 2011, the Facility reported that the Management of Acute Illness and Injury Protocol and Documentation Guidelines had been fully implemented. However, from the findings of the Monitoring Team noted below, essentially no improvement was seen in the nursing assessments and documentation in the IPNs. ▪ In September 2011, Advanced Practice Nurses taught the State-mandated RN physical assessment and documentation class. Thus far, 45 of nurses participated in the training. From discussions with the CNE, follow-up training and competency-based check offs would be scheduled and completed before the next review. Although the curriculum for the training was extremely comprehensive and its implementation was valuable in identifying nurses who had issues related to basic competencies in assessment, no noticeable difference was seen in the nurses' documentation of assessments for acute changes in status. ▪ Although the Facility reported that on 10/17/11, the Hospital, Transfer, Discharge Nursing Protocol had been implemented, and information obtained from hospital visits currently was being documented on the Hospital Liaison Report, the CNE reported that none of these documents had been completed at the time of the review. ▪ In October 2011, the CNE, NOO, Infection Control Nurse, Hospital Liaison, Infirmary Nurse Manager, and Nurse Educator began attending the daily morning medical meetings. This was a positive step forward in facilitating communication between disciplines regarding acute events, and updates on individuals who were in the hospital. ▪ The NOO began meeting with the Nurse Managers and Campus nurses twice weekly to discuss staffing, and other pertinent issues. Although this was another positive step in increasing communication among nurses, no minutes had been kept of these meetings, or the issues, and actions discussed. From interviews with the CNE, the Facility had not implemented any overall system modifications that would have resulted in any measurable changes regarding the documentation of nursing assessments, identification of health care problems, the timely notification of physicians/practitioners of health care problems, and/or the on-going monitoring of individuals needing nursing reassessments and interventions addressing changes in health/mental health status. Consequently, since the Monitoring Team's past reviews, no progress had been made with regard to this requirement of the Settlement Agreement. A review of 11 individuals' medical records (i.e., Individual #14, Individual #56, Individual #199, Individual #165, Individual #153, Individual #316, Individual #309, Individual #403, Individual #423, Individual #357, and Individual #72) who had been	

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		transferred to a community hospital, emergency room, or the Infirmary found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%). ▪ Licensed nursing staff timely informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. ▪ Appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate and complete assessments as dictated by the symptoms in none (0%) of the cases. ▪ The nurse conducted frequent assessments of the individual's clinical condition in none (0%) of the cases. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases. ▪ The documentation indicated that acute illness/injuries were followed through to resolution in none (0%) of the cases. A review of these 11 individuals found virtually the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past three reviews. The overall problematic issues that were found in all 11 records included specifically: ▪ The chronic lack of nursing documentation rendered it impossible to accurately determine when changes in status were initially occurring. Gaps in nursing documentation were found for up to 24 hours for individuals with significant health issues; ▪ There was a consistent lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted nursing assessments and documentation of the findings from assessments; ▪ A consistent lack of complete and appropriate nursing assessments was noted in response to status changes in vital signs, and oxygen saturations; ▪ There was a chronic lack of follow-up for health issues noted in previous nurses' progress notes; ▪ The nursing notes consistently lacked specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of PRN medications (as needed medications); ▪ There was consistent inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ There was a chronic lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any	

#	Provision	Assessment of Status	Compliance
		associated changes in mental status from physical changes in status; ▪ There were few mental status assessments documented during status changes; ▪ There were significant gaps in nursing documentation, when the nurses' notes indicated that they were "closely monitoring" the individual's status; ▪ There was a consistent lack of documentation indicating that lung sounds were regularly assessed and documented for significant respiratory issues; ▪ There was a consistent lack of assessment of bowel sounds, and abdomen exams documented for individuals with constipation or receiving PRN laxatives; ▪ Physicians/Practitioners were consistently not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ There was consistently no documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ A consistent lack of communication was noted between shifts regarding status changes, and the need for regular assessments and follow up; ▪ There was a consistent lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the individuals; ▪ In the nursing notes, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented; ▪ A number of inappropriate abbreviations were used that could not be interpreted; ▪ A consistent lack of documentation was noted regarding the individual's status and assessment at the time of transfer to the hospital or Infirmary, or emergency room; ▪ There was inconsistent documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred; ▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ In the progress notes, there was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility; ▪ There was a consistent lack of a complete nursing assessment upon return to the Facility, especially addressing the same symptoms that precipitated the transfer to a community hospital; ▪ There was a consistent lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ Heath Management Plans addressing health issues were consistently inadequate with regard to the goals and nursing interventions, and were not effectively modified after hospitalizations; ▪ Dates and times were not consistently documented for progress notes; ▪ A significant number of nursing progress notes and signatures were illegible; and	

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		▪ There was a consistent lack of systematic documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. The above findings were consistent with the findings from each of the previous reviews at AUSSLC. Although the Facility had implemented some positive steps since the last review, some only recently had been implemented or partially implemented, and would need more time to affect clinical outcomes. To facilitate progress in addressing this requirement, the Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with regard to Section M.4) to guide nursing practices in conjunction with the competency-based nursing skills training. The Facility's POI indicated that it was not in compliance with the elements of this requirement, which was consistent with the Monitoring Team's findings. Based on the number of individuals with medical complexities at AUSSLC, this area should be considered a priority for the implementation of related monitoring tools, and the generation and implementation of plans of action addressing the significant deficits that exist in the nursing care. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that very few documents were missing from the active records. However, it could not be determined if missing documents from the Monitoring Teams' documentation requests were due to the documents not being completed, not being available in the active records, or inadvertently not included in the requested packets. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Infection Control (IC)</u> Since the last review, AUSSLC continued to have one full-time Family Nurse Practitioner as the IC Nurse, who was responsible for the Infection Control duties for the Facility. From the Facility's POI, interviews with the IC Nurse, review of the documentation, and information gathered during the review, the area of Infection Control had made some essential progress in the process of building an infrastructure to meet the requirements of the Settlement Agreement. Some of the improvements noted included; ▪ The IC Nurse had outlined a procedure addressing data reliability, which was a crucial element in being able to accurately identify the Facility's trends related to infectious, and communicable issues; ▪ A very promising database was developed and implemented to track, analyze and trend infectious diseases;	

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		▪ A pilot project was initiated on two units to test the use of a weekly Infection Control Management Report form in an effort to facilitate better reporting of infections; ▪ Training was completed for staff regarding Impetigo, Clostridium difficile (C-diff), types of Influenza Viruses, Ringworm, Viral Gastroenteritis, MRSA Prevention, and Bed Bugs; and ▪ Hand Washing audits were conducted and the data indicated that 419 staff were monitored regarding hand hygiene from January through September 2011, and demonstrated 100% compliance with appropriate procedures. However, a number of systems that address clinical issues and outcomes were in need of further attention, including; ▪ A formalized immunization schedule and system to track immunization information was not in place. One should be developed, and implemented to ensure all individuals have received all the required current immunizations as outlined in the Health Care Guidelines; ▪ Although the documentation indicated that Infection Control Quarterly Rounds focusing on the Facility's environment were conducted, members of the Monitoring Team along with the Infection Control Nurse, the Director of Housekeeping, and the Director of Facility Supports Services found numerous problematic issues with cleanliness in the Infirmary, and Buildings 797 and 793, which did not comport with AUSSLC's data. ▪ The Facility should expand its pool of staff that conducts environmental monitoring auditing. Including different staff members would prevent auditors from becoming desensitized, and not accurately and adequately assessing the environment. ▪ The same problematic issues were found during this review as were found during the previous three reviews. Specifically, of the 54 individuals listed as having an infectious illness during the review period, only 19 (35%) had health management plans (HMPs) addressing the infectious issue. Of the 19 HMPs reviewed addressing infectious diseases, none (0%) were found to be adequate. This is discussed in more detail with regard to Section M.3. The Facility should develop and implement a system to ensure the HMPs for individuals with infectious/communicable disease are clinically appropriate and consistently implemented. ▪ The Facility should continue to focus its efforts on the implementation of the clinical auditing tools assessing the clinical practices and treatments of infectious and communicable diseases. ▪ Although timelines were provided regarding outbreaks of C-diff, bed bugs, and MRSA, the documentation was not specific regarding the exact dates and times of events, rendering it more of a summary than a timeline. A structured format	

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		should be implemented to organize and document actions taken in response to outbreaks that should improve the Facility's ability to analyze the events more clearly. ▪ At the time of the review, there were no real-time audits being conducted for individuals with acute infectious diseases. IC should initiate the auditing of all individuals who are suspected and/or diagnosed with an acute infectious/communicable disease. These should be real-time audits that do not fall under the randomized sampling procedures of the Facility. Due to the acute nature of infectious diseases and the potential for spread, auditing for this area needs to be conducted while the acute infection is active. Conducting retroactive auditing (conducting an audit after the event), which was frequently what the Facility was doing, would not be clinically appropriate, nor would choosing only a percentage of these cases to audit. ▪ From review of the Infection Control Committee meeting minutes, there were some attempts made at analyzing the Facility's IC data regarding urinary track infections. However, there were no other analyses conducted for other related infection control issues, such as cases of MRSA or C-Difff. The Facility should continue to conduct analyses of the IC data, implement plans of action addressing problematic issues, and document the interventions implemented, and the resulting outcomes. Since the last review, the Facility and the IC Nurse had implemented some positive steps forward. However, much work was yet to be done to make substantial gains in meeting the requirements of the Settlement Agreement. In addition, since the last review, the Statewide Infection Control Manual was approved. Although some progress had been made regarding AUSSLC's infection control issues, consideration should be given to having additional expertise in Infection Control provided to the Facility to assist in effectively operationalizing the Infection Control Systems in alignment with IC standards of practice, as well as providing professional feedback regarding the quality and completeness of the finalized Infection Control Manual. <u>Mock Code Drills and Emergency Response Systems</u> Since the last review, the Facility had made some progress in its efforts toward addressing issues regarding emergency response, including the following: ▪ In August, the Medical Emergency Response Committee was established to review the Facility's systems related to the emergencies. The members of the Committee included representatives from Competency Training and Development, Medical, Nursing, Risk Management, Support Services, and Quality Assurance. A review of the minutes of the committee meetings indicated that the initial focus of the committee was to bring the Facility into compliance with the DADS Medical Emergency Response policy. This was a very positive step for	

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		the Facility. ▪ A "pass or fail" designation was added to the Mock Drills conducted in order to easily identify if all emergencies procedures were executed appropriately. ▪ CTD had initiated a tracking form for recommendations generated from the drills conducted that consisted of recommendations for a Cardiopulmonary Resuscitation Refresher Course. Since the last review, they had included the date the staff completed the CPR refresher class to ensure that staff received the needed skills training. ▪ By December 2011, the Facility was expected to have 12 additional Automated External Defibrillators (AEDs), bringing the total of AEDs in the Facility up to 16. Although the Facility implemented some positive steps addressing the Emergency Response System, a number of problematic issues were found that should be addressed in order for additional progress to be made: ▪ Although the CTD staff reported some improvement, they noted that some staff refused to participate in the drills. In addition, they noted no participation in the drills from the physicians. ▪ There continued to be no system in place to analyze the data from the Medical Emergency Drills or actual medical emergencies to identify problematic trends and implement timely plans of correction. The newly established Medical Emergency Response Committee would be an appropriate forum for this type of discussion. ▪ Since the last review, the CTD staff that conducted the Medical Emergency Drills decreased from six staff to three. Consequently, the required number of drills was not conducted during the review period. ▪ From review of the minutes of the Medical Emergency Response Committee, and observations of a Medical Emergency Response Committee meeting while on site, the committee was trying to identify additional staff members who could assist with conducting the Medical Emergency Drills. The State policy, Emergency Response, dated 9/7/11, indicated that a Trainer or Drill Instructor could be staff that had completed competency-based training on emergency response training. However, at the time of the review, no such training curriculum existed. The CNE and the State Office Nursing Services Coordinator verified this. Requiring a specific training, but then not developing the training for an area so crucial for the individuals' health and safety was extremely troubling. Consequently, any SSLC needing additional Drill Instructors will be unable to move forward in meeting the policy requirements for conducting drills. ▪ At the time of the review, no other scenarios were included in the drills, such as heat stroke, bee stings with anaphylactic shock, head injuries, or scenarios addressing first aid issues. As previously recommended, the Facility should	

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		expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions in addition to CPR. ▪ Consistent with the previous reviews, the CTD staff reported that they bring the AEDs to the drills, rather than having the staff demonstrate that they know where they are on the units. 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, just as they would during an actual emergency. ▪ From a review of the Emergency Equipment Checklists from each building for August, and September 2011, a significant number of blanks were found on these forms. This indicated that the Emergency Equipment was not being checked daily as required. In addition, the documentation from the Facility noted that: "Castner Estates had no emergency check list for the months of August and September 2011." This indicated that the emergency equipment had not been checked for two months on a unit where many of the most medically complex individuals resided. In addition, the Nursing Department had provided no oversight to ensure these checks were being conducted. ▪ The documentation from a Nursing Mortality Review for Individual #21 indicated that on 7/17/11, the community hospital Emergency Room record stated: "apparently EMS arrived to find the patient on 4 liters of nasal cannula but there was no oxygen in the tank." This illustrated the serious implications of the Facility's ongoing failure to have checks and balances in place to ensure emergency equipment was in good working order, and supplies were maintained. The Corrective Action Plan indicated that competency-based training was to be conducted with nursing staff on medical emergency response, including equipment and supplies. However, the documentation on the CAP did not clearly indicate if, as of 10/25/11, three months after this incident occurred, the training had been completed, or if it was still in progress. ▪ The Monitoring Team's observations of nurses demonstrating the emergency equipment at the Infirmary, and Buildings 797, and 793 indicated that the nurses at AUSSLC continued to be unfamiliar with the use of the emergency equipment. The problematic issues observed included staff not knowing where the oxygen tank was kept, staff unable to readily identify the key to the locked cabinet where an oxygen tank was stored, no checklists for some of the suction machines, Infirmary staff unable to find the checklists for some of the emergency equipment, and an RN in the Infirmary reporting that the emergency equipment was not being consistently checked as required. The data from the drills conducted since the last review were as follows: ▪ Six drills conducted in May 2011 – two passed (33%);	

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		▪ 11 drills conducted in June 2011 – six passed (55%); ▪ 16 drills conducted in July 2011 – 10 passed (63%); ▪ Six drills conducted in August 2011 – five passed (83%); ▪ Five drills conducted in September 2011 – three passed (60%); and ▪ Six drills conducted in October 2011 – two passed (33%). Overall, the findings of the Monitoring Team regarding AUSSLC's Emergency Response Systems were extremely troubling in light of the fact that the Facility had a number of individuals who had significant medical complexities. The Facility should review all data related to its emergency systems to ensure that Mock Drills include the actual use of the emergency of equipment, and ensure that any training provided translates into improved practices in the residences. In addition, trends from the actual codes (6200 calls) should be identified and analyzed, so that appropriate corrective actions can be timely implemented. Although the Facility had implemented some positive steps, the Facility continued to have much work to do in adequately developing and implementing systems addressing it emergency response systems.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	In assessing its progress, in the Facility's POI, AUSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ *"09/13/2011 - 09/16/2011 State mandated RN physical assessment and documentation class taught by Advanced Practice Nurses - total of 45 nurses participated to date.* ▪ *10/17/2011 - Supervision of all nurse case managers (who perform the quarterly and annual nursing assessments) has been moved from the unit nurse manager to the Nursing Operations Officer (NOO).* ▪ *11/2/2011 - Not currently trending or analyzing data."* In addition, from review of the information contained in the Section M Presentation Book addressing this requirement and discussions with the CNE, some modifications were made to the Quarterly/Annual Comprehensive Nursing Assessment form that included the addition of the Braden Scale regarding skin integrity, categories for discussion in the Summary Section, and statements regarding the supports and services provided by nursing and community integration. Also, the Facility had developed an RN Case Manager Tracking Calendar that indicated when specific assessments or documentation were due for each individual, such as the quarterly and annual nursing assessments, the MOSES and DISCUS, and nursing progress notes for the HMPs. Although these were positive steps forward, the Monitoring Team found that there essentially had been no progress made regarding the quality of the quarterly/annual nursing assessments. The Quarterly/Annual Nursing Assessments for 24 individuals who the Facility identified	Noncompliance

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		as being at risk for specific health indicators were reviewed, including those for: Individual #269, Individual #398, Individual #117, and Individual #100 for osteoporosis; Individual #87, Individual #57, and Individual #195 for cardiac; Individual #74, Individual #212, Individual #421, and Individual #262 for behavior; Individual #309, Individual #90, and Individual #274 for fluid balance; Individual #62, Individual #147, and Individual #442 for skin integrity; Individual #239, Individual #353, Individual #43, and Individual #382 for weight issues; Individual #186, Individual #426, and Individual #82 for infections. Of the 24 individuals' nursing quarterly assessments reviewed, 13 (54%) were timely completed. Assessments that were not timely completed, or were possibly not included in the documentation that the Monitoring Team requested were for Individual #398, Individual #195, Individual #212, Individual #421, Individual #262, Individual #90, Individual #62, Individual #442, Individual #239, Individual #426, and Individual #82. ▪ There was an adequate analysis of the health/mental health data between the previous and current quarters in none (0%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues. ▪ There was an adequate assessment of the high-risk health indicators included in none (0%) of the Comprehensive Nursing Assessments. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. Since the last review, despite some of the variations seen in the format of some of the Summary Sections of the Comprehensive Nursing Assessments, such as including a significant number of pages of nurses' notes that were taken directly from the IPNs, and typed into Summary Sections, no observable difference was noted in the quality of the documentation in the Comprehensive Nursing Assessment summaries. Whatever format was used, none of the Comprehensive Nursing Assessment summaries included an analysis of the individuals' health/mental health issues between quarters. Similar to the last review, the summaries contained in the nursing assessments were essentially a listing of sequential data, and dates of events, such as hospital admissions, with no associated analysis of the data indicating if the health issue was improving or getting worse. From the consistent and ongoing problematic findings regarding the Comprehensive Nursing Assessments, it was apparent that nursing at all levels lacked the understanding of how to analyze, summarize, and document health/mental health issues to determine whether or not there was progress regarding health and behavioral issues. The Facility should provide competency-based training to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Without adequate and	

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		appropriate competency-based training regarding the documentation of a clinical analysis, changes in the Comprehensive Nursing Assessment form, and variations in the summary format will not result in improving the quality of the Comprehensive Nursing Assessments, and ultimately improving the quality of care provided to the individuals as the Settlement Agreement requires. Regarding the nursing documentation for discharges/transitions to the community, from discussions with the CNE, no changes had been made regarding the process and content of Nursing Discharge Summaries. However, the State Nurse Practitioner Consultant reported that the State was working on a form for nursing to document an assessment, supports and services for individuals being transitioned from the Facility to the community. Consequently, the Facility continued to use the Comprehensive Nursing Assessment form for transitions, which was noted in the last report to be inadequate since these assessments were actually the most recent quarterly Comprehensive Nursing Assessment, and not an updated and comprehensive assessment for someone who was being discharged from the Facility. It is essential that AUSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that this documentation is specific and detailed enough to maintain continuity of care in the community. Overall, the same problematic issues were found in all the Comprehensive Nursing Assessments reviewed as noted during the previous reviews. These problematic issues included: ▪ A significant lack of clinical assessments for critical clinical health indicators; ▪ A lack of timely completion of the quarterly Comprehensive Nursing Assessments; ▪ A lack of an analysis of the individuals' health/mental health issues; and ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments. 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 high-risk or at-risk health	In assessing its progress, AUSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ *"05/01/2011 Management of Acute Illness and Injury Protocol and Documentation Guidelines fully implemented.* ▪ *09/13/2011 - 09/16/2011 State mandated RN physical assessment and documentation class taught by Advanced Practice Nurses - total of 45 nurses participated to date.* ▪ *10/18/2011 Case Managers received follow-up training from State Office on PST*	Noncompliance

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	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.	*process.* ▪ *11/2/2011 - Case Manager meeting held which was attended by DADS State Office consultants who discussed the role of the case manager within the Personal Support Team (PST) and Interdisciplinary Team (IDT) in proactively addressing the needs of residents. Issues discussed included clarifying case manager responsibilities, the need for improvements in healthcare status documentation and assuring quarterly nursing assessments are completed in a timely manner, role of the case manager in interpreting data to make it relevant and meaningful to the rest of the team.* ▪ *Not currently trending or analyzing data. Discussed plan to have a standardized campus-wide PSP schedule to avoid meeting and clinic conflicts and allow for key players to attend the PSP meetings (e.g. not having meetings scheduled at change of shift)."* From discussions with the CNE, she indicated that some basic nursing protocols that the State had developed from the training addressing documentation were placed on small laminated cards for easy portability, and recently were given to the nurses. However, since the last review, the Facility had not implemented any other interventions directly addressing Health Management Plans (HMPs). In addition, only sporadic audits had been conducted for nursing due to staffing absences. Consequently, no progress had been made in this area as illustrated by the Monitoring Team's findings discussed below. The records of 24 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #269, Individual #398, Individual #117, and Individual #100 for osteoporosis; Individual #87, Individual #57, and Individual #195 for cardiac; Individual #74, Individual #212, Individual #421, and Individual #262 for behavior; Individual #309, Individual #90, and Individual #274 for fluid balance, Individual #62, Individual #147, and Individual #442 for skin integrity; Individual #239, Individual #353, Individual #43, and Individual #382 for weight issues; and Individual #186, Individual #426, and Individual #82 for infections. Of the 24 individuals' Health Management Plans reviewed: ▪ A total of 18 (75%) were found to have a HMP addressing their high-risk health/mental health indicator. Those individuals that did not have a related HMP included: Individual #74, Individual #421, Individual #274, Individual #186, Individual #426, and Individual #82. ▪ None (0%) of the goals listed in the 18 HMPs were clinically appropriate. ▪ None (0%) of the nursing interventions contained in the 18 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.	

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		▪ None (0%) of the 18 HMPs were found to be clinically adequate. ▪ None (0%) of the 18 HMPs included proactive interventions addressing the health indicator. ▪ None (0%) of the 18 HMPs were adequately individualized. Consistent with the findings from the previous reviews, AUSSLC's Nursing HMPs continued to lack the following key elements: ▪ The interventions addressing risk indicators; ▪ Clinically appropriate goals/objectives related to the etiology of the identified health/mental health problems; ▪ Individual-specific interventions based on the individuals' needs; ▪ Adequate specific directions for caring for individuals who were identified as being at high risk related to their health/mental health issues; and ▪ Proactive interventions directed at preventing or minimizing the specific health risks. As was found during the previous reviews, the Health Management Plans reviewed were essentially the same basic protocol templates for each individual who had a specific health issue, such as constipation, osteoporosis, falls, and pneumonia, with only minimal modifications made to the template. While on site, a review of Individual #72's medical record was conducted with some members of the nursing staff, members of the Physical Nutritional Management Team (PNMT), Facility Administration, the CNE, direct support professionals, the State Office Nurse Practitioner Consultant, and the QA Nurse. The documentation indicated that the individual was at high risk for aspiration, was enterally nourished by a gastrostomy feeding tube (G-tube), had episodes of increased and varying body temperature, and had several hospitalizations in the past year for respiratory and aspiration issues. In addition, the PNMT was following this individual. The Integrated Progress Notes reviewed indicated that there were a number of changes in the individual's status, such as decreases in oxygen saturations, and variability in vital signs. In reviewing the documentation, specifically the IPNs, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included: ▪ A lack of recognition by nursing of changes in status; ▪ No regular and complete nursing assessments conducted in response to changes in status; ▪ No consistent and regular nursing documentation to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, swelling to legs, treatments provided, pain assessments, vital signs, oxygen saturations, functioning of G-tube, site inspections for G-tube, and bowel and urinary output;	

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		▪ Significant gaps in the nursing documentation (i.e., up to 24-hours without a nursing assessment and an associated IPN) for an individual with several health risks and changes in status; ▪ No indication that the physician was timely notified of changes in status; ▪ No indication that the PNMP was notified regarding changes in status; and ▪ No Nursing HMPs adequately addressing the individual's current health risks that provided specific nursing interventions to guide nursing care. Due to the significant deficits found regarding the care of this individual, the Monitoring Team requested that a HMP be developed and implemented during the onsite review to address the significant health risks of this individual. The Facility scheduled a meeting with the appropriate disciplines to address this issue, along with the State Nurse Practitioner Consultant and one of the State's ISP Consultants. AUSSLC's efforts at developing an interdisciplinary integrated HMP for Individual #72 were very promising. Given the short time frame in which the team had to meet to develop the plan, the team did an extraordinary job executing this task. It was obvious that after this meeting of the disciplines, each participant viewed the needed care of Individual #72 very differently than before the meeting. The team participants were able to speak to the clinical needs of the individual based on supporting clinical data. From observations of the team's presentation regarding the newly developed HMP, the team needed to gather more information from the direct support professionals who work directly on the units and with Individual #72. While the team had planned an intervention related to positioning during bathing, the direct support professional promptly pointed out that since the individual's specific unit did not have the structure to accommodate the intervention, it was not possible to implement. Collaboration with all disciplines, including the direct support professionals is essential for constructing an adequate HMP. In addition, the input from the Medical Director during the team's presentation of Individual #72 HMP appeared to diminish the team's positive and appropriate efforts regarding setting up clinical systems to obtain baseline measurements and values in order to determine under what circumstances changes in status occur. Unfortunately, these clinical divides between disciplines have been ongoing barriers at AUSSLC, and have contributed to the lack of overall progress made in addressing many of the areas of the Settlement Agreement. However, the collaboration that was demonstrated in developing Individual #72 HMP was a positive step forward for the disciplines, and most importantly the individual. From a professional and clinical perspective, it is not acceptable for the Facility to continue to allow disciplines to not develop HMPs, or to accept HMPs that are clinically inadequate for the individuals under their care. Having the experience of developing an integrated HMP, albeit under some pressure from the Monitoring Team, the Facility	

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		should continue to develop and implement appropriate HMPs based on priority and risk for all individuals at AUSSLC. The significant deficits that were found regarding the care of Individual #72, as well as the other individuals who experienced a change in status and were sent to a community hospital as discussed with regard to Section M.1, were directly related to the fact that AUSSLC did not have nursing protocols in place, and a system to ensure that nurses were using them. Nursing protocols should guide the frequency, and specify the elements that need to be included in the nursing assessments, and should be clearly outlined in clinically adequate HMPs. Although the Facility's POI and CNE indicated that some nursing protocols had been implemented, it was noted that the protocols only recently had been passed out to the nurses prior to the current review. Thus, no improvement was noted in the HMPs reviewed. 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. The Facility's list of individuals having had an infectious/contagious illness (acute and chronic) during the review period indicated that there were a total of 54 individuals. However, the Monitoring Team's request for these individuals' HMPs yielded only 22 HMPs, with only 19 of these HMPs actually addressing the infectious illness. The HMPs for 19 individuals (i.e., Individual #72, Individual #3, Individual #309, Individual #289, Individual #290, Individual #454, Individual #147, Individual #310, Individual #306, Individual #204, Individual #73, Individual #137, Individual #117, Individual #118, Individual #296, Individual #188, Individual #186, Individual #53, and Individual #395) that had a variety of infections since the last review period were reviewed. The following summarizes the results of this review: ▪ Of the 54 individuals listed as having an infectious illness during the review period, 19 (35%) had HMPs addressing the infectious issue. ▪ Of the 19 Nursing Care Plans 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 HMP 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 Inappropriate goals that did not address the prevention of the spread of the infectious illness, but rather indicated that the individual would remain free from the symptoms of the infection, when the individual already had the infection; o The lack of specific interventions addressing teaching and education for staff, as well as the individual regarding prevention of the spread of the	

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		infection; o The lack of proactive interventions; and o The lack of documentation demonstrating that interventions were actually being implemented. Consistent with the findings of the previous reviews, AUSSLC had no system in place to ensure that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. It was very troubling to find that individuals with highly contagious/infectious illnesses, such as MRSA or C-Diff, did not have HMPs addressing these illness two years into the review process. As noted in all the past reports, due to the clinical ramifications of not having HMPs adequately addressing infectious and communicable diseases, it is imperative that this requirement of the Settlement Agreement be addressed. Nursing Administration, in conjunction with the Infection Control Nurse, should develop and implement a system to ensure that the HMPs addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. In order for progress to be made regarding this section of the Settlement Agreement, the Health Management Plans should be: ▪ Individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the interventions will be reviewed and by whom. As required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should continue to occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding an individual's health risk into one plan. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement, which was in alignment with the findings of the Monitoring Team.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals	In response to this requirement, AUSSLC's POI indicated the following actions were implemented: ▪ *"08/09/2011 - Medical Emergency Response Committee established. Committee membership established. Reviewed DADS Emergency Response Policy. Identified areas that need to be improved in order to be in compliance with policy.* ▪ *08/24/2011 - Medical Emergency Response Committee meeting held. Discussed*	Noncompliance

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	served.	*need to determine who can conduct drills in addition to the current Competency Training and Development (CTD) CPR instructors (3 staff) and the need to identify more staff from other areas to conduct drills. Discussed corrective action for anyone who fails a drill and the retry.* ▪ *09/29/2011 - Medical Emergency Response Committee to review the DADS Medical Emergency Response policy revised 09/07/0211 and discuss key changes related to definitions added, emergency equipment, drills, immediate plan of action and Quality Assurance. The number of additional staff from Nursing, Risk Management/Support Services, Medical and Residential Services was identified.* ▪ *10/01/2011 Nursing regularly attends daily morning medical meeting: includes CNE, NOO, Infection Control Nurse, Hospital Liaison, Infirmary Nurse Manager and Nurse Educator.* ▪ *10/17/2011 Implemented statewide standardized competency based training curriculum with the Nursing Education Handbook rolled out with the October New Employee Orientation nurses. This will be used for annual and ongoing competency based training and education. Includes power point on management of illness and injury protocol along with post-test. Implemented new statewide Medication Variances Policy. Nursing Protocols for Antibiotic Therapy, Constipation, Contacting the PCP, Diarrhea, Head Injury, Pre-Treatment and Post-Sedation, Respiratory Distress-Aspiration, Temperature Elevations, and Vomiting initiated with full implementation expected by 11/04/2011.* ▪ *10/18/2011 - Identified areas needing improvement regarding Emergency Equipment section of Medical Emergency Response policy. Discussed need to identify locations on campus such as vocational areas that need emergency equipment. Continued review of DADS Medical Emergency Response Policy to identify continued need for areas that need to meet compliance.* ▪ *11/2/2011 - Not currently trending or analyzing data.* In addition, the Presentation Book for Section M included the curriculum and training rosters for the Nursing Physical Assessment Training that the State Office Nurse Practitioner Consultant Group provided. Also, from discussions with the State's Nurse Practitioner Consultant during the onsite review, initial training will be provided regarding nursing documentation that includes the use of nursing protocols. The current nursing protocols that recently were distributed to the nurses included head injuries, antibiotic therapy, diarrhea, temperature elevations, respiratory distress/aspiration, constipation, and vomiting. From a review, these nursing protocols were found to be clinically appropriate and in accordance with nursing standards of practice. Although at the time of the review, no positive outcomes had yet been seen in the nursing documentation, the introduction of the use of nursing protocols for the assessment and documentation of health issues was a promising step, and should be continued. In	

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		addition, as has been recommended previously, adequate modifications should be made to the procedures and protocols contained in the resource books that were obtained after the Monitoring Team's initial review in order to bring them into alignment with the Facility's structure and systems. These modifications should include identification of 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 and PNMT, if indicated. Unfortunately, there continued to be a lack of comprehension at AUSSLC regarding the importance of nursing protocols, and how they structure nursing practice and documentation. This was illustrated by the consistent significant problematic findings regarding nursing assessments, Health Management Plans, and the overall nursing care and documentation for individuals, especially individuals with high-risk health indicators and/or changes in status warranting hospital admissions. Due to the lack of appropriate nursing protocols, no structured system was in place guiding nursing practice and documentation to ensure that: ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data was established to quickly recognize changes in health status; ▪ Timely communication occurred with practitioners/physicians or other disciplines regarding changes in status; ▪ Appropriate and clinically adequate HMPs were developed that outlined specific nursing interventions for specific health issues; and ▪ Audits addressing nursing practice included quality standards by which to accurately measure the nursing care, and documentation would result in accurate compliance data. The findings from this review and the previous three reviews indicated that AUSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. Although some initial nursing protocols were initiated prior to the review, based on the Monitoring Team's findings, the Facility's interventions thus far had had no positive impact on the nursing practices, or reporting protocols that the Settlement Agreement required. The Facility indicated that it was not in compliance with this requirement, which was consistent with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18	In response to this requirement, AUSSLC's POI indicated that since the last review, progress made included the following: ▪ *"09/01/2011 - Database was developed and implemented to analyze and trend*	Noncompliance

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	months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	*infectious diseases.* ▪ *10/01/2011 Nursing regularly attends daily morning medical meeting: includes CNE, NOO, Infection Control Nurse, Hospital Liaison, Infirmary Nurse Manager and Nurse Educator.* ▪ *10/17/2011 Continuing hand-washing spot checks. Two incidents of homes with bed bugs identified within past two months with timeline of handling of incidents by infection control nurse.* ▪ *Supervision of all nurse case managers (who perform the quarterly and annual nursing assessments) has been moved from the unit nurse manager to the Nursing Operations Officer (NOO).* ▪ *10/21/2011 Infection Control Nurse beginning certification process with Certification Board of Infection Control and Epidemiology, Inc., (CBIC). This was reviewed with Infection Control Nurse during performance plan review and will be incorporated into annual performance evaluation.* ▪ *11/1/2011 - Draft version completed of formalized system (procedures) for reporting infections to Infection Control Nurse and system of identifying discrepancies including how reconciled and tracked.* ▪ *11/2/2011 - Not currently trending or analyzing data."* Since the last review, the Facility had implemented steps to develop an At-Risk database to facilitate the analysis of the At-Risk system and the implementation of the Clinical Care Committee. These are discussed in more detail with regard to Section I.1. Although some progress, although inconsistent, had been made regarding the At Risk System, significant work remained to be done in addressing the needs of the at-risk individuals at AUSSLC. The information contained in the Facility's Presentation Book for Section M indicated that the Facility had provided some training in March and April 2011 regarding the Monitoring Tools, the development of the Infection Control database, and individual-specific training for some episodes of infectious illnesses. However, there was nothing found specifically addressing the At-Risk Individuals and process. Regarding the nursing assessments for risk indicators, essentially no progress was noted in relation to this issue. The CNE reported that for individuals who were designated as being at high or medium risk for specific health indicators, nursing continued using the last quarterly or annual Comprehensive Nursing Assessment to meet the requirement of a nursing assessment for risk. These assessments were used even if they had been completed months prior or after the meeting at which the risk levels were determined, and consistent with past review findings, included little to no information or assessment of the specific risk indicator(s). Consequently, the Comprehensive Nursing Assessments were inadequate, and not representative of a focused assessment addressing health risk	

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		indicators. A review of 24 individuals' Comprehensive Nursing Assessments (i.e., Individual #269, Individual #398, Individual #117, Individual #100, Individual #87, Individual #57, Individual #195, Individual #74, Individual #212, Individual #421, Individual #262, Individual #309, Individual #90, Individual #274, Individual #62, Individual #147, Individual #442, Individual #239, Individual #353, Individual #43, Individual #382, Individual #186, Individual #426, and Individual #82) found that none (0%) were adequate nursing risk assessments due to: ▪ None specifically addressed the high-risk health indicators; ▪ None had been updated regarding health issues related to the high-risk health indicators; and ▪ None included a nursing assessment, as opposed to just a narrative summary of health information. A review of these 24 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. Although some of the categories for some of the Risk Rating forms did include specific clinical information, especially in the area of osteoporosis, the review found that none (0%) consistently contained specific clinical information to enable the IDTs to adequately evaluate and designate risk levels. Some of the problematic issues included: ▪ Lack of specific data indicating regular bowel medication regimens, the frequency of needed bowel pro re nata (PRN, or "as needed") medications, and additional factors such as medications, fluid intake, and positioning affecting risk of constipation; ▪ Lack of results of cultures and sensitivities for urinary tract infections to evaluate hygiene practices by staff; ▪ Lack of data regarding the number of seizures during the past year compared to previous years, medications changes needed to stabilize the seizure disorder, and the date of the last seizure activity; ▪ Lack of specific dates and locations of past fall and/or fractures; and ▪ Lack of specific information, such as dates, locations, and organisms of infections. A review of the same 24 individuals records was conducted to assess nursing staff's role in the development and implementation of Action Plans related to the high and medium risk indicators. Based on the documentation provided by the Facility, 14 of the 24 individuals did not have an ISP or Risk Action Plan (i.e., Individual #87, Individual #195, Individual #74, Individual #421, Individual #262, Individual #90, Individual #274, Individual #62, Individual #147, Individual #442, Individual #353, Individual #43, Individual #382, and Individual #82). Based on the review of the documentation	

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		provided, individuals' teams had: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in 10 of the 24 individuals (42%). ▪ Implemented a plan that met the needs identified by the IDT 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 ISPs in five of the cases (21%). ▪ 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 ISP to allow the team to measure the efficacy of the plan. ▪ Plans included the clinical indicators to be monitored and the frequency of monitoring for none of the individuals (0%). During the previous onsite review, the State Office Nurse Practitioner Consultant reported that the State was in the process of reviewing and redefining the "assessment" requirement noted in the At-Risk Individuals policy in an effort to clarify the expectations regarding risk indicators and nursing assessments. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. 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 findings of the Monitoring Team.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the	In response to this requirement, AUSSLC's POI indicated that since the last review, progress made included the following: ▪ *"05/01/2011 - 23 nurses did not pass the medication transcription exercise and were required to repeat the exercise with 1:1 training.* ▪ *08/01/2011 Dialogue with Habilitation Therapies Director regarding placement of PNMP in the MAR to have readily available to nurses during medication pass.* ▪ *10/17/2011 -Medication Variance Committee meeting held - discussed medication variances and plans of correction. Implemented new statewide Medication Variances Policy. Implemented Medication Administration Observation Guidelines. Dialogue with Habilitation Therapies Director regarding placement of PNMP in the MAR to have readily available to nurses during medication pass - discussed process of having PNMPs printed and sent to nursing to include in MAR and*	Noncompliance

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	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.	*process for when changes are made to PNMP. By 11/07/2011 all MARs will have a copy of the most recent PNMP included.* ▪ *11/2/2011 - Not currently trending or analyzing data."* Since the previous review, there had been a number of significant issues regarding AUSSLC's overall medication administration system. From review of the Medication Variance Committee meeting minutes, the Pharmacy and Therapeutics Committee meeting minutes, emails to nursing from the Pharmacy, medication variance report data, and discussions with the CNE, the following were some of the problematic issues found: ▪ On the Phoenix Unit, calcium supplements (used to promote bone strength, and treat/prevent osteoporosis) were not reordered for two months indicating that they were not being administered as ordered; ▪ Based on a physician's order, an individual was to receive Eucerin Lotion, a skin lotion, three times a day, but it had not been refilled since February 22, 2010 indicating that it was not being administered as ordered; ▪ In September 2011, 172 bottles (approximately 2580 doses) of Miralax, used to treat constipation, was delivered to the Castner Unit, and in October 2011, 25 unopened and 29 opened bottles (a total of 520 doses) were retrieved by the Pharmacy, indicating that it was not being administered as ordered; ▪ In September 2011, 182 bottles (approximately 2870 doses) of Lactulose, a medication used to treat constipation and reduce levels of ammonia in the blood, was delivered to the Castner Unit, and in October 2011, 57 bottles (approximately 899 doses) were retrieved by the Pharmacy, indicating that it was not being administered as ordered. Facility physicians noted that ammonia levels were not decreasing for some individuals prescribed this medication; ▪ In October 2011, ten orders for medications were not taken to the Pharmacy in a timely manner, resulting in delays in medications being initiated as ordered; ▪ Several doses of Morphine, used for pain, were not appropriately documented when administered, nor was follow-up documented regarding the effectiveness of the medication in the IPNs, or on the Medication Administration Record (MAR); ▪ Diastat, used to stop ongoing seizure activity, was administered to an individual 60 minutes after the seizure activity had ceased causing significant lethargy; ▪ Medication Observations were not being conducted every quarter in accordance with the Facility's Medication Observation Schedule; ▪ The Medication Administration Observations that were conducted essentially indicated that few, if any problematic issues were found. From the lack of comments found on these audits, one would surmise that nurses were consistently implementing appropriate medication administration practices. This was not in alignment with the Facility's documentation or the Monitoring	

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		Team's observations; ▪ Although the PNMPs recently were placed in the MARs, nurses were not using them to assess correct positioning prior to and after administering medications; and ▪ The CNE reported that there was significant under-reporting of medication variances, and consequently, the medication variance data provided was unreliable. To address some of the problematic issues, the Pharmacy had conducted Medication Room Sweeps throughout the Facility in an effort to identify what bulk medications were not being used, and clearly not being administered as ordered. As a result of the numbers of medications the Pharmacy found during these sweeps, the Facility had converted some of the bulk medications to unit dose medications in the hopes that these medications would be administered as ordered, and to better monitor that they were being administered. However, the Nursing Department appeared to take no actions to determine the etiology of the problem to identify and implement a sustaining solution, such as implementing regular and spot check Medication Administration Observations. Although ensuring that individuals receive their medications as ordered is of paramount importance, just making it harder for nurses not to administer medications by using expensive unit dose medications leaves the origin of the problem unresolved. On a positive note, the Facility had initiated a prompt and clinically appropriate plan of correction (POC) regarding Diastat in response to the incident noted above. The POC included the following interventions: ▪ Nurses were provided training regarding the use, and the documentation of the administration of Diastat; ▪ The Case Managers reviewed the medical records and physician orders for all individuals who were prescribed Diastat to ensure the orders had been transcribed appropriately; ▪ A protocol was developed addressing the use of Diastat; and ▪ On 10/1/11, a monitoring tool was developed and implemented to review 10% of all individuals who have an order for Diastat on a monthly basis. A review of the medication variances reported by the Facility indicated the following: ▪ May - no variance data available; ▪ June - no variance data available; ▪ July - two reported variances; ▪ August - two reported variances; ▪ September - five reported variances; and ▪ October - two reported variances.	

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		As reported by the CNE, from the exceedingly low number of variances noted above, AUSSLC had a significant problem regarding the under-reporting of medication variances. Thus, the Facility's variance analyses reports were meaningless. It was extremely troubling that in light of the significant problematic issues that existed regarding AUSSLC's medication administration systems that the Nursing Department had not taken steps to ensure that all nurses who audited medication administration observations were competent to do so, that medication administration observations were not increased in response to the massive amounts of medications the Pharmacy retrieved; and regular spot checks of the MARs were not initiated to verify appropriate documentation of medications. In addition, a review of the Medication Variance Committee meeting minutes found that due to the lack of content contained in the minutes, it was difficult to discern the specific issues the committee discussed, what action steps were decided upon, and if and when they were implemented. The lack of specific content gave the appearance that essentially little to no action had occurred to address the problems regarding the medication administration systems. Based on the Monitoring Team's observations of medication administration at the Infirmary, the following significant issues were found. Specifically, the nurse did not: ▪ Ensure individuals were in the proper positioning prior to and after medication administration. Neither the nurse administering the medication nor the Nurse Educator conducting a Medication Administration Observation reviewed the PNMP to verify correct positioning prior to medication administration; ▪ Know the medical issues that precipitated the Infirmary admission for some of the individuals; ▪ Ensure that the individuals' adaptive and positioning equipment was brought to the Infirmary and was being used as prescribed in the PNMP; ▪ Consistently utilize the PNMP when administering medications; ▪ Reconcile inconsistencies regarding vomiting episodes in the documentation; ▪ Listen to lungs sounds both before and after administering medications via G-Tube to assess for possible aspiration, especially when individuals began coughing when taking their medications; and ▪ Receive competency-based training on the PNMPs for individuals for whom she was responsible for administering medications. Based on these consistent problematic issues observed during medication administration at AUSSLC, the current auditing process for this area was clearly inadequate to capture the lack of compliance regarding positioning and interventions for	

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		medication administration in alignment with the PNMPs. A critical lack of understanding continued to exist within the Nursing Department regarding the clinical importance of consistently implementing the PNMPs. The Facility should develop and implement a system to ensure that prior to nurses providing care to individuals with a PNMP, they are provided competency-based training regarding the PNMPs. In addition, training should be provided to nurses who are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and other medication administration interventions, including following the instructions in the PNMPs. Also, as mentioned with regard to Section M.1, a procedure should be developed and implemented to establish inter-rater reliability, and assist in generating reliable data regarding medication administration observations. Although the Nursing Department knew about the problematic issues regarding the medication administration systems, no plan was in place to systematically review all of the elements of the medication administration system in an organized and thoughtful manner to accurately assess the extent of the problems. The Facility had much work to do to address the requirements of this section of the Settlement Agreement. By the next review, the Facility should critically review all aspects of the medication administration system to accurately identify problematic areas, and implement actions aimed at long-term resolution rather than initiating interventions that bypass the actual problem. The Facility also should develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the Medication Administration Records (MARs), and documenting these as audits. Given the consistent problematic issues noted from this review and the previous reviews regarding medication administration, little progress was noted this area, and individuals continued to be placed at risk during medication administration, as well as from not receiving their prescribed medications. The Facility indicated that it was not in compliance with the elements of this requirement, which comported with the Monitoring Team's findings.	

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

1. The QA Nurse and the Program Compliance Nurse or designee should determine a plan for the implementation of the nursing auditing tools based on priority, including a plan for dividing the responsibilities for monitoring between the two positions. (Section M.1)
2. The Facility should consider providing orientation and training to the QA Nurse, with opportunities for collaboration with the other QA Nurses throughout the SSLCs. (Section M.1)
3. The Facility in conjunction with the State should ensure that each monitoring tool has appropriate instructions, identifying the specific criteria that constitute compliance with each item being monitored. (Section M.1)
4. The Facility in conjunction with the State should develop and implement a procedure for establishing inter-rater reliability to ensure it is

executed appropriately and consistently. (Section M.1)

5. The presentation of data and data graphs 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. (Section M.1)
6. The Facility should consider decreasing the number of Health Monitoring audits conducted, and implement the remaining critical pieces of the monitoring system listed above with regard to Section M.1. This is necessary to generate credible data going forward. Once these systems are put in place, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring tools, based on the problematic areas that affect the health and safely of the individuals at AUSSLC. (Section M.1)
7. The QA Nurses, and the Nursing Department should ensure that all auditors are clinically competent, critically auditing clinical issues, and focusing on the quality of the nursing services provided, not the just completion of required documentation. (Section M.1)
8. The Facility should address aggressively the lack of the implementation of nursing protocols to guide nursing care, as well as the lack of development of appropriate Health Management Plans, and the associated documentation. (Section M.1)
9. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. (Section M.1)
10. A formalized immunization schedule and system to track immunizations should be developed, and implemented to ensure all individuals have received all the required current immunizations as outlined in the Health Care Guidelines. (Section M.1)
11. The Facility should continue and expand its efforts in the implementation of the clinical tools assessing the clinical practices and treatments of infectious and communicable diseases, since these issues affect clinical outcomes. (Section M.1)
12. The Facility should expand its pool of staff that conducts environmental monitoring auditing. Including different staff members would prevent auditors from becoming desensitized, and not accurately and adequately assessing the environment. (Section M.1)
13. The Facility should develop and implement a system to ensure the adequacy and implementation of Health Management Plans addressing infectious and communicable diseases. (Section M.1)
14. A structured format should be implemented to organize and document actions taken in response to outbreaks to improve the Facility's ability to analyze the events more clearly. (Section M.1)
15. The Facility should initiate the auditing of all individuals who are suspected and/or diagnosed with an acute infectious/communicable disease. These should be real-time audits that do not fall under the randomized sampling procedures of the Facility. Due to the acute nature of infectious diseases and the potential for spread, auditing for this area should be conducted while the acute infection is active. Conducting retroactive auditing (conducting an audit after the event) would not be clinically appropriate, nor would choosing only a percentage of these cases to audit. (Section M.1)
16. The Facility should conduct additional analyses of the Infection Control data, implement plans of action addressing problematic issues, and document when the interventions were actually implemented. (Section M.1)
17. As recommended in past reports, 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. Such expertise also should be used to obtain professional feedback regarding the quality and completeness of the finalized Infection Control Manual. (Section M.1)
18. The Facility should review all data related to its emergency systems to ensure that Mock Drills include the actual use of the emergency of equipment, and ensure that any training provided translates into improvement in the actual practices in the residences. (Section M.1)
19. Trends from the Mock Code Drills and from actual emergencies should be identified, so that appropriate corrective actions can be implemented timely, and included in the Mock Code Drills Committee minutes. (Section M.1)
20. The Facility should ensure that the required numbers of Mock drills are conducted as required by the policy. (M.1)
21. The Facility should expand its emergency drills to include a variety of scenarios, so that the emergency drills are more reflective of emergencies that warrant actions in addition to CPR. (Section M.1)

22. 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 during an actual emergency. (Section M.1)
23. The Facility should implement a system to ensure that the emergency equipment is being checked daily as required. (Section M.1)
24. The Facility should provide competency-based training to ensure nursing assessments include adequate clinical analysis, resulting in an appropriate summary of the individual's progress regarding his/her health/mental health issues. (Section M.2)
25. AUSSLC should review and revise its current nursing discharge procedures and documentation requirements to ensure that this documentation is specific and detailed enough to maintain continuity of care in the community. (Section M.2)
26. Competency-based training should be provided to the nursing staff regarding the criteria and structure of the development of adequate Health Management Plans. (Section M.3)
27. As required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated into all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding a health risk into one plan. (Section M.3)
28. It is critical that the Facility develops and implements additional adequate nursing protocols. Modifications to the available resource materials should include identification of 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 and PNMT, if indicated. (Section M.4)
29. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. (Section M.5)
30. The Facility should develop and implement a system to ensure that prior to nurses providing care to individuals with a Physical Nutritional Management Plan, they are provided competency-based training regarding these plans. (Section M.6)
31. The Facility should critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolution, rather than initiating interventions that bypass the actual problem. (Section M.6)
32. The Facility also should develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the Medication Administration Records, and documenting these as audits. (Section M.6)
33. The Facility should continue to expand its analysis of the medication variance data in conjunction with the Pharmacy and Therapeutics Committee. As additional reliable variance data is collected, it should be thoroughly analyzed to identify trends, and generate plans of correction, as needed. (Section M.6)
34. Training should be provided to nurses that are 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. (Section M.6)
35. Further collaboration should occur between the Pharmacy, Nursing, and Medical Departments in constructing a solid process that lends to a critical review of the overall medication system. (Section M.6)

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 Draft policy and procedure: AUSSLC Pharmacy Services, effective 10/25/11; o All Drug Utilization Evaluation (DUE) reports completed since the Monitoring Team's last visit, including background information, data collection forms utilized, results, any minutes reflecting action steps based on the results for: Zocor, dated 6/9/11; Seroquel and Seroquel XR, dated 7/27/11; Miralax, dated 8/15/11; Lactulose, dated 9/1/11; Saphris, dated 9/2/11; Xigris, dated 10/25/11; methylene blue, dated 10/21/11; Zyvox, dated 10/21/11; and Seroquel and Seroquel XR follow-up study, dated 10/27/11; o Any follow-up studies completed for any prior Drug Utilization Evaluation reports; o Minutes of Pharmacy and Therapeutics Committee meetings and any attachments since the last compliance visit, dated October 18, 2011; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the last compliance visit: Medication Variance Committee Meeting minutes, dated 10/17/11; o Minutes of the committee addressing seizures with any attachments since the last compliance visit; o For quarterly drug regimen reviews, two most recent per residence with physician signatures and dates, including those for: Individual #92, dated 11/3/10; Individual #183, dated 2/8/11; Individual #332, dated 12/17/10; Individual #282, dated 12/14/10; Individual #355, dated 2/24/11; Individual #266, dated 1/5/11; Individual #258, dated 3/2/11; Individual #244, dated 3/8/11; Individual #128, dated 3/3/11; Individual #279, dated 6/8/11; Individual #351, dated 3/7/11; Individual #274, dated 3/2/11; Individual #21, dated 12/16/10; Individual #12, dated 3/8/11; Individual #175, dated 2/24/11; Individual #6, dated 2/1/11; Individual #324, dated 12/14/10; Individual #321, dated 5/24/11; Individual #417, dated 1/3/11; Individual #48, dated 1/6/11; Individual #290, dated 1/6/11 (copy of date unclear); Individual #160, dated 1/12/11; Individual #307, dated 3/3/11; Individual #32, dated 5/24/11; Individual #152, dated 1/4/11; Individual #151, dated 12/20/10; Individual #432, dated 1/18/11; Individual #204, dated 6/8/11; Individual #113 , dated 3/9/11; Individual #154, dated 2/8/11; Individual #353, dated 2/14/11; Individual #29, dated 2/25/11; Individual #375, dated 2/21/11; Individual #297, dated 2/16/11; Individual #187, dated 6/8/11; Individual #179, dated 12/30/10; Individual #146, dated 10/12/10; Individual #319, dated 2/10/11; Individual #381, dated 3/3/11; Individual #215, dated 2/10/11; Individual #174, dated 3/3/11; Individual #135, dated 6/8/11; Individual #380, dated 12/21/10; Individual #452, dated 11/3/10; Individual #194, dated 12/16/10; and Individual #442, dated 2/3/11; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders. For 10 most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement. For

	following individuals: Individual #65, dated 5/20/11; Individual #23, dated 6/8/11; Individual #182, dated 5/20/11; Individual #286, dated 5/20/11; Individual #14, dated 5/20/11; Individual #402, dated 5/20/11; and Individual #189, dated 5/24/11; o All single patient intervention reports in WORx system since the Monitoring Team's last visit, from 5/1/11 to 9/29/11; o Copy of all notes extract associated with single patient intervention reports, from 5/1/11 to 9/29/11; o DUE calendar for next 12 months: 2011/2012 DUE fiscal year schedule; o For the past six months, any adverse drug reaction reports completed; o Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation, and potential errors: SSLC Statewide Policy and Procedures: Policy #053 Medication Variances, effective 9/23/11; o Number of medication errors/variance per month for prior 12 months by error type, nurse, home, shift, unit, individual, category of severity, error mode. Graphs, charts (per month, per quarter), and analysis reports, including corrective action plans root cause analysis summaries, etc.; o Copies of the last ten medication error forms completed and any plans of corrections arising from review of the medication errors; o Reprint of medication reconciliation spreadsheet; o 10 patient order interventions with documentation of follow through for following individuals: Individual #6, dated 11/8/11; Individual #108, dated 11/17/11; Individual #193, dated 11/4/11; Individual #357, dated 11/26/11; Individual #253, dated 10/20/11; Individual #283, dated 11/17/11; Individual #74, dated 11/16/11; Individual #56, dated 11/10/11; and Individual #56, dated 11/16/11; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Copy of any communication between pharmacy and Nursing Department concerning medication errors/variance (emails, memo, etc.) since the last compliance visit, including: numerous emails May to October 2011; report: pharmacy findings and concerns regarding bulk medication administration, dated October 26, 2011; report: new process to assist in the identification of adverse drug reactions, dated October 31, 2011; medication reconciliation charts for May 2011, June 2011, July 2011, August 2011, and September 2011: document: AUSSLC "Medications that should not be crushed;" o Any policies, procedures and/or other documents addressing medication administration: DADS SSLC procedure: Medication administration guidelines, dated February 2011; o Schedule of when quarterly drug regimen reviews are conducted by home/unit, revised 10/21/11; o Polypharmacy risk assessment forms for past six months for five individuals most recently rated as being at high risk for polypharmacy, and five individuals rated as being at medium risk for polypharmacy, including: Individual #21, dated 9/29/11; Individual #72, dated 8/16/11; Individual #432, dated 7/21/11; Individual #284, dated 10/10/11; Individual #381, dated 7/11/11; Individual #422, dated 7/26/11; Individual #121, dated

	6/14/11; Individual #239, dated 8/26/11; Individual #453, dated 9/20/11; and Individual #56, dated 6/8/11; o All documentation for each emergency chemical restraint, including restraint checklist for: Individual #332, dated 6/29/11; Individual #175, dated 5/29/11; Individual #210, dated 4/1/11; Individual #342, dated 5/22/11; Individual #325, dated 6/9/11; Individual #325, dated 8/17/11; Individual #374, dated 6/30/11; Individual #374, dated 7/2/11; Individual #374, dated 7/6/11 1045 hour; Individual #374, dated 7/6/11 1640 hour; Individual #374, dated 7/12/11; Individual #374, dated 7/21/11; Individual #421, dated 6/6/11; Individual #421, dated 6/16/11; Individual #30, dated 8/2/11; Individual #159, dated 4/9/11; Individual #103, dated 4/4/11 1320 hour; Individual #103, dated 4/4/11 1445 hour; Individual #103, dated 4/6/11; Individual #77, dated 4/4/11; Individual #77, dated 5/30/11; Individual #77, dated 6/18/11; Individual #77, dated 6/25/11; Individual #350, dated 9/19/11; Individual #360, dated 5/19/11; Individual #195, dated 5/17/11; Individual #195, dated 7/24/11; and Individual #109, dated 6/3/11; o Any trend analysis of chemical restraint use: Restraint trend report 3rd quarter FY 2011, and 4th quarter FY 2011; o For each database maintained on use of chemical restraints, summary lists of all chemical restraints administered over the last six months, with the name/source of the database clearly identified: WORx Pharmacy System from 4/1/11 to 10/1/11, behavioral services spreadsheet from 4/1/11 to 10/1/11; o Presentation Book for Section N; and o Handouts of Pharmacy and Therapeutics follow-up meeting on 11/17/11, including medication area inspection record compliance data for September 2011; Adverse drug reaction reporting form, dated 10/11/11, and 10/24/11; and procedure for laboratory monitoring of targeted drugs. ▪ **Interviews with**: o Kenda Pittman, Pharm D, Pharmacy Director; and o Zach Corbell, Pharm D. ▪ **Observations of**: o Site visits to medication rooms, including: 787 Wood Hollow, Castner: Hummingbird, Roadrunner, and Phoenix; o Pharmacy and Therapeutics Committee Meeting follow-up, on 11/17/11; and o Medication Variance Committee Meeting, on 11/14/11.
	Facility Self-Assessment: The Facility's POI indicated that it was not in compliance with any subsections of Section N. This was consistent with the Monitoring Team's findings. The Facility provided some helpful narrative information in its POI, including explanation regarding some of the barriers to achieving compliance. A lack of adequate staffing in the Pharmacy Department was the biggest issue. However, the Facility provided no data in its POI to substantiate its findings. Such data might come from a variety of sources, including monitoring data, or outcome measures. However, it will be important as the Facility's self-assessment processes evolve for data to be available and utilized to assist

	the Facility in identifying areas of strength as well as weakness. As issues are identified, corrective action plans should be developed and implemented to improve outcomes. Although the Facility had developed action plans to address inclusion of laboratory results on Quarterly Drug Regimen Reviews (QDDRs), Adverse Drug Reactions (ADRs), and DUEs, the action steps in each of these plans often had not been completed.
	Summary of Monitor's Assessment: The Pharmacy Department was aware of its many areas of noncompliance. Regression in compliance appeared to be due to staff shortages in critical areas. However, the Facility appeared to be resolving the shortages. A clinical pharmacist position recently was filled, and the Facility continued to recruit for another pharmacist position. The Facility continued to make progress with regard to Section N.1, and incorporating lab monitoring into the order entry system. Documentation of follow-through with the patient interventions was needed. For example, when the PCP was contacted, documentation was necessary to show the impact of that communication (e.g., new orders, etc.). Internal monitoring was needed to ensure all the steps of the new order review were completed. The QDRR process had been put on hold due to loss of the clinical pharmacist. With refilling this position, these sections should improve. The addition of pre-treatment sedation information to the QDRR was a positive contribution. However, additional focus was needed on the sections involving justification of polypharmacy and justification of anticholinergic medications. Reconciliation of chemical restraint use with behavioral services information was ongoing. The adverse drug reaction interim protocol provided a short-term system, but further work was needed to complete the adverse drug reaction policy. Once this was finalized, a major task will be the education of the many staff that would need to implement the policy. Since the Monitoring Team's last visit until August, he Pharmacy Department was unable to initiate a DUE. At the time of the most recent review, a calendar of future DUEs had been created. The department developed a process and database for internal medication variances. However, the Facility had made little progress in researching the reasons for the medication errors and medication variance reports.

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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	For the prior six months, the Pharmacy Department had been understaffed. There was no clinical pharmacist for a number of months, but this position had been recently filled (i.e., November 1, 2011). At the time of the Monitoring Team's onsite review, the Pharmacy Department was recruiting a staff pharmacist, because they remained	Noncompliance

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	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.	understaffed. On 7/7/11, a pre-treatment sedation policy and procedure was implemented. It excluded chemical restraints. It focused on the role of pharmacy in reviewing a medication regimen to identify risks associated with the administration of the medication when given with the individual's current drug regimen. This medication also would be addressed in the QDRR. If dental anesthesia was used, the pharmacy was to be informed of the medications to be administered, and the anesthesiologist would be expected to review the prescription profile for potential drug-drug interactions. A sample was submitted of 10 new prescription interventions, including documentation of any follow-through as needed. These included the relevant computer screen shot that alerted the pharmacist to review and enter information in the appropriate section of the drop down box under recommendation/description. Of these, the following impact of the reviews was noted: ▪ There was evidence provided of three individuals for which four orders were changed. ▪ One review indicated the new medication did not alter the current drug regimen schedule or dosing. No change in orders was indicated based on this information. ▪ For one order, there was a potential drug interaction between antibiotics, but the submitted documents did not indicate that the PCP was contacted, or if the order was changed. The screen snap shot might not have been able to copy the entered information. ▪ One alert indicated a potential cross allergy, but no information was submitted to show any communication with the PCP, and whether discussion occurred of the level of risk of the potential cross allergy. No order change was submitted. ▪ For two orders, the screen snapshots indicated a "therapeutic duplication alert," but the submitted information did not include any changes in orders, and the meaning of the alert was not clear. ▪ One order resulted in no order notes. The interpretation was not clear, but this might have indicated there were no red flag alerts on the order. Going forward, it will be important for the Facility to provide evidence of a sample of new orders that have undergone the process of steps outlined in this section of the Settlement Agreement including: reviewing significant interactions with the individuals' current medication regimen, side effects, allergies, need for laboratory results, and additional lab testing needed regarding risks associated with the use of the medication, as well as a review of dosage adjustments. Evidence should include copies of appropriate screen snapshots inclusive of the above requirements. If a patient intervention is generated, evidence the PCP was contacted, with date, and response of the PCP (e.g., PCP note,	

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		signature, etc.), and/or entry into the WORx system of the PCP response would be important evidence to fulfill the requirements of this section. Additionally, the clinical pharmacist, as part of the internal QA process, should review a random sample of these orders on a monthly basis to ensure all aspects of the process are completed. There should be evidence of this monitoring process, including name of the individual, date of the new order, the description of the new order, the screen snapshots reviewed to fulfill each of the components of the review, copy of the patient intervention, and evidence of PCP contact and response. For new orders, when the pharmacy noted a concern, WORx interventions were recorded, and communication with the PCP was documented. Subcategories were created: allergy/disease state contraindication, interaction/compatibility intervention, adverse drug reaction, and therapeutic consultation. For May 2011, there were six interventions. In June 2011, there were six interventions. In July 2011, there were two interventions, and in August 2011, there were two interventions. The intervention entry included the medication and dosage. Of the 16 interventions entered into the WORx system, five out of 16 (31%) included a record that the PCP had been contacted, and the PCP's decision was included in the intervention note. It is recommended that the Pharmacy Department document that it communicated with the PCP, and enter a brief entry in the intervention note about the PCP's plans. The current system of patient intervention entries did not provide evidence that the PCPs had been contacted routinely in a timely manner. The October 18, 2011 P&T Committee meeting minutes documented that the pharmacy was in the process of creating a guideline for recommended lab monitoring at the time of new physician orders, if applicable. It was dated 10/17/11, and focused on several classes of medications, including: antidepressants, antihypertensives, antihyperlipidemics, diabetic individuals, psychoactive medications, all individuals on thyroid medications, Terbinafine, and proton pump inhibitors. This would assist the pharmacist in compliance with the Settlement Agreement requirement that the pharmacy review the need for laboratory results, and ongoing lab testing to monitor therapeutic levels or significant side effects, and potential risks of the new medication or increased dosage of medication. Additionally, to reduce complexity of having additional fields/folders of information, it might be helpful to place the "notes extract" in the "patient intervention" field/folder, with its own subcategory of "diet changes," for instance. Alternatively, listing the criteria for when a "notes extract" should be created separate from an entry in the "patient intervention" field/folder would be helpful.	

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N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A copy of the QDRR review schedule was submitted, dated 10/21/11. At AUSSLC, the QDRRs were completed by residence in the order documented on the schedule. The order was repeated each quarter. A total of 23 residences were included in the QDRR schedule. A sample of 46 QDRRs was reviewed. These are listed above in the documents reviewed section. Of these 46 QDRRs, only five were completed since the Monitoring Team's previous visit. None of these five was completed within 90 days of the prior QDRR. None were completed in the three months prior to the Monitoring Team's visit (0%). It is important to note that none of the 46 QDDRs met the basic requirement of being timely. However, the Monitoring Team conducted a review of the quality of the QDDRs merely to provide the Facility with feedback that should be useful moving forward. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 46 out of 46 QDRRs (100%). ▪ The lab results included exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (Hgb) A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic drug levels with therapeutic ranges). ▪ All labs had the date the lab was drawn. ▪ Significant abnormal values were identified and addressed under the notes/comments section line for that particular lab. The Pharmacy Department submitted a copy of a blank QDRR. A new entry which was included was entitled "pre-treatment sedation: medication and dosage, last date/time administered, and appointment/clinic information." This summary would be important information for all PST members to have readily available.	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 to ensure that medications are used in a clinically justifiable manner,	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 28 chemical restraints used from 4/1/11 to 9/19/11. These are listed above in the documents	Noncompliance

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	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.	reviewed section. The chemical restraint documentation indicated that 15 individuals had 28 chemical restraints. Information was not provided on these forms indicating how the maintenance medication was being changed in order to reduce the use of chemical restraints. For the 28 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 28 chemical restraint forms, eight forms (29%) included information concerning the justification of use due to the behavior. ▪ None (0%) included information concerning whether the maintenance medication had been changed to reduce chemical restraint use, especially for the individuals that had multiple chemical restraint events. ▪ Effectiveness of the chemical restraint was documented in one out of the 28 chemical restraint forms completed (4%). ▪ Side effects and adverse effects were noted in none of the completed chemical restraint forms (0%). ▪ Risk analysis of use of the medication was documented on none of these forms (0%). ▪ There were eight statements that were considered recommendations. ▪ The range of time for completion of the forms was from zero to 17 days. ▪ The documents submitted indicated that pharmacy only completed nine of the "chemical restraint clinical review" sections. Compliance was nine out of 28 (32%). ▪ All 28 chemical restraint forms indicated the medication prescribed, the dosage and the time administered. One form did not include the route of administration of the chemical restraint. To assist the pharmacy in review of future chemical restraints, the content of the form was expanded to ensure the pharmacy completed four areas, including: "was the medication used in a clinically justifiable manner? Y/N, summary of assessment. Has pharmacy previously screened the order for drug-drug interactions? Y/N. Potential medication related risks to consider: staff should monitor: and additional actions/recommendations: was the chemical restraint reported to be effective? Y/N. " This ensures the Pharmacy Department responds to areas within its expertise. The psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Review of these documented showed:	

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		▪ Of the 28 completed, there were eight forms (29%) on which the psychiatry comment section was completed. ▪ For eight of the chemical restraints used (29%), by describing the behaviors and steps taken, clinical justification was provided. ▪ For none of those who required frequent chemical restraints (0%) was there a comment regarding whether maintenance medication had been changed, the BSP had been amended, or other environmental changes were completed. ▪ Side effects were mentioned in none of the reviews (0%). ▪ Effectiveness was documented in two of the cases (7%). ▪ Information discussing the risks of drug-drug interactions, or other risks was addressed in none (0%). ▪ There were three recommendations documented. Separately, two other databases listed other individuals to whom a chemical restraint was administered. These were labeled WORx pharmacy system (4/1/11 to 10/1/11) and Behavioral services spreadsheet (4/1/11 to 10/1/11). Additional restraint use was documented in these databases, but no Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint, and no pharmacy review or psychiatry reviews were submitted. These chemical restraints were for: Individual #139 on 5/12/11 at 1040 hour, Individual #139 on 5/12/11 at 1145 hour, Individual #139 on 6/2/11, Individual #374 on 7/1/11, and Individual #374 on 8/18/11. The additional one for Individual #360 on 6/27/11 was the only one documented in the WORx system. Others for Individual #374 on 7/21/11, and Individual #374 on 8/18/11 were noted in the Face-to-Face forms and the WORx system, but not the Behavioral Services spreadsheet. The three databases agreed for many of the chemical restraints used, but there were differences. It is recommended that the Psychology and Pharmacy Departments monitor the databases to identify any discrepancies, and develop a database management system that has identical and complete information across the three databases. Email correspondence between the Behavioral Services and Pharmacy Departments indicated interdepartmental cooperation in ensuring all databases were complete. <u>Polypharmacy</u> Of the 46 QDRRs reviewed, polypharmacy was noted in 21 reviews. ▪ Each medication identified in the polypharmacy section had a diagnosis listed in all reports. This was considered justification for each of these medications being used. There was 100% compliance with this initial aspect of justification of medication use. ▪ However, clinical justification for the use of all the medications identified in the group of medications that resulted in a polypharmacy regimen was addressed in none of the 21 reports (0%). Examples of justification could include the following: for multiple seizure medications, a neurologist saw the individual and	

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		confirmed the continued need for the polypharmacy; or reference to the polypharmacy committee minutes with a specific date, and comment by the pharmacy that there was sufficient information to justify polypharmacy (for instance, a prior reduction had resulted in increased psychiatric symptoms). Such brief entries would provide evidence for justification, and indicate that the pharmacist agreed that the evidence was sufficient for justification. Currently, the document identified polypharmacy, but did not include statements of justification. ▪ Side effect risk was reviewed in 15 (71%) of those with polypharmacy. The Facility did not have a committee that addressed polypharmacy for non-psychotropic medication. The Pharmacy Department contributed to the risk categorization of polypharmacy. Recently completed risk assessment forms for 10 individuals were submitted. The categorization of polypharmacy was divided into non-psychotropic medications and psychotropic medications. Additionally, the documentation included definitions of polypharmacy, psychotropic medication polypharmacy, and side effects associated with polypharmacy, which were consistent with the "Risk Guidelines" in the State Office document. However, what appeared to be missing was the actual final categorization by the pharmacy of the polypharmacy risk based on this detailed information. There was no statement to guide the team that the pharmacy clearly indicated the individual was at high, medium, or low risk. Each team member would presumably have to review the polypharmacy health risk assessment tool, and make a determination of risk level based on this submitted information. Depending on the clinical or non-clinical background of the PST members, this could lead to different conclusions. It is recommended a final statement or recommendation of risk level for polypharmacy be indicated on the form. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 10 of the 46 QDRRs. ▪ Of these, 10 (100%) documented justification with appropriate diagnoses; and ▪ Nine QDRRs (90%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 46 QDRRs, 31 (67%) drug regimens were identified as having potential significant anticholinergic side effects. All 31 QDRRs identified specific medications contributing to anticholinergic drug load. The categorization of severity categories (low, moderate, high) of anticholinergic drug load appeared appropriate and adequate for clinical guidance to the PCPs. The results of the review of the QDRRs are as follows: ▪ All 31 (100%) documented a diagnosis as clinical justification for the use of each	

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		of the medications contributing to anticholinergic load. ▪ For none of the individuals for whom there was a risk of significant anticholinergic side effects was there a justification of use of the medications (i.e., based on the review of the current anticholinergic side effects the individual was experiencing (if any), the amount of side effects justified the continuation of the medication causing or contributing to the anticholinergic side effect). This analysis should be completed with all individuals prescribed such medications as Cogentin and Scopolamine, but also any other medication or combination of medications with significant anticholinergic potential. Developing criteria to determine when the side effects reach an unacceptable level (and are no longer clinically justifiable) might require collaboration with the PCP, and guidance from the psychiatrist and Medical Director. ▪ All 31 (100%) QDRRs addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 46 QDRRs reviewed, 16 listed atypical antipsychotic medication. Of these, 13 (81%) included lab values that reviewed endocrine and metabolic risks (i.e., basic metabolic panel, glucose level, Hgb A1C, and/or lipid panel, as appropriate). From the information reviewed with regard to Sections N.2 and N.3, the variability across SSLCs for QDRR documentation suggested the need for State Office guidance in the form of a policy/procedure. For Section N.2, it would be beneficial to provide guidance and standardize the labs that should be included, and the expectations of when the lab data should be followed by comments, as well as set forth the expectations of when lab data discussion/comments should result in a pharmacy recommendation. Similarly, with regard to Section N.3, defining the criteria used to justify polypharmacy and anticholinergic medication use would assist Pharmacy Departments in fulfilling the requirements of the Settlement Agreement. In addition, it would be helpful to standardize the labs and frequency of monitoring for the metabolic and endocrine side effects of the newer generation antipsychotics.	
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	Review of 46 QDRRs showed the following: ▪ Of the 46, 45 QDRRs (98%) had the PCP signature. ▪ Of the 46, 33 (72%) had the date the PCP reviewed the document. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 44 out of 46 (96%). o Agreement was documented in 43 out of 44. o There was disagreement by the PCP for one QDRR. For this one QDRR, a note of justification and plan was recorded on the QDRR. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed 23 QDRRs, and agreement or	Noncompliance

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	recommendation is not followed.	disagreement with justification and plan was documented in nine out of (39%). ▪ The date of the psychiatry review was recorded in 20 out 23 QDRRs (87%). ▪ A psychiatry signature was noted in 22 out of 23 QDRRs (96%). The October 18, 2011 P&T Committee meeting minutes indicated that the pharmacy was to enhance communication concerning QDRR findings and recommendations by having the clinical pharmacist meet individually with the PCPs to review the findings. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted seven active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of seven, seven (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	As discussed above with regard to Section J.12, 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. An important component of this was also the latency between the time that the nurse completed the exam, and subsequently, the prescribing physician reviewed the documentation. The review of the sample of the records of 24 individuals who were prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months, was present for all but the following four individuals (followed by most recent MOSES completion date): Individual #271 (3/16/11), Individual #412 (3/11/11), Individual #355 (3/4/11), and Individual #59 (2/11/11). Thus, the MOSES was completed on schedule for 20 of the 24 individuals (83%). The records of 20 individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for all but four individuals. Those individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #412 (3/11/11 - 3/23/11), Individual #355 (3/4/11 - 3/24/11), Individual #332 (6/29/11 - 7/19/11), and Individual #165 (7/21/11 - 8/5/11). Thus, the MOSES evaluations were reviewed in a timely manner for 20 of the 24 individuals (83%). The purpose of the DISCUS is to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 22 individuals (Individual #353 and Individual #332 were not receiving antipsychotic	Noncompliance

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		medication and, thus, monitoring with the DISCUS was not required) identified documentation that the DISCUS was current, and had been performed quarterly for the past year for all but the following four individuals (date of most recent DISCUS evaluation): Individual #271 (6/24/11), Individual #412 (3/11/11), Individual #355 (6/13/11), and Individual #59 (5/20/11). Thus, the DISCUS had been performed as specified for 18 of the 22 individuals (82%) who required this monitoring. Those individuals whose records documented that there was a significant delay between the date the nurse completed the DISCUS evaluation, and the prescribing physician reviewed and signed it (latency before review) were as follows: Individual #271 (6/24/11 - 7/7/11), Individual #355 (6/13/11 - 7/19/11), Individual #33 (10/8/11 - 11/1/11), and Individual #156 (10/27/11 – 11/18/11). Thus, the prescribing physician reviewed the DISCUS in a timely manner for 18 of the 22 individuals (82%). 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 also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS for those individuals who were receiving antipsychotic medication. Thus, a Psychiatric Nurse would monitor an individual for side effects if they were receiving Reglan as well as an antipsychotic 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 and who were not also prescribed psychotropic medication. The following sample of four individuals (100% of those who fit the above criteria) was selected, and included: Individual #454, Individual #62, Individual #269, and Individual #200. The review of the records of these individuals for documentation related to the MOSES indicated that the examination had been performed as required, and the prescriber had reviewed and signed them in a timely manner for Individual #62, and Individual #269. There was no MOSES contained in the requested documentation for Individual #454, or Individual #200. Thus, these evaluations had been completed and reviewed as expected for 50 percent of the sample.	

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		The same methodology was utilized to select the sample of individuals receiving Reglan for completion of the DISCUS. The results of this review indicated that these evaluations were completed as specified and reviewed in a timely manner for only one of the four individuals (25%) (i.e., Individual #62). No DISCUS evaluations were included for Individual #269. There was a gap of five months (5/20/11 to 10/19/11) in between DISCUS evaluations for Individual #454, and a gap of over two weeks for the review and signature by the prescribing physician. The most recent evaluation for Individual #200 was dated 5/20/11, and there was a gap of six months between that evaluation and the prior (12/29/10) assessment. The prescriber had not reviewed the 12/19/10 assessment until weeks after the evaluation was completed. The discrepancy between the results on the completion of the MOSES and DISCUS for the individuals receiving psychotropic medications, and those who were prescribed Reglan and no traditional psychotropic medication was significant. As noted above, a Psychiatric Nurse completed the DISCUS for those individuals who received psychotropic medication, whereas the individual's RN Case Manager completed the DISCUS for those who received only Reglan. An RN on the Unit completed the MOSES for both groups of individuals. On 8/1/11, DADS changed this policy, so that on a quarterly basis, the RN Case Managers now would complete the MOSES/DISCUS as part of their Quarterly Nursing Assessments. This could not be delegated to other nursing personnel. A policy to parallel this change in protocol was not available for review, but was documented in an internal DADS e-mail, dated 7/12/11. This policy should be fully implemented by the time of the next monitoring review, and its effects on the timely completion and review of the MOSES and DISCUS evaluations will be assessed at that time. During the prior review, the subject of the latency between the completion of the MOSES and DISCUS and the date the prescribing physician reviewed and signed them was discussed with the Psychiatry Department. At that time, staff 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. 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 may require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. The Facility might want to proactively monitor the degree to which the MOSES and	

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		DISCUS are being carried out as scheduled to assess for any decrease in the frequency of the monitoring following the transition. The Department should also ensure that the RN Case Managers have the necessary training to correctly perform the DISCUS evaluation. The finding of Noncompliance for this Section of the S.A. primarily related to the deficiencies in the completion of these important side effect monitoring tools for individuals who were prescribed Reglan as well as the lack of a method to document that any sudden significant changes in an individuals side effect status was immediately reported to the prescribing physician.	
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 submission of documents, the Pharmacy Department noted that the ADR program discussed at the time of the Monitoring Team's last visit had not been able to be "effectively implemented." This was due in part to the staffing shortages in the Pharmacy Department. A process described below was created as an interim procedure until the planned ADR program could be implemented. The minutes of the 10/18/11 P&T Committee meeting indicated that no ADRs had been reported. The Pharmacy Department's goal was to identify ADRs at the time of occurrence. PCPs were expected to write new orders or change orders based on ADRs, and to also include information on the order concerning the presence of an ADR. This system should be reviewed, because ADRs can be identified after completion of an order, and might not create a need to change an order or write a new order. Similarly, ADRs in the hospital setting would not result in a PCP at AUSSLC writing a change in order. On 11/17/11, a P&T Committee follow-up meeting was held, and a member of the Monitoring Team attended the meeting. Two potential ADRs were discussed to determine P&T recommendations. Appropriate background information had been prepared for committee members, which was important to allow the committee to provide recommendations concerning the potential ADRs. The pharmacy provided a brief summary of the details of the new process in place for identification of adverse drug reactions, dated 10/31/11. At the time of entry of a new drug order, a drug monograph would be forwarded to the home. The monographs would include potential side effects and be a reference for potential ADRs. The procedure for reporting an ADR remained unchanged. If suspected, the pharmacy was to be notified of an ADR. If a change in medication was due to a potential ADR, the PCP was to note this as part of the order with specific phrases used such as "d/c due to ADR," or "dose decreased due to ADR." The pharmacy then was to complete the newly updated ADR reporting form with subsequent presentation to the P&T committee. The committee would determine if it was an ADR, and if it needed to be reported to the Federal Drug Administration (FDA) MedWatch program.	Noncompliance

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		This section requires ongoing education by the Pharmacy Department to the departments that would be responsible for identification of an ADR, including: Medical Department, Nursing Department, and residential services. For compliance, training rosters for all staff in these departments is an essential component. Although providing a monograph for every new order is a good first step, it does not provide evidence the residential staff read the monograph or understand the content, especially if the monograph is lengthy and contains information about other aspects of the medication. It might be difficult to find the side effect profile in the document, and it might be difficult for non-clinical staff to interpret the detailed side effect profiles that are often part of the monographs. When there is sufficient pharmacy staff, and once the ADR policy and procedure and process are finalized, there should be a methodical approach to training on the topic of ADRs to these departments. The Pharmacy Department continued to develop the Facility adverse drug reaction policy and procedure. On 10/31/11, a revision to the original draft occurred, and was sent to the Medical Director and Chief Nurse Executive (CNE) for review and approval. Additionally, on 11/15/11, the initial revised reporting form for an adverse drug reaction was completed. According to the timeline submitted, it was anticipated that by 3/15/12, full implementation of the adverse drug reaction reporting policy and procedure would occur. This would include a component of new nurse orientation training. During the pharmacy session, ADR discussion would be included.	
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.	A calendar for the fiscal year 9/11 to 8/12 identified the medications to be included in drug utilization reviews. At the October 18, 2011 P&T Committee, the calendar was approved. The DUEs included: the use of Miralax and Lactulose and the frequency of bowel movements for the first fiscal quarter (9/11 to 11/11), Levetiracetam and seizure frequency for the second fiscal quarter (12/11 to 2/12), second generation antipsychotics and the metabolic syndrome for the third fiscal quarter (3/12 to 5/12), and neutropenia with antipsychotics other than Clozapine for the fourth fiscal quarter (6/12 to 8/12). A number of the pharmacy's reviews were focused on changes in FDA recommendations/warnings for prescribed medications. The Facility was calling these drug utilization evaluations. The pharmacy determined it was important to review the materials provided by the FDA, and ensure the individuals residing at AUSSLC did not need a change of medication regimen based on these new recommendations. This is an important aspect of the role of any SSLC pharmacy, but is independent of the DUE process as outlined in the Health Care Guidelines. The FDA warnings also might require prompt review, and would be independent of any P&T Committee approved calendar for DUE completion. These FDA reviews the pharmacy conducted included the following:	Noncompliance

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		▪ On 6/9/11, Zocor was reviewed based on new recommendations for the 80 mg dosage, as well as new information concerning new maximum recommended dosages, if prescribed with drugs that might alter drug levels of Simvastatin. The pharmacy reviewed the individuals' profiles, and documented no individuals were prescribed the 80 mg dosage, nor were any exceeding new maximum recommended dosages when prescribed with drugs that might alter blood levels. For two individuals on Simvastatin, for which other medications were prescribed that might alter the drug level, a note was added to the individuals' profile to alert the pharmacy of maximum recommended dosages as a result of the drug interaction. ▪ On 7/27/11, the pharmacy also reviewed the use of Seroquel and Seroquel XR based on an expanded warning by the FDA, when used with certain other medications. The pharmacy reviewed all individuals on these medications, and determined one individual was prescribed a medication with which there was the possibility of drug interaction. This information was referred to the psychiatrist and PCP, and referral was made to the cardiologist, with no change in medication advised. On 10/27/11, follow-up study was completed for Seroquel and Seroquel XR. Of 22 individuals prescribed this medication, none required additional action of change in medication or increased monitoring. For these individuals, pharmacy completed a QT prolongation (electrocardiogram measurement) risk assessment and provided an active score based on level of risk. The active score was to be used by the pharmacist to assist in determination of level of risk for any drug interactions with Seroquel. ▪ A number of other medications were recalled by the drug manufacturer, or had further FDA warnings. The pharmacy reviewed each individual's medication profile to determine if medications needed to be substituted or other changes were needed. On 10/25/11, the Pharmacy Department completed a campus-wide review on Xigris. No individuals were prescribed this medication. On 10/21/11, the pharmacy completed a campus-wide review of Methylene Blue. No residents were currently prescribed this medication. The pharmacy completed a campus-wide review of Zyvox. No individuals were prescribed Zyvox. On 9/2/11, the pharmacy completed a campus-wide review of Saphris, and found that no individuals were prescribed this medication. Starting on 8/15/11, a study that the Pharmacy Department considered to be a DUE was completed for Miralax (a two-month evaluation). The goal was to "identify a method to improve reconciliation of bulk medications across AUSSLC." The pharmacy discovered that 1535 doses of medication had been returned to the pharmacy. This indicated 29% of the prescribed doses were potentially not being administered. Because of the bulk distribution, it was difficult to determine the source of the medication variances.	

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		On 9/1/11, the pharmacy began a similar study for lactulose, another medication supplied by bulk containers. This was a one-month evaluation. Over the one-month period, 899 doses of 2870 doses (31%) were returned to the pharmacy that should have been administered to individuals. Although the Pharmacy Department called both of these studies DUEs, they were focused on determining whether or not medication errors/variances occurred and potential causes, rather than focusing on side effects, accuracy of diagnoses, etc. Based on the definition of DUEs in the Health Care Guidelines, these did not meet the requirements of the Settlement Agreement with regard to DUEs. Based on the findings of the Miralax and Lactulose DUEs, the pharmacy determined that an appropriate functioning system of accountability did not exist for the doses administered through the bulk container system. The pharmacy was unable to monitor the medication variances. The pharmacy also was unable to assess effectiveness of these two medications, because of the uncertainty regarding whether they were actually administered. Based on this information, the pharmacy changed four of the most commonly refilled bulk medications to unit dose packaging. These included: Miralax, Lactulose, Levetiracetam, and calcium citrate/ Vitamin D. The Pharmacy Department indicated there were no follow-up studies completed on prior DUEs. There were no DUE submitted which had been completed in the interval of May to August 2011. The update on the Miralax DUE of 8/15/11 was the earliest in the prior six months.	
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.	<u>Policies and Procedures regarding Medication Variances</u> A new statewide policy or "Pharmacy Services" was finalized, and had been implemented recently. The Facility was undergoing revision of the local policy, which was in draft form, dated 10/25/11, and awaiting approval by the Medical Director. It was a 42-page document covering all aspects of pharmacy, including DUEs, stat medication use, ADRs, and medication variances. Separately submitted were two policies: DADS SSLC Procedure: Medication Administration Guidelines, dated February 2011, which provided detailed step-by-step guidance for the various aspects of this clinical area, and DADS SSLC Statewide Policy And Procedure: Medication Variances, dated 9/23/11, which provided detailed step-by-step guidance concerning types of variance, categorization of severity and procedure in completing the medication variance report, investigation, and data analysis. <u>Pharmacy Review of Categorization of Errors</u> The Pharmacy Department was not active in verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy's interpretation of the medication error categorization. For instance, the Nursing Department was still	Noncompliance

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		categorizing errors of omission as category B. <u>Committee Monitoring of Medication Errors/Variances</u> The analysis and discussion of the medication error process was reflected in the minutes of the Medication Variance Committee meetings. The following described some of the findings of this committee: ▪ From the 10/17/11 Medication Variance Committee meeting minutes, concerns included the use of Eucerin Cream, because it had not been refilled for a year. Lactulose was provided as a unit dose after the pharmacy completed a medication room sweep. The pharmacy observed the Lactulose was not being given, because the amount did not change in the bottles. Additional monitoring steps were discussed including spot checks and count check sheets for every medication, every shift. A responsible person was assigned follow-up, although there was no projected date of completion for any of the tasks assigned. ▪ The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the P&T Committee Meeting, dated 10/18/11. Due to the large number of bulk medication dosages that had not been administered, and due to the inability to track medication errors for each individual when bulk dosing was delivered to the homes, the pharmacy converted several bulk medications with frequent use into a unit dose system. The group discussed the conversion to unit doses for Miralax, lactulose, Keppra, and calcium citrate. The high return rate of bulk medication also was the impetus for the pharmacy's decision to create a DUE to track laxative use. Reviewing bowel movement (BM) logs, as well as ammonia levels were to be part of the DUE. To ensure medication errors were reported to the PCPs, it was recommended that medication errors/variances be added to the business discussed at the morning provider meetings. To assist with reducing medication variances, the pharmacy changed the pharmacy label on the medications dispensed in bulk supply. It included the number of days supplied and was date-stamped in red with the dispensing date. The pharmacy also used a "pharmacy accountable drug record" on which the RN picking up the medication agreed the medication and the quantity received for the order was correct. Additional brightly colored labels were created to assist in reduction of medication variance. Reconciliation record forms were created by pharmacy to be completed by nursing for each unit dose cup that was returned, including the date, name of resident, and number of unit doses being returned. Examples were provided for Lactulose and Levetiracetam. The Pharmacy Department indicated it was unable to provide any report that provided tracking or trending of medication errors. There also had been no root cause analysis or	

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		corrective action plan for any medication error reported. Data was submitted from internal pharmacy information that indicated a need for a continued aggressive approach to medication variance resolution. The following information was available from the Pharmacy Department, but the completeness and reliability of information was a concern, because medication error forms were not completed for medications returned to the pharmacy: ▪ For May 2011, 10 medication error slips were completed, but were doses of medication 100 returned to the pharmacy for unknown reasons, and 71 medication shortages of unknown cause occurred. For May 2011, the Pharmacy Department was the source of 43 medication variances. ▪ For June 2011, seven medication error slips were completed, but 86 doses of medication were returned to the pharmacy for unknown reasons, and 72 medication shortages of unknown cause occurred. For June 2011, the Pharmacy Department was the source of 25 medication variances. ▪ For July 2011, no medication error slips were completed, but 72 doses of medication were returned to the pharmacy for unknown reasons, and 48 medication shortages of unknown cause occurred. For July 2011, the Pharmacy Department was the source of 15 medication variances. ▪ For August 2011, 31 medication error slips were completed, but 71 doses of medication were returned to the pharmacy for unknown reasons, and 59 medication shortages of unknown cause occurred. For August 2011, the Pharmacy Department was the source of 18 medication variances. ▪ For September 2011, 20 medication error pink slips were completed, but 108 medication doses were returned to the pharmacy for unknown reasons, and 81 dosage shortages of unknown cause occurred. The pharmacy was unable to determine the cause of these discrepancies. In September 2011, the Pharmacy Department was the source of 19 medication variances. ▪ In October 2011, 11 medication error pink slips were completed, but 130 medication doses were returned to the pharmacy for unknown reasons, and 65 dosage shortages of unknown cause occurred. Internally, 61 errors were corrected by the Pharmacy Department before medications were dispensed. This was the result, in part, of a new monitoring tool for medication variance tracking internal to the Pharmacy Department. Once dispensed, the Pharmacy Department was the source of 28 medication variances. The Pharmacy Department submitted considerable documentation of correspondence with the Nursing Department concerning medication variances. A summary of pharmacy findings and concerns regarding bulk medication administration was submitted. The findings on bulk medications for Miralax and Lactulose have already been discussed, as	

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		the findings were the reason to initiate DUEs for these medications. Additionally, in September 2011, a residence ordered a multivitamin liquid refill, but the prior refill order had been in April and May. The pharmacy completed a medication room sweep and removed any liquid multivitamin. The next day, it was noted the nurse had signed the MAR indicating the medication had been administered, when it was not available for administration. The Nursing Department was notified of this event, as well as of the other bulk medication returns. From the email correspondence, little communication was sent back to pharmacy regarding the steps the Nursing Department completed in resolving this problem. Another example of lack of definitive follow-up provided through email correspondence was related to the order for Eucerin Lotion to be applied "head to toe three times daily," but it had not been refilled since February of 2010. The email correspondence also indicated the pharmacy discovered a medication variance for an individual attending school where noontime doses of medications were administered. It was noted that nursing had responsibility to inform the school of any medication changes, but no information was submitted concerning the Nursing Department's resolution of the pharmacy's concern. In the example reviewed, the individual had a discontinuation of one of the noontime medications, but that had not been conveyed to the school. The pharmacy learned of the communication gap when the school requested a refill of the medication that had been discontinued. This resulted in the individual receiving doses for an additional 16 school days. Given the significant numbers of individuals with osteoporosis residing at AUSSLC, timely treatment should be a high priority. Yet, on 8/17/11, the pharmacy noted in email correspondence to the nursing staff that calcitonin vials had been returned with large amounts of the medication remaining in the vials. The inference was that the medication was not administered correctly or not at all. In one instance, several vials were completely full, and multiple vials had been returned for one individual. The Pharmacy Department suggested the need for nursing re-education on administration of this medication. Information was not submitted concerning resolution of this medication variance. Separately, through email correspondence, the pharmacy provided a list to the Nursing Department of "Medications that should not be crushed," a six-page comprehensive document. It is recommended that a shorter list be created of those medications used at AUSSLC that should not be crushed, and that this list be distributed to the nursing staff. Each of these should have identical directions on the MARs to remind nursing staff about the proper administration of these medications.	

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		In the email correspondence, the pharmacy also noted that on 7/27/11, they had received orders for a change in dosage of medication that was written on 7/19/11. This left little time for the pharmacy to obtain the needed medication, and dispense it in a timely manner. The reason for the delay was also a concern, and whether the individual received the increased dosage in a timely manner (i.e., the nurse might have had sufficient medication to increase the dosage during that period of time). There was no correspondence indicating the Nursing Department had communicated to the Pharmacy Department about findings from any nursing investigation review or the steps that were taken to prevent recurrence. Additional email concerns included potential administration of potassium chloride to one individual using another individual's supply, lack of Lovenox injection administration for an entire week, excessive requests for refills of Lacosamide, orders for changes in Dilantin on 5/4/11 that were received in the pharmacy on 5/31/11, and orders on another individual written on 5/26/11, but not received by the pharmacy until 6/1/11. The pharmacy conducted a number of medication room "sweeps," using a detailed Medication Room Inspection Report. There was near complete noncompliance with the following areas: "medications that have passed a stop-date have been returned to the pharmacy," "vacation medications used/dated have been returned to pharmacy," "containers with worn/illegible, dated or missing labels have been returned to pharmacy," "medication showing any unusual changes in color, odor or appearance have been returned to pharmacy," and "medications previously prescribed for expired or discharged individual have been returned to pharmacy." Several other areas needed improvement, such as "date of first puncture is noted on multiple dose injectable vials." A member of the Monitoring Team toured several different medication rooms on campus. There was considerable variation in size, lighting, maintenance and cleanliness. Some appeared to not have sufficient storage space to meet the needs of the residence without potentially compromising safe and timely administration of medication, and orderly storage of medication. Reviewing the challenges nursing faced in utilizing some of these medication rooms, and providing practical steps for better lighting and storage would likely assist in improvements in medication variance rates. <u>Medication Error Reports</u> The Facility submitted copies of 10 recent medication error forms. ▪ The severity of the medication errors were: Category A - one medication error, Category B - four medication errors, and Category C - four medication errors. There was one form for which no category was assigned. There appeared to be multiple medication errors for the same individual at the same medication pass,	

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		which were then addressed in the forms as one medication error event. This approach may reduce the actual count of medication error doses that occur. ▪ The new index categorization was not used for medication omissions, as they were still considered Category B instead of Category C errors. ▪ There was a written corrective action follow-up by the nursing supervisor in four of the 10 medication errors (40%). It is recommended that an accurate investigation as to the reason for the medication error occur immediately after identification of the medication error, and that corrective action steps be defined and implemented. Follow-up corrective action steps should be entered into an information management system for nursing and pharmacy review, including the steps taken, as well as tracking for recurrence of similar medication errors. If the same type of medication error occurs, then the action steps should be revised until there is improvement in the outcome. <u>Medication Observation Monitoring</u> Reports were submitted of any medication administration observations for the past two months. A total 31 reports were submitted for 19 nurses. Dates of observation were 8/2/11, 8/23/11, 9/5/11, 9/6/11, 9/7/11, 10/14/11, 10/19/11, and 10/20/11, with one report undated. Overall, few to no problems were found. The final score was only tabulated in two of the 10 submitted documents. Given the significant issues that pharmacy had discovered with large numbers of returned medications and known medication errors, the current medication administration observation system did not appear to be sufficiently sensitive to further uncover medication errors. No information was provided related to inter-rater reliability. No information was submitted that indicated the Pharmacy Department participated in medication observation passes, and/or whether their findings were consistent with the medication pass findings of the Nursing Department. The current medication pass observation process appeared to be unhelpful in assisting with the resolution of the large number of medication errors at AUSSLC.	

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

1. The pharmacy should provide evidence of the processing of steps through to completion of entry of a new order. Screen snapshots should incorporate the areas stated in the Settlement Agreement (e.g., drug interactions, allergies, side, effects, need for lab, etc.). Evidence should include a copy of the patient intervention documentation in WORx, and the prescriber's response, including a copy of a physician order if appropriate. (Section N.1)
2. The clinical pharmacist should provide evidence of monitoring of new order entries to ensure all the required aspects are completed. This could be done through a random sample or selected percentage of orders. Review and analysis should be completed of the data from these reviews, with trending by month or quarter. Action should be taken, as appropriate, to correct issues identified. (Section N.1)
3. For completeness and ease of tracking, the patient intervention note in WORx should include that the Pharmacy Department communicated with the PCP. There should also be a brief comment about the PCP's plan in response to the information. (Section N.1)

4. The "notes extracts" for new orders should be merged with the patient intervention note section. (Section N.1)
5. As part of the chemical restraint form, information should be included indicating if or how the maintenance medication was being changed in order to reduce the use of chemical restraints. (Section N.3)
6. The Psychiatry Department should monitor the completion of the psychiatry section of the chemical restraint forms for completion of the section and quality of the information provided. (Section N.3)
7. The Psychology and Pharmacy Departments should monitor the chemical restraint databases to identify any discrepancies, and develop a database management system that has identical and complete information across the databases. (Section N.3)
8. Clinical justification of polypharmacy should be more than the diagnostic justification for each medication. The justification requires the Pharmacy Department to obtain evidence from the record for the continuing need for polypharmacy. (Section N.3)
9. When submitting a risk rating for polypharmacy for PST discussion and review, it is recommended that the pharmacy clearly state the level of risk being recommended. (Section N.3)
10. Clinical justification of anticholinergics should include a review of side effects being experienced and whether it justifies reduction of the anticholinergic load, and when possible, noting the location in record where justification is recorded. (Section N.3)
11. Developing criteria to determine when the side effects reach an unacceptable level (and the medications are no longer clinically justifiable) might require collaboration with the PCP, and guidance from the psychiatrist and Medical Director. (Section N.3)
12. Given the variability across SSLCs for QDRR documentation, the State Office should provide guidance in the form of a policy/procedure. For Section N.2, it would be beneficial to provide guidance and standardize the labs that should be included, and the expectations of when the lab data should be followed by comments, as well as set forth the expectations of when lab data discussion/comments should result in a pharmacy recommendation. Similarly, with regard to Section N.3, defining the criteria used to justify polypharmacy and anticholinergic medication use would assist Pharmacy Departments in fulfilling the requirements of the Settlement Agreement. In addition, it would be helpful to standardize the labs and frequency of monitoring for the metabolic and endocrine side effects of the newer generation antipsychotics. (Section N.3)
13. The system for identification of ADRs should be reviewed, because ADRs might be identified after completion of an order, and might not create a need to change an order or write a new order. Similarly, ADRs in the hospital setting would not result in a PPC at AUSSLC writing a change in order. (Section N.6)
14. The Pharmacy Department should finalize development of the Facility ADR policy and procedure, implement the policy, and begin the extensive training process needed for success of the policy. (Section N.6)
15. The Pharmacy Department should review a sample of the medication error reports to determine if there is agreement between the most recent definitions with the nursing categorization of errors. (Section N.8)
16. Medication rooms should be user-friendly, with adequate lighting, adequate space for storage, and meticulous attention to cleanliness. (Section N.8)
17. Given the communication gap between the Nursing and Pharmacy Departments, monthly meetings should be held to address findings and action steps necessary to resolve issues. This would provide an additional forum for resolving medication variances. (Section N.8)
18. An accurate investigation should occur immediately after identification of the medication error to determine the reason for the medication error, and corrective action steps should be defined and implemented. (Section N.8)
19. Follow-up corrective action steps should be entered into an information management system for nursing and pharmacy review, including the steps taken, as well as tracking for recurrence of similar medication errors. If the same type of medication error occurs, then the action steps should be revised until there is improvement in the outcome. (Section N.8)
20. The Pharmacy and Nursing Departments should collaborate to develop a medication administration observation system that would be more apt to reflect the causes leading to medication variances. (Section N.8)
21. As the Facility's self-assessment processes evolve, data should be available and utilized to assist the Facility in identifying areas of strength as well as weakness. As issues are identified, corrective action plans should be developed and implemented to improve outcomes. (Facility Self-Assessment)

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 for Section O; o The following documents: Occupational Therapy/Physical Therapy/Speech Language Pathology and Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition assessment, OT/PT/SLP consultations for the last year, Personal Support Plan (PSP) and PSP Addendums (PSPA) for the last year, including PSPAs for Integrated Risk Rating Form and risk action plan, Physical and Nutritional Management Plan (PNMP) with pictures, Integrated Risk Rating Form, risk action plan, individual-specific monitoring for past three months, competency-based training for staff, supporting documentation for implementation of IDT risk assessment and action plan, Health Management Plan, Aspiration Trigger sheets for past six months, and Daily Schedule for 13 individuals (Sample O.1), including: Individual #178, Individual #117, Individual #100, Individual #452, Individual #6, Individual #359, Individual #358, Individual #174, Individual #121, Individual #68, Individual #166, Individual #223, and Individual #403; o The following documents: APEN Assessment, Head of Bed Elevation (HOBE) assessment, Physical and Nutritional Management Team (PNMT) assessment and action plan, PSP and PSPAs for past year, IDT action plan, PNMP and supporting written and pictorial instructions, Integrated Risk Rating Form, competency-based staff training related to PNMT action plan, individual-specific monitoring for PNMT action plan for the past six months, supporting documentation for implementation of PNMT assessment and action pan, Health Management Plans, PNMT Discharge Plan/Summary for 16 individuals (Sample O.2), including: Individual #72, Individual #426, Individual #199, Individual #402, Individual #182, Individual #65, Individual #81, Individual #3, Individual #90, Individual #194, Individual #357, Individual #286, Individual #1, Individual #416, Individual #435, and Individual #86; o The following documents: OT/PT/SLP assessments, nutrition assessment, APEN assessment, HOBE assessment, PSP and PSPAs for past year, PNMP with pictures, pleasure/therapeutic feeding program/plan, therapy (OT and/or SLP) progress notes for pleasure/therapeutic feeding program, individual-specific monitoring for past three months, staff competency-based training, and OT/SLP/Registered Dietician (RD) Consultations for the past year, for 10 individuals (Sample O.3), including: Individual #235, Individual #422, Individual #398, Individual #200, Individual #189, Individual #321, Individual #351, Individual #196, Individual #31, and Individual #310; o The following documents: PNMPs, dining plans and Medication Administration Records (MARs) for 27 individuals (Sample O.4), including: Individual #416, Individual #100, Individual #375, Individual #358, Individual #16, Individual #56, Individual #334,

	Individual #215, Individual #356, Individual #64, Individual #213, Individual #239, Individual #78, Individual #408, Individual #115, Individual #306, Individual #453, Individual #297, Individual #84, Individual #241, Individual #412, Individual #52, Individual #148, Individual #278, Individual #15, Individual #312, and Individual #193; o List of PNMT members and corresponding Curricula Vitae (CVs) along with Compliance Reports, various dates; o List of multiple individuals seen by the PNMT, various dates; o List of PNMT members participating in tooth brushing guidelines meeting, dated 8/16/11; o List of Physical and Nutritional Management (PNM) training sessions for clinical instruction and corresponding certificate of completion, from 6/11 through 10/11; o PNMT meetings for multiple individuals and corresponding minutes along with attendance documentation, from 10/10 through 9/11; o PNMT evaluation form (template), undated; o Completed PNMT evaluations on multiple individuals, from 7/11 through 9/11; o List of multiple individuals with PNM needs, undated; o List of multiple individuals without PNM needs, undated; o Completed PNMPs for all individuals with identified needs, from 10/10 through 11/11; o PNMT Monitoring forms (templates), revised 9/30/11; o Completed PNM Monitoring forms for multiple individuals, from 7/11 through 10/11; o PNM Quality Assurance/Enhancement Reports for multiple individuals, from 6/11 through 10/11; o List of individuals on modified diets/thickened liquids, dated 10/20/11; o List of individuals who require mealtime assistance, dated 10/12/11; o List of individuals who require enteral feeding, undated; o List of individuals whose diets have been downgraded or changed to modified texture, 9/10 through 9/11; o List of individuals with Body Mass Index (BMI) greater than or equal to 30, from 12/10 through 10/11; o List of individuals with BMI less than or equal to 20, from 3/11 through 10/11; o List of individuals who have had unplanned weight loss greater than or equal to 10%, from 5/11 through 10/11; o List of individuals who have had a choking incident, from 2/11 through 8/11; o List of individuals who have had an aspiration and/or a pneumonia incident, from 11/10 through 8/11; o List of individuals who have had a fall during past 12 months, undated; o List of individuals who have had a decubitus/pressure ulcer, from 11/10 through 6/11; o List of individuals who have experienced a fracture, from 12/10 through 10/11; o List of individuals who are non-ambulatory or require assisted ambulation, undated; o List of individuals with poor oral hygiene, from 4/11 through 10/11; o List of individuals who have received a video fluoroscopy, modified barium study, or other diagnostic evaluation during past 12 months, dated 10/12/11; o Reports for choking incidents, dated 8/2/11;

	○ Schedule of meals – by home, revised 10/1/11; ○ Schedule of PNM-related meetings during week of onsite review, undated; ○ Current and new PNM curricula used to train new staff, dated 9/11 and 10/11; ○ Agenda and curriculum for competency-based in-services related to PNM, from 4/11 through 10/11; ○ Tools and checklists used to provide competency-based training related to PNMPs and Dining Plans (templates), undated; and ○ PNMP (template) and HOBE PNMT Evaluation (template), undated. ▪ **Interviews with**: ○ Kim Ingram, MEd, CCC/SLP, Habilitation Therapies (HT) Director; ○ Karen Hardwick, State Coordinator for Specialized Services; ○ Shelley Conroy, MS, CCC/SLP, PNMT Lead; ○ Chris Strickling, Ph.D., OTR, PNMT member; ○ Susan Chmiel, PT, PNMT member; ○ Vira Benson, Director; and ○ Jennifer Russell, Assistant Director of Programs (ADOP). ▪ **Observations of**: ○ Infirmary, and Residences 501, 732, 772, 792, 793, 796 and 797, including dining rooms.
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section O of the Settlement Agreement, the Facility found it was in compliance with Sections O.1 and O.2, and remained out of compliance with the subsections O.3 through O.8. The POI for Section O.1 and Section O.2 did not provide data and/or adequate documentation to substantiate the Facility's finding of compliance. The POI comments/status columns provided numerous updates, but no self-assessment results were presented and/or discussed to justify compliance. As is discussed in greater detail below, the Monitoring Team did not find the Facility in compliance with Section O.1 or Section O.2. The Monitoring Team concurs with the Facility's finding of noncompliance with Sections O.3 through O.8. The POI did not document self-assessment monitoring results, and/or inter-rater reliability for monitoring activities. Focus should be placed on defining the sample(s) for Section O, reviewing and improving instructions for the audit tools, and developing and implementing standardized procedures to achieve inter-rater agreement. The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater agreement between therapists and the Program Compliance Monitor (PCM) will result in audit findings that the Monitoring Team would not consider reliable and/or valid. In the POI, the Facility had developed action plans for all subsections with the exception of subsection O.2. The status of action step completion for all action plans were "in progress," or "not started." Action plans addressed future responsibilities of the PNMT nurse, revision of PNMPs to provide information for medication administration and oral care, expansion of suction tooth brushing, auditing PNMPs; implementation of mealtime supervision, completion of competency-based training for all staff; and development of protocol for monitors.

	These multiple action plans were all necessary components of achieving compliance with the Settlement Agreement. However, they did not prioritize completion of initiatives to address the needs of individuals with high and medium PNM risk factors. In addition, the Action Plan for Section O.6 should be expanded to include the development of policies/procedures for monitoring, including a formal schedule for individuals at high and medium risk for PNM concerns; development of a feedback system with administration to resolve staff noncompliance and systemic issues; and integration of monitoring results into the QA/QI system.
	Summary of Monitor's Assessment: The AUSSLC PNMT continued to make progress in implementing the PNMT process. However, it was significantly impacted by the Facility not embracing the mission of the PNMT. This was evidenced by staff's noncompliance with PNMT action plans and PNMPs, as well as the PNMT and IDT members not working collaboratively together. To achieve compliance with Section O, the Facility should create a culture in which the implementation of PNMPs and dining plans are non-negotiable, and an environment where all team members work collaboratively to achieve success in implementing outcomes for individuals at highest risk. To do its part, the PNMT should improve its collaboration with all team members supporting individuals on its caseload. This should involve increasing all team members' input in developing plans, improving team members' understanding of the importance of implementing the plans, and increasing capacity related to PNM supports. Positive developments for the PNMT included the development of transition plans for individuals returning from the hospital, PNMT members visiting individuals on their caseload in the hospital, completion of a retroactive record review to look at events prior to an individual's hospitalization, the tracking of monitoring results and graphing intervention results to determine the efficacy of their interventions, as well as the initial development of integrated care plans for two individuals. The Facility should critically review the PNMT's Levels of Involvement, including the definitions for Level I and II. These levels might be appropriate in the future. However, AUSSLC IDTs did not currently have the skills to complete comprehensive assessments and develop effective action plans for individuals at highest risk. State and Facility policy had been revised to require additional components in PNMPs. The Facility should prioritize individuals at highest risk to incorporate these revisions into their PNMPs as soon as possible. PNMPs for individuals at high risk should be audited to ensure that they include adequate staff strategies for wheelchair and alternate positioning throughout the 24-hour day, mealtimes, oral care, medication administration, bathing, personal care, and transfers. The Facility had implemented a pilot program for mealtime management, which was a positive initiative. The plan was to expand this initiative to all residential units by the end of the year. A draft protocol had been developed that identified mealtime management participants, training requirements, and responsibilities.

	The HT Director was in the process of altering the current PNMP monitoring process, which should result in improvements. Habilitation Therapies had revised and piloted a universal tool that would monitor all PNMP activities. The new tool will allow for tracking and trending of monitoring results to assist in resolving staff non-compliance and systemic issues. The Facility did not have a system that provided data to track and trend the progress of individuals with PNM concerns. IDTs that support individuals with high-risk physical and nutritional management difficulties should track and analyze the efficacy of their interventions to minimize and/or reduce identified risk indicators, and make changes when appropriate. Individuals who received enteral nutrition were to receive an APEN evaluation. The purpose 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. APEN evaluations were not consistently adequate to address the Settlement Agreement requirements.

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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, 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 evaluations and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement. The Monitoring Team's record sample for Section O is as follows: ▪ Sample O.1 – Six of 13 individuals (46%) identified at high risk of aspiration on the AUSSLC list of risk ratings (i.e., Individual #117, Individual #100, Individual #452, Individual #6, Individual #359, and Individual #358), and an additional seven individuals who had experienced a change in status, including: Individual #178 (diagnosed with aspiration pneumonia), Individual #174 (high risk for respiratory compromise), Individual #121, Individual #68, Individual #166 (hospitalized with discharge diagnosis of aspiration pneumonia), and Individual #223 and Individual #403 (tube placement). ▪ Sample O.2 – Five of the nine individuals designated as Level I (55%) formally followed by the PNMT, including: Individual #3, Individual #65, Individual #81, Individual #107, and Individual #72; one of one individual (100%) designated as Level 2: Individual #90; three of the 10 discharged individuals (30%) designated	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.	as Level 3, including: Individual #416, Individual #435, and Individual #86; and four of seven individuals designated as Level 4 (57%), including: Individual #194, Individual #357, Individual #286, and Individual #1. ▪ Sample 0.3 – 10 of the 48 individuals (21%) who received nutrition through non-oral methods, including: Individual #235, Individual #422, Individual #398, Individual #200, Individual #189, Individual #321, Individual #351, Individual #196, Individual #31, and Individual #310. ▪ Sample 0.4 – Observations of staff compliance with PNMPs and dining plans in residences and the Infirmary for 25 individuals, including: Individual #416, Individual #100, Individual #375, Individual #358, Individual #16, Individual #56, Individual #334, Individual #215, Individual #356, Individual #64, Individual #193, Individual #213, Individual #239, Individual #78, Individual #408, Individual #115, Individual #306, Individual #453, Individual #297, Individual #84, Individual #241, Individual #412, Individual #52, Individual #148, and Individual #278. <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> The PNMT core members were an OT, PT, RD, SLP, Nurse, and Qualified Developmental Disabilities Professional (QDDP). These positions were dedicated to the PNMT and did not carry caseloads beyond the PNMT, with the exception of the RD position that was part-time. However, at the time of the review, the PNMT was not fully staffed. The PNMT Nurse and RD positions were vacant. The HT Director was in the process of recruiting for these vacant positions. In addition, the previous PNMT QDDP had resigned and a newly hired QDDP was expected to fill the position on 11/16/11. PNMT core members attended multiple state-sponsored webinars that included Assessment of Technologies, Dietician's Role in the PNMT, Gastrointestinal/Dysphagia Issues in Individuals with Developmental Disabilities, Introduction to PNMT, Issues in Evaluation and Treatment of Individuals with Developmental Disabilities, PNMT Meeting for all SSLCs, and PNMT Roles and Procedures. Additional continuing education courses related to PNM issues were completed. Attendance rosters, course certificates of completion, and agendas were submitted. The State-sponsored webinars and continuing education courses attended provided relevant and appropriate clinical instruction for PNMT members. <u>PNMT meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> The Facility PNMT Process, revised 11/7/11, stated that the "PNMT will meet at least weekly to review active cases to insure continued stability and avoid adverse outcomes."	

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		PNMT minutes and signature sheets were reviewed. The PNMT conducted administrative meetings on a weekly basis. In addition, the PNMT was meeting weekly, and in some cases several time a week to discuss the current status of individuals on their caseload, document updates to action plans and review monitoring results. In addition, the PNMT minutes documented meetings with PSTs to discuss the progress of individuals on their caseloads. AUSSLC was not yet in compliance with this provision of the Settlement Agreement. As is illustrated in the sections that follow, the Facility remained out of compliance with other provisions of Section O, which also were encompassed in Section O.1.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>A process is in place that identifies individuals with PNM concerns.</u> The Facility PNMT Process had been revised since the previous visit. The major change in the PNMT process was the identification of the PNMT Levels of Involvement: ▪ Level I included individuals at high risk who had been referred to the PNMT, who were formally served/followed by the PNMT, and who required extensive assistance from the PNMT. Services might include assessment, treatment, development of an action plan, follow-up, staff training, IDT integration, and other activities as indicated. ▪ Level II included individuals at medium or high risk who had a change in status or aspiration pneumonia that were determined to require oversight/ consultation by the PNMT. ▪ Level III included individuals who had been formally served/followed by the PNMT and whose cases had been returned to the PNMT for management/oversight, but who were now stable with supports in place. ▪ For individuals designated as Level IV, the PNMT conducted review/oversight of individuals or trends identified through daily medical rounds, concerns that the PCP or Medical Director noted, hospitalization census, Infirmary census, incident management reports, changes/potential changes in status, action plan review, and/or other concerns. The Facility should critically review the PNMT Levels of Involvement, including the definitions for Level I and II, and further define the criteria for the assignment of an individual to Level II. The Monitoring Team's review of the one individual who was designated at the second level of involvement (i.e., Individual #90), which was defined as receiving oversight/consultation by the PNMT, showed that this level of involvement was not appropriate. This individual's acute clinical status required extensive support from the PNMT. These levels might be appropriate in the future, but AUSSLC IDTs currently did not have the skills to complete comprehensive assessments and develop effective action plans for individuals at highest risk.	Noncompliance

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		Individuals in Sample O.1 were rated at high risk for aspiration pneumonia or respiratory compromise, or had been hospitalized for aspiration pneumonia/pneumonia or tube placements. These were significant PNM concerns, but their IDTs had not developed plans and/or the plans were inadequate to address their health risk ratings. Based on a review of individuals in Sample O.1 as well as other documentation the Facility provided, issues were noted with regard to the adequate and appropriate identification of individuals at risk related to PNM issues, and referral to the PNMT. Concerns included: ▪ AUSSLC's list identifying risk levels, undated, was not congruent with individual Integrated Risk Rating Forms. For example, individuals were rated at high risk for aspiration on AUSSLC's risk level list, but their Integrated Risk Rating Form indicated that they were at medium risk for aspiration pneumonia (e.g., Individual #178, Individual #100, and Individual #452). ▪ AUSSLC hospitalization list did not document any hospitalization for the month of May. However, PSPAs of some of the individuals in the sample documented hospitalizations that the hospitalization list did not include. ▪ IDTs referred none of the individuals (0%) in Sample O.1 to the PNMT, even though they were rated at high risk for aspiration pneumonia or respiratory compromise, or had experienced a health status change (i.e., hospitalized for aspiration pneumonia/pneumonia and/or had a tube placed). ▪ Seven of the 13 individuals (50%) did not have risk action plans (Individual #6, Individual #358, Individual #174, Individual #68, Individual #166, Individual #31, and Individual #403). The remaining seven individuals had risk action plans, but these plans were inadequate to address their risk levels. <u>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment and strategies that focus 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> Positive developments for the PNMT included the following: ▪ The PNMT developed transition plans for individuals returning from the hospital to the Infirmary that included steps to be taken during hospitalization, day of return, and subsequent days. ▪ The PNMT worked with IDTs to reassess individuals' Integrated Risk Rating Form and action plan for individuals formally followed by the PNMT who were returning from a hospitalization. ▪ PNMT members were visiting individuals in the hospital, and communicating with the hospital liaison nurse and registered nurse case manager. ▪ PNMT members were completing a retroactive record review back to 24 hours before admission to the emergency room and/or hospital. The PNMT should	

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		consider expanding the timeframe of a retroactive record review to support a more comprehensive review. IDT members should participate in this record review. ▪ The PNMT was tracking monitoring results and graphing intervention results to determine the efficacy of their interventions. The PNMT should work with Facility Administration to determine how this information can be integrated into QA/QI and Risk Management. ▪ PSP Addendum Report for Individual #81, dated 11/9/11, documented that the PNMT, therapists, nursing staff, respiratory therapy, and residential services provided input into the development of an integrated care plan. A review of the care plan for Individual #81 showed that the PNMT and team members were developing comprehensive action steps to address high and medium risk factors. During the onsite review, the PNMT, IDT members, and State consultants developed an integrated care plan for Individual #72, but the PNMT and team members did not have time to address all risk factors. The Monitoring Team supports the continued expansion of this approach for individuals with an overall high risk rating and/or supported by the PNMT. The PNMT's caseload, including individuals' Level of Involvement was: ▪ Level I – nine individuals: Individual #72, Individual #426, Individual #199, Individual #402, Individual #182, Individual #65, Individual #81, Individual #107, and Individual #3; ▪ Level II – one individual: Individual #90; ▪ Level III – 10 individuals, but three of them had died: Individual #54 (deceased), Individual #396 (deceased), Individual 121 (deceased), Individual #398, Individual #103, Individual #338, Individuals #14, Individual #86, Individual #435, and Individuals #416; ▪ Level IV – seven individuals: Individual #186, Individual #423, Individual #194, Individual #357, Individual #286, Individual #16, and Individual #1. Based on interview, the PNMT did not have a waiting list. The Monitoring Team reviewed Integrated Risk Rating Forms, PNMT Assessments, and action plans for individuals in Sample O.2 designated as being at Level I who were formally followed by the PNMT. The following observations were noted: ▪ In five of the five records reviewed (100%), there was documentation of the PNMT reviewing the individuals' risk levels during the comprehensive assessment process, and updating them, as appropriate. ▪ In five of five records (100%), there was documentation of a PNMT assessment. ▪ In none of the five records reviewed (0%) did the PNMT assessment reflect a comprehensive review/assessment of identified high and medium risk levels. ▪ In none of the five records (0%) did the PNMT assessment include an analysis to	

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		consistently provide a rationale for the development of recommendations and measurable, functional outcomes for high and medium risk factors for individuals at highest risk to minimize and/or reduce the identified health risk(s). ▪ In none of the five records reviewed (0%), a PNMT action plan was found that addressed all high and medium risk factors identified on the Integrated Risk Action Form. ▪ For five of the five individuals (100%) was a PNMT/PSPA meeting conducted within established timeframes to discuss the Integrated Risk Rating Form, PNMT Assessment, and action plan. The AUSSLC PNMT continued to make progress, but was significantly impacted by the Facility not embracing the mission of the PNMT. This was evidenced by staff's non-compliance with PNMT action plans and PNMPs as well as, the PNMT and IDT members not working collaboratively together. Staff non-compliance with the implementation of plans, and the lack of IDT integration resulted in individuals not receiving the supports they required. To achieve compliance with Section O, the Facility should create a culture in which the implementation of PNMPs and dining plans are non-negotiable, and an environment where all team members work collaboratively to achieve success in implementing outcomes for individuals at highest risk. To do its part, the PNMT should improve its collaboration with all team members supporting individuals on its caseload. This should involve increasing all team members' input in developing plans, improving team members' understanding of the importance of implementing the plans, and increasing capacity related to PNM supports. On a positive note, the content of PNMT assessments for individuals' high risk factors met expectations, but the assessment did not address medium risk factors. Likewise, PNMT action plan steps adequately addressed high risk factors, but did not consistently address medium risk factors. Review of individuals designated as being at Level I in Sample O.2 revealed the following concerns: **Referral to the PNMT** ▪ Individuals had multiple hospitalizations and experienced a change in status, but their IDTs did not refer an individual to the PNMT. In most cases, the PNMT became involved in response to a hospitalization. At the time of the review, the IDTs generally did not have the clinical skills to provide comprehensive assessments and develop action plans for those individuals at highest risk. IDTs should not have the option, at this time, to reject assistance from the PNMT. The	

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		Facility should provide training to the IDTs on the Facility PNMT process. ▪ Five individuals had feeding tubes placed since the last review: Individual #402, Individual #452, Individual #186, Individual #381, and Individual #403. None of these individuals had been referred to the PNMT, nor had the PNMT assessed these individuals pre- and/or post-placement of the feeding tube. **PNMT Comprehensive Assessment** ▪ The PNMT General Caseload Tracker documented a referral date. However, multiple PNMT assessments did not document the reason for referral and the date. The PNMT assessment should document the date that the IDT, PCP, or PNMT made the referral, and the reason for the referral. ▪ PNMT assessments evaluated high-risk factors, but did not assess medium risk factors. **PNMT Action Plan** ▪ Multiple action plans assigned responsibilities to the PNMT that were not appropriate. IDT members should understand the importance of their responsibility in the implementation of action plans. The Monitoring Team reviewed Individual #90 from Sample O.2, who was identified as Level II. The following concerns were noted: ▪ The PNMT Minutes, dated 9/9/11, stated: "Individual #90 is currently in the hospital for hypothermia and hyponatremia. The PNMT would talk with the [IDT] and participate in the transition plan meeting to determine if further PNMT involvement is necessary." The IDT had not made a referral to the PNMT, even though Individual #90 had been hospitalized five times over the past year with discharge diagnoses of pneumonia, urinary tract infection, hypothermia, dehydration, and emesis. He had been admitted to the Infirmary five times with reasons for admission that included pneumonia, hypernatremia, hypothermia, emesis, anorexia, and dehydration. The Facility IDT should have made a referral to the PNMT as a result of his recurrent hospitalizations/Infirmary admissions and his unstable health status. ▪ Interim Staffing, dated 9/22/11, indicated that the team met to discuss preventative/safety measures that needed to be in place prior to Individual #90's discharge from the Infirmary. The Monitoring Team could not determine if these recommendations had been implemented, because no Risk Action Plan was submitted and/or additional IDT documentation. ▪ PNMT minutes acknowledged that the PNMT met with the IDT on 9/22/11 to review the risk ratings for Individual #90, and on 9/23/11, to develop an action plan. The IDT did not complete a PSPA to document the revised Integrated Risk Rating Form and Risk Action Plan. The PNMT made multiple attempts to secure this documentation. No final Integrated Risk Rating Form or Risk Action Plan was submitted. Multiple recommendations were documented in the PNMT	

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		minutes, but the Monitoring Team could not determine if these recommendations had been integrated into the Risk Action Plan. ▪ It was unclear to the Monitoring Team why this individual was not formally served by the PNMT, because the IDT had not resolved his significant health concerns. The PNMT should have formally followed him, and provided him a PNMT comprehensive assessment and action plan. As part of Sample O.2, the Monitoring Team reviewed three individuals identified as meeting the criteria for Level III. The following concerns were noted: ▪ IDTs providing support to individuals with recurrent hospitalizations and compromised clinical status did not refer individuals to the PNMT and/or refused assistance from the PNMT (e.g., Individual #416, and Individual #86). ▪ Facility staff were not consistently following the established Risk Guidelines (e.g., for Individual #86 regarding aspiration pneumonia). ▪ IDTs had not developed adequate action plans for these individuals. As part of Sample O.2, the Monitoring Team reviewed four individuals identified as Level IV. The following concerns were noted: ▪ IDTs were not effective in stabilizing individuals at high risk, and did not request assistance from the PNMT. ▪ PST members were not implementing PNMT recommendations. AUSSLC was not yet in compliance with this provision of the Settlement Agreement. Individuals with significant physical and nutritional needs were not being provided with adequate and effective interventions and supports sufficient to meet their needs.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing	Positive developments with regard to the Facility's progress towards compliance with Section O.3 included the following: ▪ Habilitation therapists had developed written and pictorial instructions for some individuals to support the implementation of PNMPs for wheelchair and alternate positioning, day habilitation chairs (used in the workshop or activity center), walkers, transfers, walking with gait belt, assistive equipment, positioning for meals, position of chain for bed elevation, and lemon ice for mealtimes. ▪ Initial interdisciplinary collaboration had begun with the Medical Director, Dental Director, Chief Nurse Executive, Infection Control Nurse, PNMT SLP, Lead OT, and HT Director to discuss the implementation of suction tooth brushing programs. The Presentation Book for Section O included four drafts of oral care plans that had been developed based on oral hygiene classification, risk for aspiration, and level of independence for tooth brushing. These programs were to be incorporated into individuals' PNMPs. The protocol for implementation	Noncompliance

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	difficulties.	remained under development. Implementation was expected to begin 1/1/12. <u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> The Monitoring Team was provided a draft revision of the State policy for Physical Nutritional Management (Policy #012.2). Additional components had been added to the PNMP, including risk areas, projected outcomes, and triggers for risk areas; positioning for oral eating; instructions for medication administration, mealtime practices, and oral care; and communication strategies. These PNMP additions were constructive. On 10/17/11, the Facility revised the PNMP templates. Based on interview, the majority of current PNMPs were not in the revised format. PNMPs were to be updated as annual PSPs occurred. The new format included outcomes to decrease high-risk indicators, identification of high risk factors, and individual triggers related to high risk. Sample PNMPs included the following categories: medication administration, oral care/dental, dining plan, transfers, mobility, bathing, assistive equipment, communication, positioning, mobility, and movement instructions. Review of PNMPs showed additional individualized categories would be added (e.g. Individual #3's plan had hearing aid, toileting, skin program, and urinary tract precautions). The Facility should prioritize individuals at high and medium risk related to PNM concerns, and incorporate proposed PNMP revisions as soon as possible. PNMP revisions for individuals at highest risk should not wait for their annual PSP meeting. The AUSSLC Inclusion of the Physical Nutritional Management Plan within the Medication Administration Record, dated 11/11, procedures indicated that HT would provide the current and/or revised PNMP to each Unit Nurse Manager or designee. The Unit Nurse Manager or designee was responsible for inserting the current and/or revised PNMP in the appropriate MAR. PNMPs were to be inserted into the MAR on the same day of delivery. The procedure did not address generic and/or individual-specific PNMP competency-based training for nurses. The PNMPs in Sample O.2 for individuals designated to be at PNMT Level 1 included constructive additions. For example, they provided: ▪ Identification of individual-specific risks with outcomes and triggers; ▪ HOBE assessment results, which identified safe elevation ranges for wheelchair and alternate positioning; ▪ Instructions for personal care; ▪ Medication administration instructions discussed positioning, as well as food/fluid consistency, and mealtime adaptive equipment for individuals who ate orally; ▪ The section on individual assistive equipment identified the reason for the equipment; and	

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		▪ Pictorial and written instructions for wheelchair and alternate positioning, including elevation range. The PNMPs for individuals in Sample O.1 were reviewed. Although a lot of important information was included, some essential components were missing. More specifically: ▪ In two of 13 records (15%), positioning instructions were included for wheelchair and alternate positioning, including strategies for safe elevation ranges (i.e., Individual #178 and Individual #6). ▪ In 13 of 13 records (100%), transfer instructions were included. ▪ In 13 of 13 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 13 records (85%), the mealtime/dining plan included food/fluid textures, and/or addressed receiving nutrition through a feeding tube. Individual #174 and Individual #166's PNMPs did not address food textures. ▪ In 11 of 13 records (85%) the time an individual needed to remain upright after eating and/or receiving enteral nutrition was identified. Individual #6 and Individual #166's PNMPs did not address time to remain upright following a meal. ▪ In 13 of 13 records (100%), the mealtime/dining plan included behavioral concerns related to intake, and/or addressed receiving nutrition through a feeding tube. ▪ In one of 13 records (8%), strategies for medication administration were included (i.e., Individual #6). ▪ In eight of 13 records (62%), strategies for oral hygiene were included (i.e., Individual #178, Individual #100, Individual #452, Individual #6, Individual #359, Individual #358, Individual #174, and Individual #121). ▪ In 13 of 13 records (100%), individual adaptive equipment was included. ▪ In six of 13 records (46%), bathing/showering positioning and related instructions were included (i.e., Individual #117, Individual #452, Individual #6, Individual #359, Individual #358, and Individual #403). ▪ In two of 13 records (15%), personal care instructions with elevation strategies during checking and changing were included (i.e., Individual #121 and Individual #403). ▪ In 13 of 13 records (100%) communication strategies were included. The following describes in greater detail concerns with PNMPs: ▪ PNMPs did not consistently direct staff to written and pictorial instructions for wheelchair positioning, alternative positioning, head of bed elevation, assistive equipment, etc. ▪ Individual photographs did not consistently support optimal alignment and	

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		support in seating systems and/or alternate positions. Staff using these photographs would position individuals inappropriately. Therapists should review photographs to ensure optimal alignment and support for individuals in wheelchairs and alternate positioning (e.g., bed, recliner, right and left sidelying). ▪ PNMPs for the individuals identified at high risk for aspiration and/or those who received enteral nutrition within this sample did not include adequate staff strategies to support safety in daily activities. Current strategies in PNMPs should be reevaluated using HOBE assessment results to identify safe elevation ranges. PNMPs should present safe elevation ranges for when individuals are in or engaged in wheelchairs, alternate and nighttime positioning, bathing/showering, mealtime, medication administration, personal care, and oral hygiene. Staff strategies to achieve a safe degree of elevation should be clearly defined through photographic and written instructions. ▪ PNMPs for individuals identified at high risk for aspiration did not consistently identify a recommended time to remain upright after a meal. For those who eat orally and/or are enterally nourished, this should be an essential PNMP staff instruction. ▪ PNMPs did not present adequate instructions for nursing staff for medication administration and oral care. Medication administration instructions should include the position of the nurse (e.g., eye level with individual); individual-specific positioning instructions, including elevation range in wheelchair and/or alternate position; use of adaptive equipment; presentation techniques; and medication presentation that is consistent with the prescribed diet texture (e.g., crushed pills for a pureed diet) and fluid consistency (e.g., nectar-thick fluids). ▪ PNMPs did not consistently identify the position of staff and an individual during tooth brushing. Positioning for the individual and staff during oral care should be clearly defined by photographic and written instructions for individuals at high risk for aspiration and respiratory compromise. PNMPs for individuals at high risk should be audited to ensure adequate staff strategies are included for wheelchair and alternate positioning throughout the 24-hour day, mealtimes, oral care, medication administration, bathing, personal care, and transfers. <u>PNM plans were incorporated into individuals' ISPs.</u> None of the 13 individuals' PNMPs in Sample O.1 were incorporated and/or integrated into individuals' ISPs. Information from the PNMP should be integrated within the ISP and other supporting documents (e.g., health management plans, Positive Behavior Support Plans, skill acquisition programs, etc.), not simply referenced and/or listed. The PNMT had not formally discharged any individuals whom they formally followed.	

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		When the PNMT does discharge an individual, a PSPA meeting should be held to collaborate on the PNMT discharge plan and discuss strategies for ongoing implementation. <u>PNMPs are developed with input from the IDT, home staff, medical and nursing staff.</u> Review of individuals in Sample O.1 revealed that none of the PNMPs (0%) were developed with input from the IDT, with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Individuals in Sample O.1 were at high risk for aspiration and/or had a diagnosis of pneumonia and/or aspiration pneumonia. The Monitoring Team would expect IDT members (e.g., nursing, therapists, respiratory therapists, direct support professionals, etc.) to analyze the current PNMP strategies for the efficacy of minimizing the individual's risk for aspiration, not simply state the PNMP strategies were appropriate. For example, the team should determine and document whether or not a HOBE assessment had been completed to determine the safe range of elevation in daily activities. In addition, the team should discuss how to integrate PNMP strategies into Health Management Plans. A review of these individuals' ISPs did not show that the IDT members had engaged in these types of discussions. <u>PNMPs are reviewed annually at the ISP meetings, and updated as needed.</u> Review of individuals in Sample O.1 revealed that none of their PNMPs were integrated annually at the ISP meeting, and updated as needed. Evidence was found that that PNMP content was listed, but PNMP strategies were not integrated, as appropriate, into skill acquisition programs, BSPs, nursing/health management care plans, and/or daily schedules. <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 the records for Sample O.1 (0%) were PNMPs reviewed and updated as necessary based on a revised Integrated Risk Rating Form, a change in the individual's status, a transition (change in setting), and/or as dictated by monitoring results. The PNMT Process indicated that the PNMT nurse would "attend daily rounds to keep abreast of changes in status and keep PNMT apprised of any cases of aspiration pneumonia" and "collaborate with the hospital liaison nurse, nurse educator, and infection control nurse to integrate hospital duties, training, and infectious issues with PNMT services." The PNMT SLP Lead was performing this responsibility until the PNMT Nurse position was filled. AUSSLC was not in compliance with this provision of the Settlement Agreement. Individuals with physical and nutritional needs were not being provided with adequate PNMPs, and the PNMPs were not integrated into PSPs, nursing/health care plans, etc.	

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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.	Positive developments with regard to the Facility's progress towards compliance with Section O.4 included the following: ▪ A Mealtime Management Committee had been formed to develop a dining room supervision procedure to ensure safe meal practices and provide oversight of the meal management process. The mealtime management process was being piloted in Castner. ▪ Habilitation Therapies had developed Mealtime Management Guidelines, a Mealtime Management Guidelines form, and instructions to test mealtime manager's competency and initiate inter-rater agreement between mealtime managers and therapists. <u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> The Monitoring Team observed implementation of PNMPs and dining plans in the Infirmary, and Residences 501, 732, 772, 792, 793, 796, and 797. The Monitoring Team observed multiple examples of staff noncompliance with PNMP and/or dining plan strategies. As noted during the exit conference, observations conducted in the Infirmary raised serious concerns for individual's health and safety. A dinner observation revealed staff assisting individuals with no dining plans present or prescribed mealtime adaptive equipment. The Monitoring Team requested that dining plans be made available. Staff were able to locate some dining plans, but for some individuals staff had to return to residences to secure dining plans. The absence of dining plans for individuals in the Infirmary placed individuals at an undue risk of harm. The presence and implementation of PNMPs, dining plans, and assistive equipment for individuals in the Infirmary should be nonnegotiable. The following summarizes the results of observations for individuals in Sample O.4: ▪ In two of 22 observations (9%), staff were following dining plans for positioning, use of adaptive equipment, and/or presentation techniques. ▪ In none of two observations (0%) were staff following wheelchair-positioning instructions. ▪ In none of two observations (0%) were staff following alternate positioning instructions. ▪ In none of one observation (0%) were staff completing a pivot transfer correctly. ▪ In none of one observation (0%) were staff completing a mechanical lift transfer correctly. ▪ In none of two observations for medication administration (0%) were nursing staff following the PNMP instructions for individuals. The purpose of the AUSSLC Meal Management draft protocol, dated 11/4/11, was to	Noncompliance

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		"develop a dining room supervision procedure to ensure safe meal practices and provide oversight of the meal management process." The Mealtime Management Committee (MMC) members were the Facility Director, Assistant Director of Programs, four Unit Directors, Director of Habilitation Therapies, Quality Enhancement Director, QDDP Coordinator, and Director of Active Treatment Services. The protocol identified the following multiple disciplines responsible for the implementation of meal management: Unit Directors (scheduling and implementation), Home Supervisors (primary), QDDPs (secondary), Lead QDDPs, QDDP Educator, Unit Psychologists, Psychology Assistants, Active Treatment Coordinators, and PNMP Coordinators. Habilitation Therapists would be responsible for training, monitoring, and compliance reporting. QA professionals would conduct monitoring and compliance reporting. Habilitation Therapists (OTs and SLPs) conducted a two-hour mealtime training session for mealtime managers. It was unclear if two hours of instruction was sufficient to train meal managers to achieve competency with mealtime foundational skills. Mealtime managers completed a written test that was not sufficient to test their skills and competencies. The protocol stated that onsite meal coaching/mentoring would be conducted until competency was demonstrated. To be effective, mealtime managers should complete foundational mealtime competency check-offs prior to assuming the role of a mealtime manager. Therapists were to work with a meal manager for four different meals. The fifth coaching/mentoring session would require the meal manager to complete the Meal Management Guideline form. A spreadsheet was submitted for coaching sessions with identified staff's name, position, dining room, mealtime, completion date, trainer, and trainer position. No documentation was submitted to address the content of the coaching/mentoring sessions. AUSSLC Meal Management Guidelines were developed as a reference for meal managers. The guidelines provided a comprehensive list of mealtime manager responsibilities. The AUSSLC Meal Management Guidelines Form was used to test the competency of meal managers. To test competency the meal manager and therapist would observe an assigned meal together. The form would be completed independent of each other. At the conclusion of the meal, the meal manager would provide the completed form to the therapist. The therapist would compare the ratings and score "yes" if two ratings matched for an indicator, and "no" if the two ratings did not match. By adding all the "yes" answers and dividing by the total number of items answered, a reliability score was calculated. There was no established reliability threshold score identified. As stated above, mealtime managers should be provided with foundational PNM training, and complete competency check-offs prior to testing competency with mealtime management guidelines. Based on interview, on 10/17/11, the AUSSLC Mealtime Management Process was implemented on the Castner Unit as a pilot project. The Mealtime Management Protocol	

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		was to be implemented at Wood Hollow, Sunrise, and Timer Creek no later than 12/15/11. A document entitled AUSSLC Morning Meeting Management included a section called Review of Meal Management/Supervision with the following fields: date/time of meal, home visited, issues noted-corrective action taken, follow up/person responsible, and due date. A review of mealtime issues noted with dates ranging from 10/19/11 to 11/4/11 showed reoccurring mealtime errors. However, in many cases, there was no discussion of planned corrective action to resolve compliance errors. The follow up/person responsible and due date columns were blank. Discussing mealtime compliance errors during the morning meeting was positive, but, at the time of the review, was not effective in resolving reoccurring mealtime concerns. In summary, AUSSLC was not yet in compliance with this provision of the Settlement Agreement. Staff were not consistently competent and/or compliant with implementing PNMPs and dining plan strategies that were prescribed to support health and safety for individuals with identified health and PNM risk factors.	
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> No Facility policies and/or procedures were submitted related to the provision of competency-based training for foundational physical and nutritional supports, training on individual-specific strategies/programs, and/or performance competency check-offs. The Monitoring Team reviewed the Orientation and Pre-Service schedule, dated 10/2/11. Training for approximately 22 instructional hours included: ▪ Dietician/Food Texture – duration of two hours; ▪ Orientation and Mobility – duration of two hours; ▪ Therapeutic Handling and Positioning – duration of four hours; ▪ PNMP Practicum/Lifting and Transfer – duration of four hours; ▪ Feeding/Mealtime Management – duration of one hour; ▪ PNMP/Assistive Equipment – duration of one hour; ▪ Deaf Awareness – duration of two hours; ▪ Basic Sign Language – duration of four hours; and ▪ "Communicating with People Who Live Here" – duration of two hours. The Presentation Book for Section O stated: "planned implementation of competency-based training during New Employee Orientation." However, no implementation date was provided. HT New Employee Orientation (NEO) Schedule Second Day of Unit Orientation, revised	Noncompliance

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		10/11, included an additional day (eight hours) for training and competency check-offs: ▪ SLPs were allotted two hours, but it had not been determined what would be accomplished during this time block. ▪ PTs had a one-hour block to complete competency check-offs that the HT Department had developed for hosiery, gait belt, and walking. ▪ OTs had a three-hour block to provide instruction for an "aspiration/choking talk" and "equipment introduction/table set up." Competency check-offs were to be completed for dining equipment, lemon ice, Simply Thick, wheelchair positioning, mealtime, transfer, rolling shower chair, and bath transfer bench. Competency check-off forms had been competed for these skills. ▪ Unit therapists were provided a two-hour time slot for "competencies relevant to unit." The Presentation Book for Section O, and HT schedule for the new training day did not indicate when the additional day of training and competency check-offs was initiated. Based on interview, since approximately 10/1/11, OT and PT services had completed 1475 trainings for current staff and new employees. No documentation was submitted to identify the number of new employees who had successfully completed the competency check-offs previously listed. Based on interview, a planned implementation of competency-based training for all existing employees using the NEO curriculum was under development. To support success with the mealtime manager initiative, current employees should receive competency-based training and check-offs for core PNM competencies. The Facility should appoint core leadership staff to participate in a train-the-trainer process to be completed by Facility therapists. The therapists should provide competency-based training and performance check-offs to the core leadership staff. The core leadership staff should be responsible for providing training and check-offs to current AUSSLC staff. This approach would enhance the PNM foundational skill level of core leadership staff. The enhanced PNM content knowledge also should result in additional oversight for staff compliance in implementing prescribed PNMP and dining plan strategies. <u>All foundational trainings are updated annually</u>. The Facility provided annual refresher training only for lifting/transfers. No documentation was submitted to identify the number of employees who completed the annual refresher training for lifting/transfers. <u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u> None of the 13 individuals' staff in Sample O.1 (0%) had received adequate competency-	

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		based training for core PNM competencies and individual-specific PNMP strategies. The following concerns were noted: ▪ Review of staff competency-check offs for the individuals in the sample often documented only one staff member had received a competency check-off. This was not sufficient. ▪ Individual PNMPs provided multiple staff instructions for mobility, transfers, positioning, fall prevention, earplugs, bathing, oral care, etc., but no competency-based check-offs were completed. ▪ No competency check-offs were present for nursing staff. ▪ Staff working with individuals at high risk for aspiration had received limited and/or no competency-based training for PNM core competencies and/or individual-specific PNMP strategies. The Facility should prioritize competency-based training for staff working with individuals identified at highest risk. <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 13 individual-specific staff training records in Sample O.1 (0%), for staff providing assistance to individuals determined to be at high risk for aspiration, had staff successfully completed competency check-offs for PNM core competencies and individual-specific PNMP strategies. For individuals designated as Level I in Sample O.2, staff had documented competency training and checks offs for individual-specific Trigger Data Sheet Competencies. However, for none of the five individuals (0%) was documentation present to show PNM core competency and individual-specific training and check offs testing staff competency with all PNMP strategies. Again, staff working with individuals at highest risk should be prioritized to receive competency check-offs for PNM core competencies and individual-specific PNMP strategies. <u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u> As noted above, for Sample O.1 limited and/or no competency check-offs had been completed. Multiple individuals in Sample O.1 had PNMP revisions, but no competency-based training and/or performance check-offs had been completed. In summary, AUSSLC was not yet in compliance with this provision of the Settlement Agreement. Staff responsible for individuals with physical and nutritional management needs had not successfully completed competency-based training and performance	

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		check-offs to ensure adequate implementation of PNMPs and dining plans.	
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.	Positive developments with regard to the Facility's progress towards compliance with Section O.6 included the following: ▪ The HT Director was in the process of altering the current PNMP monitoring process. HT had revised and piloted a universal tool that would monitor all PNMP activities. <u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> <u>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).</u> The Habilitation Therapy Department continued to have no policies and/or protocols for implementation of the HT PNMP Observation/Training Roster or Mealtime Snack Observation forms. No procedures were in place to formally report and resolve staff non-compliance and/or systemic issues at an administrative level. No formal schedule had been developed to monitor individuals using defined levels of PNM risk. Monitoring results had not been integrated into the Facility's QA/QI system. None of the individuals in Sample O.1 (0%) received regularly scheduled PNMP and/or mealtime monitoring to substantiate staff compliance with their PNMPs and dining plans. The following concerns were noted: ▪ Individuals at high risk for aspiration pneumonia had not been monitored and/or had received sporadic monitoring. ▪ Individuals who recently had received a feeding tube had not been monitored, or had been monitored only one time. ▪ Individuals at high risk for aspiration and recently had died had not received scheduled monitoring. ▪ HT PNMP Observation and Training Roster forms documented ongoing issues with missing assistive equipment without the development of a plan to resolve staff non-compliance. ▪ Mealtime/Snack Observation Forms documented meals were not served on time. The Monitoring Team observed multiple late meals during the on-site review. ▪ Mealtime/Snack Observation Form instructions directed the monitor to provide on the back of the form a brief explanation for all questions answered "no." The Monitoring Team could not determine if these directions had been followed, because the back of the forms had not been copied. On a positive note, the HT Director was in the process of altering the current PNMP monitoring process. HT had revised a universal tool that would monitor all PNMP	Noncompliance

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		activities. The Compliance Monitoring tool monitored eight different programs, including positioning, meals, snacks, medication administration, oral care, bathing, lifting/transfer, and communication. The form had four observation indicators, including PNMP/Dining Plan (DP) was present/easily located; equipment was present, working, and utilized; plan being performed as written/instructed; and staff communicates with individual before and during activities. Six indicators were for staff drills, including explain plan rationale, goal(s), and outcome(s); explain risk associated with not performing program; identify individual triggers; whether or not staff reported being trained on program; and whether or not staff entered data correctly in appropriate location and identified who to contact if there was a problem. The form could be utilized for individual specific monitoring, random competency checks, and corrective action competency re-checks. The compliance threshold was 80% and above. If the compliance score was below 80%, a plan would be initiated which could include notification to a Home Supervisor or Unit Director, follow-up meal observation, staff competency re-drill, and/or other plan to be identified on form. Staff with a second non-compliance score required program implementation monitoring by supervisory staff. The form included a section for reliability checks to be completed by the PNMP Coordinator and therapist. Therapists and PNMP Coordinators were to begin implementation of this tool on 11/9/11 by. No completed Compliance Monitoring forms were submitted for review. Based on the Monitoring Team's review of the Compliance Monitoring form, the instructions for the four observation indicators identified multiple areas that the monitor would be responsible for checking for meals, medication administration, oral care, bathing, lifting/transferring, and communication that were not present on the monitoring form. In the instructions, the staff drill indicators also listed multiple areas to monitor for compliance. A monitor would be challenged to remember multiple compliance indicators for each of the four observation questions. These areas were not present on the form. If an indicator was marked "no," the monitor was to document non-compliance in the form's comment section. The one-page form did not provide sufficient space to address multiple areas of compliance. In addition, the form and instructions addressed the implementation of reliability checks to be conducted by therapists. The therapy content expert(s) will have to be diligent during the reliability checks to determine if the form's indicators require revision, while testing the monitor's competency with areas requiring assessment. <u>All members of the PNM team conduct monitoring.</u> Based on a review of PNMT action plans and supporting documentation for Level I individuals in Sample O.2, five of five records (100%) showed the PNMT conducted individual-specific monitoring for high risk factors to document staff compliance with PNMT action plans. However, the following concerns were noted; ▪ A review of individual-specific PNMT monitoring forms consistently	

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		documented staff noncompliance with PNMPs, individual-specific trigger sheets, and input/output tracking. The PNMT's mission was to develop support strategies to anticipate, minimize, or remediate risk factors for those individuals identified at highest risk. The PNMT had the responsibility to work with the PST members, and if not successful, inform the HT Director that staff non-compliance continued to be an issue identified through the PNMT monitoring. The PNMT and the HT Director should collaborate with QDDPs, Unit Directors, and QA/QI staff to implement strategies that support a culture of staff compliance with PNMPs and individual-specific PNMT strategies. <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> At this time, only the PNMT was analyzing, tracking, and trending individuals on its caseload. The Facility QA/QI system did not have a system to track health risk indicators in a manner that permitted trend analysis, or to assist in determining the interrelationship of these indicators by providing information related to frequency, antecedents, and potential correlations. A PNMT designee should be represented in internal mortality reviews. At a minimum, a PNMT representative should be present for mortality reviews for individuals on their caseload who have died to gain knowledge from the individual's death, including identifying specific barriers or system issues related to significant health risk factors, and/or ways in which supports for individuals could be provided differently. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> Individuals who were identified at high risk for aspiration in Sample O.1 did not have adequate action plans developed, and action plans did not recommend individual-specific monitoring to alert staff to a change in status. In summary, AUSSLC was not yet in compliance with this provision of the Settlement Agreement. Policies and procedures were not in place for monitoring. There was no set schedule for monitoring, and no formal feedback loop to alert Facility Administration of staff noncompliance and systemic concerns.	
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	<u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.</u> For none the 13 individuals in Sample O.1 (0%) did the IDTs include measurable objectives designed to determine the efficacy of action plans. The IDTs did not document progress related to individual strategies on a monthly basis, or determine the efficacy of those strategies in minimizing and/or reducing PNM risk indicators. In none of the 13 records (0%) reviewed was documentation found describing whether or not strategies	Noncompliance

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	difficulties, and revise interventions as appropriate.	were effective. As a result, changes could not be made to potentially ineffective plans. The Facility did not have a system that provided data to track and trend the progress of individuals with PNM concerns. IDTs that support individuals with high-risk physical and nutritional management difficulties should track and analyze outcome measures or other objective data to determine the efficacy of their interventions to minimize and/or reduce identified risk indicators. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> The PNMT was to be commended for the development and implementation of individual-specific monitoring forms to assess staff compliance with PNMT action plans. Unfortunately, as discussed throughout this report, staff were not consistently compliant with PNMPs individual-specific PNMT action steps. AUSSLC was not yet in compliance with this provision of the Settlement Agreement, because the Facility did not have a system to track and trend the progress of individuals with PNM concerns.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to by mouth (PO) status.</u> According to State policy, all individuals who received enteral nutrition would receive an annual APEN assessment with input from the Primary Care Practitioner (PCP), RN, Habilitation Therapists, Dietician, Pharmacist, and other IDT members. The Nurse Case Manager was to compile the APEN assessment. Eight of the 10 individuals (80%) (i.e., Individual #235, Individual #422, Individual #398, Individual #200, Individual #189, Individual #321, Individual #196, and Individual #310) in Sample O.3 had an APEN Assessment. However, numerous concerns were noted, including: ▪ APEN assessments did not identify assessment authors and/or provide signatures. APEN assessments should document who collaborated in the completion of the assessment. ▪ Multiple APEN assessments were incomplete. APEN assessments should be audited to ensure compliance with APEN assessment requirements. ▪ APEN assessments did not assess the possibility of transitioning an individual to a less restrictive approach to receiving enteral nutrition and/or recommend a plan to return the individual to oral eating, if appropriate. There was no assessment to determine if current feeding schedules could be modified leading to a less restrictive feeding schedule, or the potential to return the individual to oral eating (e.g., Individual #200, Individual #189, and Individual #196).	Noncompliance

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		▪ APEN assessments recommended a return to oral eating (i.e., for Individual #422, Individual #398, and Individual #310), which was positive. However, no documentation was submitted to acknowledge that trials for oral feeding had been initiated for Individual #398. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the Settlement Agreement components.</u> Individuals in Sample O.3 were provided with PNMPs, but required components were absent as documented below: ▪ In one of 10 records (10%), positioning instructions were included with identified safe elevation range for wheelchair and alternate positions (i.e., Individual #321). ▪ In 10 of 10 records (100%), transfer instructions were included. ▪ In nine of 10 records (90%), staff instructions were provided to identify the prescribed time an individual was to remain upright after receiving enteral nutrition. Individual #310's PNMP did not provide the time to remain upright after meals. ▪ In one of 10 records (10%), strategies for medication administration were included (i.e., Individual #310). ▪ In 10 of 10 records (100%), strategies for oral hygiene were included. ▪ In 10 of 10 records (100%), individual adaptive equipment was included. ▪ In three of 10 records reviewed (30%), bathing/showering positioning instructions were included (i.e., Individual #189, Individual #321, and Individual #351). ▪ In none of 10 records (0%), personal care instructions for elevation during checking and changing were included. ▪ In 10 of 10 records reviewed (100%), communication strategies were included. The following concerns were noted: ▪ None of the individuals in Sample O.3 had received a HOBE assessment to determine the safe elevation range for an individual in their wheelchair, or during alternate positioning, bathing, tooth brushing, and medication administration. ▪ Staff instructions for head elevation on bathing trolleys were not adequate. No staff instructions were available regarding how to position the bathing trolley to achieve the prescribed elevation and/or identify the type of wedge to be used (e.g., wedge identified by color and/or height). ▪ Staff instructions to achieve accurate head of bed elevation were not consistently present on PNMPs. ▪ Instructions to administer medication in the most upright position did not	

#	Provision	Assessment of Status	Compliance
		provide sufficient instruction for nurses. Additional instructions were needed to identify what positions were appropriate, including elevation range. <u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.</u> Individual #182 was identified at high risk for PNM concerns, and had lost the ability to eat. The PNMT was to be commended for their diligence in returning Individual #182 to oral eating. PNMT minutes and Integrated Progress Notes tracked his progress. <u>The need for continued enteral nutrition is integrated into the PSP.</u> APEN assessments recommended trials for return to oral intake for Individual #422, Individual #398, and Individual #310. Unfortunately, these recommendations had not been integrated into their PSPs. Based on a review of individuals in Sample O.3, 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 Assessments (Nursing, MD, SLP or OT).</u> The component of the DADS At-Risk Individuals policy (Policy #006, dated 11/2/10) 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." However, the Facility had not followed this policy. AUSSLC was not in compliance with this provision of the Settlement Agreement. Individuals had not received an APEN Assessment and/or the APEN Assessment was not adequate to address the Settlement Agreement requirements.	

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

1. The Facility should critically review the PNMT Levels of Involvement, including the definitions for Level I and II, and further define the criteria for the assignment of an individual to Level II. (Section O.2)
2. The Facility should provide IDTs with training on the PNMT process to ensure teams understand and implement it, with an emphasis on PNMT referrals. (Section O.2)
3. The PNMT should expand the timeframe of the retroactive record review for individuals who have been hospitalized to achieve a more comprehensive review. IDT members also should participate in this review. (Section O.2)
4. Using the PNMT's tracking of monitoring results and graphs of intervention results, the PNMT should work together with Facility Administration and QA staff to determine how this information can be integrated into QA/QI and Risk Management systems to track and trend

the frequency, antecedents, and correlations with identified health risk indicators. (Section O.2 and Section O.6)

5. The Facility should ensure that hospitalization, emergency room, and Infirmary databases are accurate to permit valid trend analysis, and provide a useful tool for therapists and medical/nursing staff. (Section O.2)
6. The Facility should create a culture in which the implementation of PNMPs and dining plans are non-negotiable, and an environment where all team members work collaboratively to achieve success in implementing outcomes for individuals at highest risk. To do its part, the PNMT should improve its collaboration with all team members supporting individuals on its caseload. This should involve increasing all team members' input in developing plans, improving team members' understanding of the importance of implementing the plans, and increasing capacity related to PNM supports. (Section O.2)
7. To support successful implementation of the PNM process leading to adequate and effective comprehensive PNMT evaluations and action plans the following is recommended:

   Referral to the PNMT

   a. Individuals at risk of receiving a feeding tube should be referred to the PNMT.

   PNMT Assessment

   b. The PNMT assessment should document the referral date by the IDT, PCP, or PNMT, and the reason for the referral.
   c. PNMT assessments should assess high and medium risk factors.

   PNMT Action Plan

   d. The PNMT should improve its collaboration with all team members supporting individuals on its caseload. This should involve increasing all team members' input in developing plans, improving team members' understanding of the importance of implementing the plans, and increasing capacity related to PNM supports. (Section O.2)
8. The Facility should prioritize individuals at high and medium risk with PNM concerns and incorporate proposed PNMP revisions as soon as possible. (Section O.3)
9. PNMPs should address the following:
   a. PNMPs should consistently direct staff to written and pictorial instructions for wheelchair positioning, alternative positioning, head of bed elevation, assistive equipment, etc.
   b. Therapists should review photographs to ensure optimal alignment and support for individuals in wheelchairs and alternate positioning (e.g., bed, recliner, right and left sidelying).
   c. Current strategies in PNMPs should be re-evaluated using HOBE assessment results to identify safe elevation ranges. PNMPs should present safe elevation range strategies for wheelchairs, alternate and nighttime positioning, bathing/showering, mealtime, medication administration, personal care, and oral hygiene. Staff strategies to achieve a safe degree of elevation should be clearly defined through photographic and written instructions.
   d. Recommended time for an individual to remain upright after a meal for those who eat orally and/or are enterally nourished should be an essential PNMP staff instruction.
   e. PNMPs should present adequate instructions for nursing staff for medication administration and oral care. Medication administration instructions should include the position of the nurse (e.g., eye level with individual); individual-specific positioning instructions, including elevation range in wheelchair and/or alternate position; use of adaptive equipment; presentation techniques; and medication presentation that is consistent with the prescribed diet texture (e.g., crushed pills for a pureed diet) and fluid consistency (e.g., nectar-thick fluids).
   f. Positioning for the individual and staff during oral care should be clearly defined by photographic and written instructions for individuals at high risk for aspiration and respiratory compromise. (Section O.3)
10. PNMPs for individuals at high risk should be audited to ensure adequate staff strategies for wheelchair and alternate positioning throughout the 24-hour day, mealtimes, oral care, medication administration, bathing, personal care, and transfers. (Section O.3)
11. Given the risk it places individuals in the Infirmary when PNMPs are not implemented, the presence and implementation of PNMPs, dining

plans, and assistive equipment for individuals in the Infirmary should be non-negotiable. (Section O.4)

12. The Facility should appoint appropriate staff (e.g., Home Supervisors) to participate in a train-the-trainer process to be completed by Facility therapists. The therapists should provide competency-based training and performance check-offs to these staff. These trained staff in turn should be responsible for providing training and check-offs to current AUSSLC staff. (Section O.4)
13. Staff supporting individuals at highest risk should be prioritized to receive competency check-offs for core and individual-specific PNMP strategies. (Section O.5)
14. When concerns are noted through monitoring activities with regard to the implementation of PNMPs and/or PNMT action plans, the PNMT should work with the PST members, and if not successful, inform the HT Director that staff non-compliance continues to be an issue. The PNMT and the HT Director should collaborate with QDDPs, Unit Directors, and QA/QI staff to implement strategies that support a culture of staff compliance with PNMPs and individual-specific PNMT strategies. (Section O.6)
15. A PNMT representative should participate in mortality reviews for individuals on their caseload who have died to gain knowledge from the individual's death. (Section O.6)
16. IDTs that support individuals with high-risk physical and nutritional management difficulties should track and analyze outcome or other objective measures to determine the efficacy of their interventions to minimize and/or reduce identified risk indicators. (Section O.7)
17. HOBE assessment should be completed for those individuals who receive enteral nutrition. (Section O.8)
18. The Facility should ensure APEN Assessments are completed thoroughly, and that resulting recommendations are integrated as appropriate into individuals' ISPs. (Section O.8)
19. Focus should be placed on defining the sample for Section O, reviewing and improving instructions for the audit tools, and developing and implementing standardized procedures to achieve inter-rater agreement. (Facility Self-Assessment)

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 Section P for Settlement Agreement Monitoring Team Visit; o The following documents: OT/PT assessment and update, HOBE assessment, Wheelchair assessment, supporting documentation for implementation of direct/indirect therapy programs, OT/PT Consultations for the past year, PSP and PSPAs for the past year, PNMP with pictures and written instructions, Dining and Diet Card, PNMP Clinic documentation for the past year, PNMP and individual-specific monitoring, staff competency-based training, daily schedule, Community Living Discharge Plan, Integrated Risk Rating Form, and Risk Action Plan for 30 individuals, including: Individual #381, Individual #77, Individual #424, Individual #73, Individual #340, Individual #43, Individual #405, Individual #442, Individual #1, Individual #34, Individual #186, Individual #175, Individual #372, Individual #357, Individual #366, Individual #62, Individual #338, Individual #243, Individual #278, Individual #137, Individual #439, Individual #50, Individual #80, Individual #26, Individual #310, Individual #113, Individual #34, Individual #320, Individual #177, and Individual #85; o OT/PT assessments for two individuals newly admitted including: Individual #60 and Individual #33; o Organizational chart of HT department, undated; o List of current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff along with corresponding caseloads, undated; o Continuing education completed by OTs/PTs with attendance rosters and certificates of completion, from 5/11 through 10/11; o Lists of individuals who use wheelchair as primary mobility, with transport wheelchairs, with other ambulation devices, and with orthotics and/or braces, undated; o Physical Nutritional Management maintenance log utilized to track modifications made to adaptive/assistive equipment, from 4/11 through 9/11; o OT/PT Evaluations and Updates (templates), undated; o Completed OT/PT Evaluations for newly admitted individuals, from 6/11 through 8/11; o Wheelchair seating and PNM clinic assessments (templates), undated; o Monitoring forms used by OTs, COTAs, PTs, and PNMP Coordinators (templates), various dates; o PNMP Coordinator's competency-based training records, from 4/11 through 10/11; o Competency-based training database, from 4/11 through 9/11; o Competency-based performance check-off sheets related to OT/PT; undated; o Summary Reports and analyses of monitoring results related to OT/PT and corresponding action plans (templates), undated;

	○ Completed Summary Reports and Monitor tracking, from 7/11 through 10/11; and ○ List of individuals receiving direct OT/PT services and focus of intervention, dated 10/5/11. ▪ **Interviews with**: ○ Kim Ingram, MEd, CCC/SLP, Habilitation Therapies (HT) Director. ▪ **Observations of**: ○ Infirmary, Residences 501, 732, 772, 792, 793, 796, and 797, including dining rooms.
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section P of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings. The POI comments/status columns provided a number of informational updates. However, the POI did not include self-assessment monitoring data or provide information regarding the establishment of inter-rater agreement between monitors. Focus should be placed on defining the sample for Section P, reviewing and improving instructions for the audit tools, and developing standardized procedures to achieve inter-rater agreement. The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater agreement between therapists and the Program Compliance Monitor will result in audit findings that are not reliable and/or valid. In the POI, the Facility had developed action plans for Sections P.1, P.3 and P.4. The status of action step completion for all action plans was identified as "in progress." Action plans addressed implementation of a master plan to perform comprehensive assessments; implementation of PNMP competency-based training for all staff; development of a database for tracking training and monitoring compliance; development of protocols for a universal monitoring tool, training of monitors, and implementation of monitoring; and completion of a database system to track and trend monitoring results. In addition, the Facility should develop action plans for the development of procedures to address therapists' roles and responsibilities, development and implementation of an audit tool to assess compliance with therapists' roles and responsibilities, and establishment of prioritization of individuals at highest risk to ensure the completion of staff competency-based training and check-offs. .
	Summary of Monitor's Assessment: Based on interview, therapy staff (OTs, PTs, SLPs, and PNMP Coordinators) were divided into teams and assigned to specific units. This was done to support integration and collaboration between therapists and unit staff, as well to have consistent therapy presence at unit meetings, PSPs, and PSPAs. The Monitoring Team viewed this as a positive restructuring of the HT Department. OT/PT assessment and assessment update formats had been revised to instruct therapists to address medium and high risks indicators that required therapy services. This was a constructive addition. Unfortunately, individual OT/PT assessment recommendations were primarily focused on service recommendations to support health and safety, and did not include recommendation that would assist

	individuals to improve their functional capacities, and/or expand their inclusion and involvement in various settings. Although improved health and wellness are important, therapy supports also should lead to individuals having greater access to activities, including potentially new environments for social interaction, learning, and work. Assessment and assessment update instructions should require an assessment of an individual's preferences, interests, and potentials. Assessments should recommend learning opportunities to be implemented through skill acquisition programs, and/or direct or indirect therapy supports to support individuals' growth and development. Seven of the 351 individuals (2%) living at AUSSLC received direct PT services. No individuals received direct OT services. Direct therapy plans were not reinforced through formal skill acquisition programs or informally during daily activities.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Monitoring Team's record sample for Section P was: ▪ Sample P.1 – eight individuals who were identified at high risk and experienced a health status change, including: Individual #381 (feeding tube placement) Individual #77 (BMI 50.3), Individual #424 (BMI 47.7), Individual #73 (lost 40 pounds over year), Individual #340 (BMI 13), Individual #43 (unplanned weight loss), Individual #405 (choking), and Individual #442 (pressure ulcer). ▪ Sample P.2 – two of two individuals (100%) newly admitted to AUSSLC, including: Individual #60 and Individual #33. ▪ Sample P.3 – five of seven individuals (71%), who were receiving direct PT services, including: Individual #1, Individual #34, Individual #186, Individual #175, and Individual #372. ▪ Sample P.4 – 17 individuals assessed with revised OT/PT update format, including: Individual #357, Individual #366, Individual #62, Individual #338, Individual #243, Individual #278, Individual #137, Individual #439, Individual #50, Individual #80, Individual #26, Individual #310, Individual #113, Individual #34, Individual #320, Individual #177, and Individual #85. Positive developments with regard to the Facility's progress towards compliance with Section P.1 included the following: ▪ Based on interview, therapy staff (OTs, PTs, SLPs, and PNMPCs) were divided into teams and assigned to specific units. This was done to support integration and collaboration between therapists and unit staff, as well to have consistent therapy presence at unit meetings, PSPs, and PSPAs. ▪ OT/PT assessment and assessment update format instructions directed therapists to address medium and high risks that require services and supports. In addition, therapists were to address "factors for community placement."	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings.

<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u> According to the current census, 351 individuals were living at AUSSLC. The Facility had budget authority for five OT and 4.7 PT positions. The following chart represents the reported current caseload of OTs, and PTs:

<table>
<tr><th>OTs</th><th>Current Caseload and Responsibilities</th></tr>
<tr><td>OT #1</td><td>Lead OT and supported 147 individuals</td></tr>
<tr><td>OT #2</td><td>Supported 98 individuals</td></tr>
<tr><td>OT #3</td><td>Supported 106 individuals</td></tr>
<tr><td>OT #4</td><td>Vacant</td></tr>
<tr><td>OT #5</td><td>Designated as the PNMT OT, supporting nine Level I individuals, one Level II individual, and seven Level IV individuals, for whom other OTs have primary responsibility</td></tr>
<tr><th>PTs</th><th>Current Caseload and Responsibilities</th></tr>
<tr><td>PT #1</td><td>Lead PT and supported 53 individuals</td></tr>
<tr><td>PT #2</td><td>Supported 102 individuals</td></tr>
<tr><td>PT #3</td><td>Supported 98 individuals</td></tr>
<tr><td>PT #4</td><td>Su0ported 98 individuals</td></tr>
<tr><td>PT #5</td><td>Designated as the PNMT PT, supporting nine Level I individuals, one Level II individual, and seven Level IV individuals, for whom other PTs have primary responsibility</td></tr>
</table>

Facility OTs, COTAs, PTs, and PTAs had attended State-sponsored webinars, including: Assessment of Technologies, Introduction to PNMT, Issues in Evaluation and Treatment of Individuals with Developmental Disabilities, and the Annual HT Conference. Documentation submitted included attendance rosters and certificates of completion. With regard to the attendance by therapists and assistants who were not PNMT members at PNMT-specific training, it was positive and important to build capacity within the HT Department for future PNMT membership, and to assist therapy staff in working with IDTs to develop and implement effective risk action plans.

Two OTs and one PT completed additional community continuing education, including a three-day workshop for Wheelchair Seating for Postural Control and Function, which a
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#	Provision	Assessment of Status	Compliance
		national seating expert conducted. The continuing education that the OTs and PTs had completed was appropriate. <u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u> Since the last onsite review, two individuals had been admitted to AUSSLC. The HT Department completed OT/PT assessments as opposed to screenings. Review of the individuals in Sample P.2 confirmed that assessments had been completed within 30 days of admission. However, neither of the two OT/PT assessments (0%) followed the format and/or instructions. Concerns included: ▪ The OT/PT assessment did not identify individual preferences and strengths that would lead to the discovery of potentials for learning and skill acquisition. ▪ They did not include individual-specific recommendations for functional skill acquisition programs, nor did they set forth outcomes expected from the implementation of plans or programs. The recommendations were more reflective of service objectives. For example: "recommend the home purchase footwear with a wide toe box," and "should be encouraged to wear socks with her sneakers to minimize the possibility of blisters." ▪ In addition, within 30 days of admission, PST members were responsible for completing a risk assessment to determine areas of risk. None of the OT/PT assessments (0%) in Sample P.2 discussed an individual's risk factors. HT should implement an audit of completed assessments to determine compliance with Facility evaluation instructions. <u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> No Facility tracking log existed for OT/PT assessments and updates. The OT/PT Update Instructions, dated 7/19/11, provided guidance to the therapists for the following sections: risk levels, other services/supports, consultations/evaluations in past year, PNMP, eating/dining/swallowing, assistive equipment, recommendations, measurable objectives, and factors in community placement. The OT/PT assessments included in Sample P.1 that the Monitoring Team reviewed did not include individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of plans or programs. The HT Department should continue to revise the OT/PT assessment template to provide adequate assessment data consistent with the revised PSP process. The assessment should identify the individual's strengths and potentials for improved health status, as well as skill performance and/or skill acquisition/learning. Therapists should use this information to assist teams to develop programs to support individuals in attaining functional outcomes in life skill areas (e.g., home, leisure, community), as well as	

#	Provision	Assessment of Status	Compliance
		maintaining or enhancing their health and wellness. Evaluation instructions for the comprehensive OT/PT assessment had been revised. The instructions required an analysis of findings and rationale for recommendations within multiple sections. The recommendations were to be stated clearly and identify the responsible person(s) for implementation. The recommendations were to include criteria to monitor and assess their efficacy. Recommendations for supports/activities, other than direct therapy were to be incorporated into the PSP and integrated into an individual's daily routine. Additions to the assessment instructions included an analysis of findings/rationale for recommendations at the conclusion of each assessment section, and incorporation of bathing and toileting under ADLs, medication administration, and oral care. Concerns regarding the content of the instructions are provided below. For individuals in Sample P.4, OT/PT assessment updates were reviewed. The following observations describe weaknesses in these assessment updates and offer recommendations to ameliorate these deficiencies: ▪ OT/PT assessment updates did not provide a description of an individual's preferences, interests, and potentials. Hands-on collaborative assessment (OT and PT) data should be sufficiently discrete to identity an individual's preferences and interests, leading to the discovery of potentials for learning and skill acquisition. The assessment data should lead to the development of functional outcomes that are meaningful for the individual in the context of everyday living at home, work, and during leisure activities. Functional outcomes should identify an integrated series of behaviors that allow an individual to achieve important everyday goals. ▪ Assessment recommendations primarily focused on providing services (e.g., "all triggers should be reported to nursing," "all recommended adaptive equipment should be consistently available to her, and maintained in good, clean working order"). Recommendations also should reflect learning opportunities for individuals through functional skill acquisition programs. None of the assessment updates for individuals in Sample P.4 (0%) recommended the achievement of functional outcomes in the context of daily living environments. ▪ The assessment should identify how to minimize an individual's impairments and functional limitations that are barriers to achieving desired functional outcomes. The current assessment format did not incorporate the preceding strategies and/or provide adequate information to assist the individual and PST members to develop and implement functional outcomes to achieve an individual's goals, preferences, and needs. The OT/PT assessment update was revised to incorporate risk levels. This was a constructive addition. Unfortunately, individual OT/PT assessment recommendations	

#	Provision	Assessment of Status	Compliance
		were primarily focused on service recommendations to support health and safety, and did not include recommendations that would assist individuals to improve their functional capacities, and/or expand their inclusion and involvement in various settings. Although improved health and wellness are important, therapy supports also should lead to individuals having greater access to activities, including potentially new environments for social interaction, learning, and work. Assessment and assessment update instructions should require an assessment of an individual's preferences, interests, and potentials. Assessments should recommend learning opportunities to be implemented through skill acquisition programs, and/or direct or indirect therapy supports to support individuals' growth and development. The HT Department should develop and implement policies and procedures to define therapist's roles and responsibilities. An audit tool should be developed and implemented to assess compliance with these roles and responsibilities (e.g., OT/PT assessments and updates). <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> None of the individuals (0%) in Sample P.1, who were identified at high risk for aspiration, respiratory compromise, weight and/or experienced a health status change, had OT/PT updates and/or consultations to address the status change or identified high risk factors. None of these individuals were receiving direct and/or indirect therapy. The following issues were noted with regard to OT/PT assessments updates: ▪ An individual who experienced a choking incident had not received an update or consultation to assess the choking incident and make recommendations, if appropriate. ▪ Individuals at risk of receiving a feeding tube did not have OT/PT assessment updates prior to the placement of the tube. ▪ OT/PT updates for individuals with unplanned weight loss and/or high or low BMIs did not address their risk levels, and address supports needed from therapists. ▪ Individuals with skin breakdown are at serious risk for infection and ongoing compromised health status, but an OT/PT assessment update and/or consultation did not discuss skin breakdown (Individual #442). Sample P.4 included two individuals (Individual #177 and Individual #320) who had transitioned to the community. None of these individual's (0%) therapy updates addressed community placement. Their therapy updates did not provide current essential information to their community providers prior to community placement.	

#	Provision	Assessment of Status	Compliance
		OT/PT assessments should be completed within the 45-day timeframe established with regard to Section T of the Settlement Agreement. In addition, the assessments should address risk factors and the strategies employed to minimize these risks. Four of the five individuals in Sample P.3 (80%), who received direct therapy, had received an OT/PT update, but these assessments did not consistently include individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of the plans or programs. An OT/PT assessment update was not provided for Individual #24. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u> Recent revisions of the OT/PT assessment and update formats integrated the OT and PT's analysis of risk factors. Three of the eight individual's assessments or updates (38%) in Sample P.1 (0%) addressed health risk indicators. <u>Evidence of communication and/or collaboration is present in the OT/PT assessments.</u> Based on review of the OT/PT assessments or updates of individuals in Sample P.1, P.2 P.3, and P.4, the signatures of the OT and PT were present with the exception of the report for Individual #130. This resulted in a compliance rate of 97%. AUSSLC was not yet in compliance with this provision of the Settlement Agreement. Revisions in assessment and update formats continued to be necessary, as well as improvement in the implementation of the revised format and related instructions.	
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,	Minimal progress had been made with regard to Section P.2 that requires the Facility to develop plans to address the recommendations in the integrated OT/PT Assessments through the incorporation of plans into individuals' ISPs. <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> Documentation revealed that seven of the 351 individuals (2%) living at AUSSLC received direct PT services. No individuals received direct OT services. Based on a review of individuals in Sample P.1, P.2, and P.4, for none of these individuals (0%) had a plan been developed based on OT/PT recommendations and integrated into the PSP. The following concerns were noted: ▪ OT/PT assessments identified individual deficits, but no skill acquisition programs had been recommended and/or developed. ▪ OT/PT assessments acknowledged individuals were dependent on staff for activities of daily living, but no plans were developed to provide opportunities	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	for skill acquisition and practice to support an individual's ability to increase independence in dressing, bathing, toileting, personal hygiene, grooming, etc. ▪ Some OT/PT assessments were not current, and as a result, did not reflect an individual's current preferences and potentials for learning, leading to the development of plans to support learning new skills. ▪ Individuals transitioning to the community did not have plans to increase their levels of independence to support a successful transition into the community. ▪ Individuals had been identified as significantly overweight, but no plans had been developed to address their overweight status to minimize health risk concerns. ▪ OT/PT recommendations mainly addressed the implementation of service objectives and not individual-specific recommendations that resulted in the development of plans to promote active learning at home, in activity centers and work sites, and during leisure pursuits. For individuals in Sample P.3, direct therapy plans were implemented for wound care, gait, endurance and safety, leg strength, and transfer ability. These therapy plans supported health and safety and/or functional skills, which was appropriate. However, based on review of individuals in Sample P.3, none of the five therapy plans (0%) recommended PSP integration of the therapy plan's outcome measures, or development and implementation of related skill acquisition programs, and/or other opportunities for practice of the new skills throughout the 24-hour day. Numerous issues were noted with regard to the implementation of therapy plans, and integration of the plans into PSPs. Generally, direct therapy plans were not reinforced through skill acquisition programs and/or during daily activities. These issues included: ▪ No documentation was submitted for Individual #1 to review his direct PT services for "wound care for left ankle." ▪ Monthly progress note documentation was not present. <u>Within 30 days of development of the plan, it is implemented.</u> Based on the documentation submitted, the Monitoring Team could not determine if therapy plans had been implemented within 30 days of development of the plan. <u>Appropriate intervention plans are: integrated into the ISP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.</u> In Sample P.3, none of individual's (0%) therapy plans were integrated into the PSP. <u>On at least a monthly basis or more often as needed, the individual's OT/PT status is</u>	

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		reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. Individuals in Sample P.3 did not have an individual-specific monthly review of their status, or review as a result of a change in status, and/or completion of individual-specific monitoring. AUSSLC was not yet in compliance with this provision of the Settlement Agreement. As discussed above, individual therapy plans had not been integrated into individuals' PSPS, did not have functional measurable outcomes, and were not consistently implemented and/or documented.	
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.	Progress had been made with regard to Section P.3 in the implementation of competency check-offs for some individual-specific PNMP instructions. Staff implements recommendations identified by OT/PT. As noted above with regard to Section O.4 of the Settlement Agreement, the Monitoring Team observed multiple instances of staff not following prescribed PNMP strategies, and/or implementing PNMT action plans. Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. A review of the individuals' records for Samples P.1, P.3, and P.4 revealed staff had completed limited competency check-offs for some PNMP strategies. These check-offs included assistive dining equipment, bath transfer bench, walking program/walking individuals, stand-pivot transfer, elbow pad, hosiery/compressions sock, shower chair, gait belt, bed positioning, two-person manual transfer, mealtime, and adaptive dining equipment. These competency check-offs were appropriate and, most importantly, required staff demonstration. None of the individuals' staff (0%) in Samples P.1, P.3, or P.4 had completed all required competency-based training and performance check-offs to address PNMP strategies. As stated above, competency check-offs had been completed for some components of the PNMP, but not all. The HT Department should analyze completed staff competency check-offs to determine what additional staff competency check-offs will be required. AUSSLC had not yet achieved compliance with this provision. The Facility had implemented competency check-offs for some PNMP strategies. The Facility had not established a policy and procedure for the development and implementation of competency-based training and performance check-offs for core competencies of PNM foundational skill training, individual-specific PNMP strategies, and strategies to reinforce skill acquisition related to direct therapy plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	Minimal progress had been made with regard to Section P.4 that requires the Facility to develop and implement a system to monitor and address individual's adaptive/assistive equipment, the OT/PT and PNMP treatment interventions, and direct support professionals' implementation of the interventions. <u>System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology.</u> The OT/PT assessment instructions for assistive/supportive devices required therapists to identify equipment, describe the function, present the schedule for use, as well as the rationale for selection of equipment, and document the efficacy of all assistive equipment. The Monitoring Team did not find that OT/PT assessments and/or updates adequately provided a comprehensive review of prescribed equipment. None of the individuals from Samples P.1, P.3, or P.4 (0%) had a comprehensive review included within their OT/PT assessment to evaluate the fit, availability, function, condition, and effectiveness of all prescribed PNMP adaptive/assistive equipment. The HT Department's audit tool should assess compliance with therapists' review of individual's assistive equipment. The HT Department did not submit a database that tracked individuals' prescribed equipment to ensure the prescribed equipment had been received, or that it fit, was available, functional, in good condition, and continued to be effective. <u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. Facility monitoring procedures should address the status of individual's assistive equipment <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. <u>For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (as discussed further with regard to Section O.5 of the Settlement Agreement)</u>. Systemic and individual-specific issues related to training staff are discussed above with regard to Section O.5 of the Settlement Agreement. <u>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</u>	Noncompliance

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		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). As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff compliance with individual-specific plans was not being completed. Data collection method is validated by the program's author(s). For none of the six individuals (0%) receiving direct OT/PT services was the data collection method validated by the program's author. AUSSLC had not yet achieved compliance with this provision. Facility procedures should be expanded to monitor the status of individuals with identified occupational and physical therapy needs; the fit, availability, function, condition and effectiveness of prescribed equipment; treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct support professionals of these interventions.	

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

1. The Facility should continue to recruit and fill vacant therapy positions. (Section P.1)
2. The Facility should develop and implement an OT/PT assessment and updated tracking log. (Section P.1)
3. The Facility should incorporate the following recommendations into the OT/PT assessment and update template and instructions:
    a. OT/PT assessment updates should provide a description of an individual's preferences, interests, and potentials. Hands-on collaborative assessment (OT and PT) data should be sufficiently discrete to identity an individual's preferences and interests, leading to the discovery of potentials for learning and skill acquisition. The assessment data should lead to the development of functional outcomes that are meaningful for the individual in the context of everyday living at home, work, and during leisure activities.
    b. Recommendations should reflect learning opportunities for individuals through functional skill acquisition programs, as well as direct and indirect therapy programs to support individuals' growth and development.
    c. The assessment should identify how to minimize an individual's impairments and functional limitations that are barriers to achieving desired functional outcomes. (Section P.1)

4. The HT Department should develop and implement policies and procedures to define therapist's roles and responsibilities. An audit tool should be developed and implemented to assess compliance with these roles and responsibilities. (Section P.1)
5. With regard to the provision of direct therapy services:
    a. 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 ISP;
    b. Monthly documentation should justify the initiation, continuation or discontinuation of assessment recommendations, and reflect the status of measurable outcomes; and
    c. 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-assessment. (Section P.2)
6. Facility policy should define the process that should occur across the 30 days post development of the plan. This should include, but not be limited to ensuring the components of the direct therapy action plan identify and support outcomes that are functional and measurable, and integrating the plan(s) within the ISP, including the plans' outcomes and objectives, as well as, as appropriate, formal skill acquisition programs and informal activities for implementation during the individual's daily routine. (Section P.2)
7. The Facility should formalize procedures for the development and implementation of competency-based training and performance check-offs for PNM core competencies, individual-specific PNMP strategies, and strategies to reinforce skill acquisition related to direct therapy plans. The implementation of competency-based training and performance check-offs should be a priority for individuals identified at high risk for choking, aspiration, respiratory concerns, falls, fractures, and skin integrity. (Section P.3)
8. If one does not exist, the HT Department should develop an information management system to track individuals' prescribed equipment to ensure the equipment had been received, and that it fits, is available, functional, in good condition, and continues to be effective. (Section P.4)
9. Facility monitoring procedures should be expanded to monitor the status of individual's assistive equipment to address the fit, availability, function, condition and effectiveness of prescribed equipment. (Section P.4)
10. The Facility should focus on the identification of a relevant sample, and development of adequate instructions and criteria for the Section P audit tools. In addition, procedures should be developed and implemented to ensure inter-rater agreement. (Facility Self-Assessment)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Local dental policies, including SSLC Nursing Protocol: Post Anesthesia Care, dated June 2010; AUSSLC Annual Dental Assessment Policy, implementation date 4/1/11; Comprehensive Dental Care Policy, implemented 4/1/11; Dental Desensitization Policy, implemented 4/1/11; Criteria for Determining Usage of Enteral Sedation or Total Intravenous Anesthesia (TIVA), revised 3/28/11; Missed/Refused Appointments Policy, implemented 4/1/11; Suction Toothbrush Instructions, undated; Oral Hygiene PowerPoint new employee orientation presentation; o For newly admitted individuals, the date of initial evaluation; o Individuals who for the past six months were seen for dental services other than annual exam, date, and type/reason of visit; o Individuals who within the past six months have refused dental services; o Individuals in past six months that missed appointments (other than refusals), including date, reason, and date of completed make-up appointment; o Individuals that have had an extraction in the past six months; o Individuals seen in last six months for dental emergencies; o Individuals who have had preventative dental care in the last six months; o Individuals who have had restorative care in the past six months; o Individuals, who were due for annual dental exams, have had exams and whether the dentist was able to complete exams. Dental clinic due for and completed exams April 2011 to September 2011; o Most recent comprehensive exam for one individual from each residence, including a copy from the Dental Department and a copy from the active record for: Individual #59, dated 3/22/11; Individual #53, dated 8/24/11; Individual #429, dated 2/10/11; Individual #64, dated 5/3/11; Individual #93, dated 1/24/11; Individual #302, dated 8/3/11; Individual #122, dated 4/18/11; Individual #22, dated 4/20/11; Individual #17, dated 5/23/11; Individual #408, dated 1/31/11; Individual #35, dated 6/22/11; Individual #267, dated 1/10/11; Individual #80, dated 6/21/11; Individual #4, dated 7/12/11; Individual #350, dated 3/3/11; Individual #83, dated 2/18/11; Individual #423, dated 3/14/11; Individual #63, dated 6/2/11; Individual #18, dated 7/21/11; Individual #425, dated 2/24/11; Individual #52, dated 3/14/11; Individual #56, dated 7/26/11; and Individual #109, dated 3/1/11; o Abbreviations used in dental records; o Attendance tracking sheet for dental appointments for the last six months; o In the past six months, individuals who have refused appointments, reason for appointment, and date of refusal; o List of individuals who have not seen a dentist in one year and reason; o List of those who have outstanding need for dental x-rays, according to current professional standards, and type of x-ray that is needed to fulfill

	requirement/recommendations; o List of individuals who were edentulous at time of last visit, and those who have become edentulous since then; o List of other reasons for missed appointments per date for past six months, including reason for appointment - prophylaxis, annual, etc.; o List of no shows/missed appointments per building per month for the last six months; o List of refusals per building per month for the last six months; o List of interventions per individual for missed appointments (e.g., follow-up appointment scheduled, whether follow-up completed, any correspondence to QDDP, home manager, team, etc.); o QDDP, IDT minutes that review, assess, develop and implement strategies for dental visit refusals and no shows during the last six months; o Five most recent emergency exams, integrated progress notes from start of emergency to closure and dental evaluation and treatment notes; o Appointment schedule for those undergoing anesthesia; o For six individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation, and post-operative checklist or monitoring forms, etc. for following individuals: Individual #151 on 9/20/11, Individual #187 on 9/29/11, Individual #34 on 9/29/11, Individual #30 on 10/3/11, Individual #271 on 10/3/11, and Individual #327 on 9/29/11; o Correspondence related to sedation/restraint use in April/May, June/July, and August/September 2011; o Complete dental records for prior three years at SSLC, for one individual most recently seen from each residential unit, including: Individual #34, Individual #82, Individual #458, and Individual #344; o For 10 individuals given dental pre-treatment sedation, progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring, including pre-treatment sedation sheets for: Individual #168 on 10/4/11, Individual #390 on 9/19/11, Individual #179 on 9/15/11, Individual #181 on 9/26/11, Individual #289 on 10/4/11, Individual #216 on 10/6/11, Individual #103 on 9/14/11, Individual #299 on 9/28/11, Individual #278 on 9/27/11, and Individual #278 on 10/5/11; o Current list of Human Rights Committee approved dental medical restraint with sedation; o Percentage of individuals utilizing TIVA per month for dental exam and treatment; o Percentage of individuals per month utilizing oral sedation for dental visits; o Percentage of individuals per month utilizing mechanical support; o For most recent five extractions in past six months, copy of initial evaluation for this, and subsequent documentation until closure for: Individual #262 on 9/6/11, Individual #358 on 9/7/11, Individual #194 on 8/17/11, Individual #306 on 8/31/11, Individual #453 on 8/18/11;

	○ Oral hygiene ratings in each exam per person and date. Corrective action plans related or oral hygiene ratings; ○ List of those who receive suction tooth brushing treatment; ○ Copy of 10 annual dental assessments completed in last 30 days and for the prior year for the same individual, list created on 10/17/11 for: Individual #151, dated 9/21/10, and 9/20/11; Individual #34, dated 9/30/10, and 9/29/11; Individual #249, dated 10/19/10, and 9/22/11; Individual #82, dated 10/18/10, and 10/12/11; Individual #181, dated 9/22/10, and 9/26/11; Individual #286, dated 10/19/10, and 10/17/11; Individual #187, dated 9/21/10, and 9/29/11; Individual #344, dated 10/19/10, and 10/10/11; Individual #271, dated 9/22/10, and 10/3/11; Individual #327, dated 9/28/10, and 9/29/11; ○ List of annual assessments in the last six months and date of previous exam; ○ Copy of 10 most recent annual dental summaries provided for the PSP for: Individual #94, dated 9/12/11; Individual #187, dated 9/29/11; Individual #34, dated 9/29/11; Individual #82, dated 10/12/11; Individual #181, dated 9/26/11; Individual #286, dated 10/17/11; Individual #344, dated 10/10/11; Individual #271, dated 10/3/11; Individual #393, dated 10/4/11; and Individual #327, dated 9/29/11; ○ Most recent/current Facility oral hygiene data; and ○ Presentation Book for Section Q. ▪ **Interviews with**: ○ Rhonda Stokley, DDS, Dental Director; and ○ Russell Reddell, DDS, MBA, State Dental Coordinator.
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section Q of the Settlement Agreement, the Facility found that it remained out of compliance with both of the subsections. This was consistent with the Monitoring Team's findings. However, it was not clear that the conclusions drawn were based on objective data. In its POI, the Dental Department outlined a number of steps taken. Although the narrative was helpful, and the action steps had contributed to progress in compliance in all aspects of dental care, no data was included in the Facility's self-assessment to show whether or not the actions were having the intended effect. The Facility should expand its self-assessment activities in this area, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate monitoring tools; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring on the review tools and their implementation; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes.
	Summary of Monitor's Assessment: The Facility remained in noncompliance with both subsections of

	Section Q, but continued to make progress in all areas. Review of dental records indicated complete and comprehensive care. An electronic annual dental assessment had been established. The dental assessment form was adapted to meet the needs of the direct support professionals by including clear oral hygiene recommendations. A number of initiatives were in place for improving oral hygiene. Attempts were made at home instruction, but with staffing shortages in the Dental Department, this was temporarily placed on hold. Additionally, corrective action plans were made for many individuals with poor oral hygiene. The multifaceted approach had a positive impact with improvement of oral hygiene ratings since the Monitoring Team's last visit. There was less progress with offering suction tooth brushing to other individuals. However, no information management system had been created to capture the energy and activity toward these endeavors, or to determine which approaches were most successful. From the documentation received, dental desensitization had not commenced at the pilot home, and the Facility needed to prioritize this endeavor. All residents in the pilot home had completed a dental task analysis. A tooth brushing task analysis was underway. The system to determine the cause of missed appointments appeared to be in place, but the challenge was to decide which areas could be resolved at the dental or Facility level and focus on those areas. The Dental Department submitted several volumes of correspondence to the residences as well as to the Nursing Department concerning missed appointments, and other dental issues. To date, collaboration with nursing to complete a dental oral sedation monitoring protocol remained an ongoing issue.

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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 had had some changes in staffing. There was a loss of one dental hygienist, and a gain of a dental assistant. Additionally, as of 10/31/11, a position for an additional dentist was funded. It was anticipated that once all positions were filled, there would be two dentists, two dental hygienists, and two dental assistants. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from April 2011 through September 2011. Of these, 189 were listed with a prior annual examination dates. Of these, 156 out of 189 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 83%. Percentage compliance with timely completion varied per month (April 2011 - 90%, May 2011 - 93%, June 2011 - 83%, July 2011 - 89%, August 2011 - 79%, and September 2011 - 60%). Overall, there appeared to be a trend of decreased compliance in the more recent months. It is recommended that the annual assessment due dates be tracked, and scheduling 30 to 60 days in advance is recommended to allow for missed appointments to occur and still have time for an annual assessment to be completed.	Noncompliance

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		Separately, copies of annual dental assessments that were completed in the 30 days prior to the Monitoring Team visit (the assessments were taken from a list created on 10/17/11) along with the prior year's completed assessment were submitted. For six out of 10 (60%) of these individuals, an annual dental assessment had been completed within 365 days. Copies of the most recently completed annual assessments for 23 individuals were submitted. This represented one individual from each residence. To ensure the active record included all of the information that the dental office also filed, the Dental Department used carbon copies of its documents. The Dental Department kept the carbon copy, and the original was filed in the active record. Each included the annual assessment and the dental progress note (DPN) entry. The annual assessment was amended (date not provided). The changes included additions of risk ratings and preparedness for transition. The following summarizes the results of this review: ▪ All 23 of the 23 submitted assessments (100%) had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ All 23 of the 23 submitted assessments (100%) had entries for oral hygiene, teeth and restorations, and periodontal condition. ▪ Risk rating was documented in 12 out of 23 (52%) assessments. ▪ Oral hygiene recommendations were documented in all 23 assessments (100%). ▪ Transfer preparedness was documented in five out of 23 (22%) assessments. ▪ A dental progress note was documented (separate from the completion of the annual assessment form) in all 23 active records (100%). Separately, copies of the 10 most recently completed annual dental assessments were submitted. All ten were one page in length, and all entries were typed. Entries were in bold print for easy review. For all 10, the following were completed: Cooperation level, sedation/restraint recommendations, current conditions (oral hygiene, teeth and restorations –mobility/wear/amount of teeth, gingival inflammation, periodontal condition, soft tissue exam, appliances, PSP dental risk rating recommendations, daily oral hygiene recommendations, appropriateness for community placement, and summary of findings. The brief descriptive entries in many sections of the annual dental assessment provided a clear composite snapshot of the current dental health status of the individual. On 7/17/11, a new Annual Dental Assessment form was created, and included a statement concerning whether the individual could be served in the community with appropriate supports. The Facility submitted the complete dental records for the prior three years for one	

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		individual from each residential unit, as a separate measure of completeness and timeliness in dental documentation. Four records were submitted, and the findings from review of these records were as follows: ▪ For four out of four (100%), the most recent annual dental assessment was within 365 days of the prior assessment. ▪ The level of cooperation and need for sedation/restraint, the oral hygiene index rating, the condition of the teeth and restorations, the level of risk, and the recommendations for oral hygiene (tooth brushing recommendations) was recorded in four out of four (100%) of the records. ▪ A statement of preparedness for community transition was recorded in three out of four (75%). ▪ It was noted that two had undergone IV sedation, and one had plans for IV sedation. ▪ The oral hygiene was rated as good in one individual, fair in two, and poor in one individual. ▪ One individual was rated as low dental risk, two as moderate/medium dental risk, and one as high risk. Additionally, during this time period, two new individuals had been admitted to the Facility. Two out of two (100%) had completed an initial dental exam in the first month (from 15 to 20 days). Two individuals were listed as not having seen the dentist in the prior year. Both were due to behaviors. The report submitted indicated that the annual assessment was pending a TIVA appointment. <u>Oral Hygiene</u> As part of the oral hygiene program, the Dental Department reported that it provided three in-service training sessions that trained 53 staff (on 7/8/11, 9/12/11, and 10/5/11). The training rosters submitted for these sessions totaled 56 staff. Once the Dental Department had a full complement of staff, the Dental Department was expected to continue to provide in-service training concerning oral hygiene. As part of the oral hygiene program, at each individual's appointment, the individual was provided oral hygiene education, when applicable. If direct support professionals accompanied the individual, these staff also were provided a brief in-service concerning oral hygiene. Oral hygiene education also was provided at each new employee orientation. The Dental Department worked with the Habilitation Therapies Department in creating a tooth brushing protocol. This remained in draft stage. The goal was to incorporate the appropriate level of risk for tooth brushing into the PNMP (i.e., those with no aspiration risks, those with aspiration risks, edentulous individuals, and those receiving suction	

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		tooth brushing). An oral hygiene index was completed on each individual at the time of the annual exam. From these scores (data collected from April 2011 through September 2011), the percentage of individuals in each category of oral hygiene (i.e., good, good/fair, fair/poor, poor, and very poor) could be calculated. According to the Dental Department's calculations, 19.6% had an oral hygiene rating of good, 0.5% had an oral hygiene rating of good/fair, 32.8% had an oral hygiene rating of fair, 9.5% had an oral hygiene rating of fair/poor, 33.3% had an oral hygiene rating of poor, and 4.2% had an oral hygiene rating of very poor. In comparing this data to the earlier time period of October 2010 through March 2011, there was a trend toward improvement in the oral hygiene index across campus. In the earlier time period, those with a good oral hygiene rating were 7%, and this more than doubled to 19.6%. The poor and very poor categories in the earlier time period totaled 51% of the individuals residing at AUSSLC. In the current time period, this was reduced to 37.5%. For those needing improved oral hygiene, corrective action plans were implemented. Many examples of PSP training objectives for tooth brushing were submitted in response to the need for improved oral hygiene. The Dental Department submitted information that 75 individuals at AUSSLC brushed their own teeth. However, there were seven residences identified in which no individual brushed their teeth independently. From the meeting notes of a "Daily Oral Hygiene Planning" meeting, those 75 identified as having the ability to brush their own teeth would be evaluated at the annual assessment for competency in tooth brushing. As part of preventive oral care, suction tooth brushing was provided to those with dysphagia and other indications for this procedure. A list submitted indicated nine individuals received suction tooth brushing. However, the date of the list was not submitted, and one individual had died, leaving eight individuals with suction tooth brushing. There was an additional note that as of 7/28/11, two others had suction tooth brushing ordered, but as of 10/3/11, the equipment had not been purchased. It is recommended that Facility Administration review the orders for purchases of equipment to reduce delays in obtaining equipment leading to delays in treatment. As part of the suction tooth-brushing program, the Dental Department attended interdisciplinary meetings that focused on expanding suction tooth brushing and identifying criteria for its use. The two challenges to expansion of the suction tooth-brushing program were providing education to the nurses, and obtaining suction	

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		machines. As part of the nurse education on this topic, the Dental Department created an instructional PowerPoint, and a competency-based training program. <u>Preventive, Restorative, Emergency Dental Services</u> According to the Dental Department, one individual was overdue for recommended dental x-rays. This individual was to be scheduled for TIVA, and there were plans to complete dental x-rays at that time. Information submitted indicated 59 individuals residing at AUSSLC were edentulous. Two of these individuals became edentulous over the past six months. The Dental Department provided the breadth of services required to care for the individuals at AUSSLC. In the prior six months (April through September 2011), 342 individuals were seen for prophylactic care (April 2011 – 48, May 2011 - 70, June 2011 – 53, July 2011 – 65, August 2011 - 53, and September 2011 - 53). A total of 63 individuals underwent restorative care. One individual was seen and treated for a dental emergency, and 15 individuals underwent dental extractions. Separately, the Facility submitted the number of appointments per month from April 2011 through September 2011 for services other than annual assessments. For clarification, the Facility indicated that the listing included services other than the annual assessments that were administered during the same visit as the annual assessment. The number of appointments per month were: April 2011 - 64 appointments, May 2011 - 83 appointments, June 2011 - 75 appointments, July 2011 – 87 appointments, August 2011 - 77 appointments, and September 2011 - 68 appointments. Monitoring and evaluation of use of oral sedation was reviewed. A sample of 10 active records was submitted for individuals who underwent oral sedation. The following summarizes the results of this review, based on entries made by the Dental Department: ▪ One out of the ten (10%) recorded nothing by mouth (NPO) status. All had orders for withholding the prior meal (breakfast or lunch), but there was no written confirmation by the dentist or dental staff in the notes that this had been verified. It is recommended that the dental office document that it has confirmed NPO status (e.g., overnight through noontime, etc.), as applicable to the visit. ▪ All 10 (100%) listed the medication administered, the dose, and the route. ▪ All 10 (100%) listed pre-procedure vital signs. ▪ All 10 (100%) had an examination note. ▪ Two (20%) documented use of mechanical restraint use. One required four staff to assist the dentist in completing the appointment. ▪ Nine (90%) had post-procedure vital signs.	

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		▪ Adequate documentation regarding effectiveness was found in 10 of the 10 (100%) of the active records. ▪ Nine (90%) had nursing Infirmary notes. All had post-visit monitoring in the Infirmary. According to an email of 7/1/11, all those individuals that received oral sedation went to the Infirmary for two hours of observation after the dental office visit in order for vital signs to be monitored. For those with scheduled extractions or special procedures, the individuals were to stay overnight in the Infirmary. For those undergoing IV anesthesia, similar to those with oral sedation, the individuals would go the Infirmary for a two-hour observation. The Dental Department and the Nursing Department met twice in the past six months concerning the monitoring of the individuals during the time period after sedation was administered and before arrival at the dental office. In July 2011, the Nursing Department indicated that nurses would be trained by September. In September, a second meeting between the departments was held, at which time, the Nursing Department stated that the training would be completed by the end of October 2011. At the time of the Monitor Team's visit, the training had not been completed. Intravenous sedation/general anesthesia services were provided monthly at AUSSLC to meet the needs of the individuals. This occurred one to five times per month. The following appointments were completed per month through IV sedation/general anesthesia: April 2011 - 12, May 2011 – four, June 2011 – 12, July 2011 – 14, August 2011 – 16, and September 2011 – 14, for a total of 72 appointments during this six month period. The active record was submitted for six individuals who had undergone general anesthesia in 2011. The date range of these procedures was from 9/20/11 through 10/3/11. The procedures under general anesthesia included one or more aspects of dental care (e.g., annual exam, cleaning, fillings, and fluoride). Review of these records revealed the following: ▪ Consent for the dental procedures/anesthesia was up-to-date in all six active records (100%). ▪ An operative note by the dentist was recorded in six out of six (100%). ▪ The operative anesthesia record was completed in all six (100%). ▪ A post-operative note by the dentist was submitted/recorded in one (17%). ▪ An Infirmary nursing note was recorded in all six (100%). ▪ An Infirmary discharge form was completed in three (50%). ▪ A pre-operative anesthesia record was completed and submitted in none (0%). ▪ A post-operative vital sign flow sheet was submitted in three (50%).	

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		▪ Pain medication was prescribed in all six. ▪ The post anesthesia care Respiration, Energy, Alertness, Circulation, and Temperature (REACT) score was submitted and complete in none (0%) of the active records. The post-operative monitoring appeared to be incompletely and inconsistently documented. It is recommended that the Dental and Nursing Departments develop expectations for documentation of monitoring, and a list of required forms to be completed while at the Infirmary. For five individuals that underwent extractions, the dental record was submitted. The following findings were made: ▪ For one of the five cases, IV sedation was used. Four were administered an oral sedative prior to the extraction. ▪ Preoperative vital signs were recorded in four of the five cases. One individual did not receive pre-treatment sedation, making this unnecessary, so compliance was 100%. ▪ At the dental visit, the number of teeth extracted ranged from one to three. Two individuals had one tooth extracted, and two individuals had two teeth extracted. One individual had three teeth extracted. ▪ All five were admitted to the Infirmary for observation post-extraction. Three stayed overnight in the Infirmary. ▪ A post-operative diet change was noted in two of the five cases. ▪ All five (100%) had a post-operative dental note. ▪ All five (100%) had post-operative vital signs recorded. ▪ Four (80%) had postoperative vital signs recorded in the dental office. ▪ Pain medication was provided in all five cases. ▪ There was a follow up post-operative dental note documented in all five records (100%). Emergency treatment was reviewed for one individual from April 2011. No dental visits were categorized as an emergency from May 2011 through September 2011. The reason for the emergency was that a tooth had fallen out. The following findings are made based on this review: ▪ The active record documented the presence or not of pain. ▪ The individual was seen the same day the tooth fell out. ▪ Follow-up occurred for the individual 13 days later, documenting healing. During a recent dental procedure under TIVA, there was an adverse outcome. Once identified, the Dental Department acted swiftly and appropriately in determining the cause of the adverse outcome to ensure no other individual was affected. This was under	

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		investigation at the time of the Monitoring Team's visit. In a meeting with the Dental Department and the State Office Dental Coordinator, it appeared that steps were immediately taken to ensure prevention of a recurrence. It is recommended that the State Office Dental Coordinator conduct periodic monitoring through unannounced visits to ensure these steps are maintained.	
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.	This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> A number of policies and procedures had been developed over the past 18 months to provide a framework for comprehensive dental services, roles, and expectations. Several of these continued to be in place, including: ▪ SSLC: Nursing Protocol: Post Anesthesia Care, dated 6/10; ▪ AUSSLC – Dental Clinic: Annual Dental Assessment Policy, dated 4/1/11; ▪ AUSSLC- Dental Clinic: Comprehensive Dental Care Policy, dated 4/1/11; ▪ AUSSLC– Dental Clinic: Dental Desensitization Policy, dated 4/1/11; ▪ AUSSLC – Dental Clinic: Criteria for Determining Usage of Enteral Sedation or Total Intravenous Anesthesia (TIVA), revised 3/28/11; ▪ AUSSLC – Dental Clinic: Missed/Refused Appointments Policy, dated 4/1/11; ▪ Suction Toothbrush instructions, undated; and ▪ New employee orientation presentation on "Oral hygiene at AuSSLC." The Facility indicated that three additional documents were at various levels of completion, including: Oral Sedation Monitoring (nursing protocol), Tooth Brushing Guidelines (in conjunction with Habilitation Therapies), and Suction Tooth Brushing Guidelines (in conjunction with Habilitation Therapies and Nursing). <u>Refusals/Missed Appointments</u> A review of information from April 2011 through September 2011 (submitted from the attendance tracking sheets in the Dental Department) indicated that 530 appointments were kept, and 77 appointments were not kept, resulting in an 85.5% show rate (453/530). Additionally, according to the data on these tracking sheets, at the time of the missed appointment, 72 out of 77 (94%) were offered a date to reschedule. As noted above, from the attendance-tracking sheet for dental appointments, 77 missed appointments were identified. Of these 17 were due to refusals. The remaining 60 were	Noncompliance

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		categorized and tabulated as follows: off campus appointment – four, in hospital – three, behaviors – six, time constraints – 10, administrative meetings – two, sickness – six, furlough - five, sedation not given – one, short staffed in home – four, appointment not on the campus-wide schedule - four, not NPO status – four, visiting a group home – one, relocation to a different residence with a gap in communication – one, dental office reasons - six, and unknown – two. This indicated diligence in determining the actual reason for the missed appointments, an important first step in attempting to reduce missed appointments. The Facility submitted two documents reporting information regarding the numbers and reasons for missed appointments that were not due to refusals. From April 2011 through September 2011, a total of 18 missed appointments were not due to refusals. The reasons provided included the pre-treatment sedation was not administered, the residence was short-staffed, the individual had behaviors prior to the appointment, the individual was not kept NPO prior to the office visit, the individual was relocating to a different residence, and the residence was not informed of the appointment/other communication issues. The main reasons included short staffing in the home, not being kept NPO, and behaviors, all of which were beyond the responsibility of the Dental Department. However, they provided an opportunity for the Dental Department to work with the various other departments that could assist with compliance (i.e., residential services, nursing services, Psychology Department). For the 17 appointments that were refused, 14 were for prophylactic visits, and three were for restorative care. An annual exam was also scheduled for two individuals that had prophylactic visits. The Facility submitted a list of no shows/missed appointments per building per month. There was no clustering effect noted. The Facility submitted a list of refused appointments per building per month. One building (#797) appeared to have more refusals than other residences, indicating a need for increased behavioral focus and PST efforts in this residence. The Monitoring Team requested IDT and QDDP minutes that reviewed, assessed, developed, and implemented strategies for dental visit refusals and no shows. The Dental Director attended an IDT meeting about several individuals with refusals and no shows, but was informed the QDDP did not write the discussion into the minutes. Copies of email correspondence inquiring about such minutes were submitted. It is recommended that the Dental Department ensure minutes/notes are recorded of future discussions of this topic. The Dental Department had in place a system in which the QDDP, home supervisor, and unit director was notified of any missed dental appointment. If the reason could not be	

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		determined, then the Dental Department sent correspondence to the QDDP requesting the reason. <u>Tracking, and Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. For the prior six months, the dental office did use mechanical restraints. From April through September 2011, mechanical restraints were used in the following percentage of completed appointments per month: April - 4.7%, May - 2.4%, June - 4%, July - 8.05%, August - 3.9%, and September 8.8%. For the six months, the mechanical restraint use for completed appointments was 5.3% For oral sedation, from April through September 2011, according to the data provided, 453 appointments were kept. Of these, there were 43 appointments in which oral sedation was given. This was submitted as a percentage of completed appointments per month for which oral sedation was administered, including: April - 4.7%, May - 6.1%, June 2011 – 9.3%, July - 14.9%, August - 9.09%, September - 11.8%. For the six months, the oral sedation rate for completed appointments was 9.5%. For IV sedation, the Facility submitted the percentage of completed appointments per month for which IV sedation was administered, including: April - 18.75%, May - 4.9%, June - 16%, July - 16.1%, August 20.8%, September - 20.6%. For the six months, the IV sedation rate for completed appointments was 15.9%. Separately, a list of HRC-approved dental and medical restraints was requested. The response from the Dental Department was that the annual dental assessment indicated the need for sedation or restraint use for dental visits. The QDDP entered this information into the PSP. A desensitization plan then was created, and the Human Rights Committee processed and approved the sedation, restraint use, and desensitization plans. The Dental Department was unable to find a list of individuals with HRC-approved dental and medical restraints. It is recommended that this be created, and if it is already in existence, it be periodically shared with other departments at quality improvement meetings. The Pre-Treatment Sedation Committee was important to the progress of the dental desensitization program, and other strategies to minimize the use of pre-treatment sedation and restraint. It also included members of the Psychiatry, Psychology, and Pharmacy Departments. This Committee approved a Dental Task Analysis (12 steps). It was completed on every individual residing in home #788, which was chosen as the pilot home. The QDDP for home #788 and the Psychologist met with the Dental Department	

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		to begin to create desensitization plans. As a first step, it was determined that a Tooth Brushing Task Analysis needed to be developed. This was to be finalized in December 2011. However, as is discussed in more detail with regard to Sections C.4 and J.4, the Facility had not moved rapidly enough in this area.	

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

1. The annual assessment due dates should be tracked, and appointment should be scheduled 30 to 60 days in advance to allow for missed appointments to occur and still have time for an annual assessment to be completed. (Section Q.1)
2. Facility Administration should review orders for purchase of equipment to reduce delays in obtaining equipment leading to delays in treatment. (Section Q.1)
3. The dental office should maintain documentation confirming NPO status (overnight, through noontime, etc.), as applicable to the visit. (Section Q.1)
4. The Dental and Nursing Departments should develop expectations for documentation of monitoring and a list of required forms to be completed while individuals are at the Infirmary after dental procedures. (Section Q.1)
5. It is essential that the Nursing Department provide adequate training to nurses on their role and responsibilities with regard to monitoring individuals who have been administered pre-treatment sedation between the time of the administration and the individuals' arrival at the dental office. (Section Q.1)
6. To assist in preventing recurrence of the significant adverse outcome for an individual while receiving TIVA, the State Office Dental Coordinator should conduct periodic monitoring through unannounced visits to ensure the identified corrective action steps are maintained. (Section Q.1)
7. The Dental Department should ensure minutes/notes are recorded during future discussion of strategies to reduce dental visit refusals. (Section Q.2)
8. The Dental Department should have access to a list of individuals with HRC-approved dental and medical restraints, and should only use such procedures when they are able to confirm that the adequate approvals and consents have been obtained. (Section Q.2)
9. The Facility should expand its self-assessment activities in this area, including identifying the methodology to be used (i.e., documents to be reviewed, staff to be interviewed, samples to be selected); modifying, as appropriate monitoring tools; providing specific, written instructions on the implementation of the tools; training staff who will conduct the monitoring on the review tools and their implementation; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. (Facility Self-Assessment)

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 Section R for Settlement Agreement Monitoring Team Visit, November 2011; o The following documents: Speech Language Pathology (SLP) assessment and updates, SLP communication program, SLP progress notes, supporting documentation for implementation of direct SLP communication programs, PSP and PSPAs for past year, Positive Behavior Support Plan (PBSP), SLP consultations for the last year, competency-based training documentation, individual-specific monitoring for the past three months for communication programs, Communication Dictionary, individual-specific monitoring for past three months for communication equipment, daily schedule, and PNMP for the following 21 individuals: Individual #355, Individual #210, Individual #128, Individual #333, Individual #154, Individual #206, Individual #284, Individual #123, Individual #293, Individual #278, Individual #298, Individual #281, Individual #156, Individual #15, Individual #327, Individual #323, Individual #409, Individual #10, Individual #337, Individual #357, and Individual #80; o Speech assessments for two individuals newly admitted: Individual #60 and Individual #33; o Continuing education completed by the SLPs since last site visit along with attendance rosters and certificates of completion, from 6/11 through 10/11; o List of current SLP and Audiology staff and corresponding caseloads, dated 10/26/11; o Communication Equipment list, revised 10/24/11; o Communication Assessment Master Plan, revised 10/26/11; o Alternative and augmentative communication (AAC) screening forms, revised 7/20/11; o AAC Evaluation and Speech-Language Assessment and Updates (templates), revised 7/20/11 and 8/11; o Speech-Language Evaluations completed for newly admitted individuals, from 6/11 through 8/11; o Tracking Log of completed Communication Assessments, revised 10/26/11; o Monitoring forms used by SLPs, SLPAs, and PNMP Coordinators since last review (templates), revised 9/30/11; o Competency-based performance check-off sheets related to SLP supports implemented since last review (templates), revised 9/13/11; o Communication Equipment Monitoring Tacking Sheets for past twelve months, from 3/11 through 10/11; o AAC-related spreadsheets, revised 10/24/11; o List of individuals receiving direct speech services and focus of intervention, dated 10/20/11; o List of individuals with behavioral issues and coexisting severe language deficits and risk

	level/status for challenging behavior, revised 10/25/11; and o List of individuals with PBSPs and replacement behaviors related to communication, updated 10/1/11. ▪ **Interviews with**: o Kim Ingram, MEd, CCC/SLP, Habilitation Therapies Director; and o Karen Hardwick, Statewide Coordinator for Specialized Services. ▪ **Observations of**: o Infirmary, Residences 501, 732, 772, 792, 793, 796, and 797, including dining room.
	Facility Self-Assessment: Based on a review of the Facility's POI, with regard to Section R of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings. The POI comments/status columns provided numerous informational updates. The POI did not include self-assessment monitoring data, or provide information regarding the establishment of inter-rater agreement between monitors. Focus should be placed on defining the sample for Section R, reviewing and improving instructions for the audit tools, and developing standardized procedures to achieve inter-rater agreement. The absence of adequate instructions for the monitoring tool and distinct trials to achieve inter-rater agreement between therapists and the Program Compliance Monitor will result in audit findings that are not reliable and/or valid. In the POI, the Facility had developed action plans for Sections R.3 and R.4. The status of action step completion for these action plans was "in process" or "not started." Action plans addressed integration of communication supports and skill expansion activities in active treatment and/or activities of daily living; monitoring of PSPs and Positive Behavior Support Plans to ensure integration of communication supports; and development of instructions and protocol for universal monitoring tool, training of staff monitors, and implementation of the monitoring system and completion of a database to track and trend monitoring results. The HT Department should develop an action plan to address the development of procedures for therapists' roles and responsibilities, as well as development and implementation of an audit tool to document compliance with therapist roles and responsibilities.
	Summary of Monitor's Assessment: Positive developments for this section included a fully staffed Speech and Hearing Department; caseload therapists and PNMP Coordinators had been divided into unit therapy teams to provide consistent HT presence at Unit meetings, PSPs, and PSPAs; SLP attendance at annual PSPs had increased; SLPs had developed staff instructions for communication strategies and individual-specific AAC systems that were an extension of the PNMP; and significant progress had been made in the provision of competency-based training and check-offs for individuals with AAC systems. The Presentation Book for Section R indicated that the Speech Update template was revised, and was being piloted at AUSSLC. The Monitoring Team's review of multiple SL assessments did not reflect the development of individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of plans or programs. The HT Department should continue to revise the SLP assessment template to provide adequate assessment data consistent

	with the revised PSP process. The assessment should identify the individual's strengths, and potentials for improved health status, as well as skill performance and/or skill acquisition/learning. Therapists should use this information to assist teams to develop programs to support individuals in attaining functional outcomes in life skill areas, as well as maintaining or enhancing their health and wellness. No Facility policy existed to define the SLPs' role and responsibilities. The HT Department should develop and implement policies and procedures to define therapist's roles and responsibilities. An audit tool should be developed and implemented to assess compliance with these roles and responsibilities. During the last two reviews, the Monitoring Team raised concerns related to the absence of resources for individuals who were deaf and/or significantly hearing impaired. This concern continued to be warranted. An individual who could sign fluently did not have staff that were proficient in sign language, nor was a translator available. This continued to place this individual in a position of not being able to communicate to the best of his abilities with peers and/or staff. As recommended before, Facility Administration, in collaboration with the HT Department, should ensure the provision of essential supports, most importantly related to communication, to individuals on campus who were deaf and/or hearing impaired. As a result of the ongoing level of staff non-compliance with communication devices as documented on monitoring forms, the Facility and the HT Department should place a high priority on implementation of a monitoring system that will allow tracking and trending of data to analyze progress with staff compliance for communication devices.

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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.	The Monitoring Team's record sample for Section R was as follows: ▪ Sample R.1– 18 of 70 individuals (26%) who had AAC systems or communication dictionaries, including: Individual #355, Individual #210, Individual #333, Individual #154, Individual #284, Individual #123, Individual #293, Individual #409, Individual #10, Individual #278, Individual #323, Individual #298, Individual #281, Individual #156, Individual #337, Individual #327, Individual #128, and Individual #80; ▪ Sample R.2 - two of two individuals (100%) newly admitted to AUSSLC, including: Individual #60, and Individual #33; ▪ Sample R.3 – 15 of 120 individuals (13%) with PBSPs: Individual #355, Individual #210, Individual #333, Individual #154, Individual #206, Individual #357, Individual #284, Individual #123, Individual #293, Individual #409, Individual #10, Individual #80, Individual #281, Individual #156, and Individual #327; ▪ Sample R.4 - 20 individuals who had been identified as Priority 1 or Priority 2 on the AUSSLC Communication Assessment Master Plans, including: Individual #355 (Priority 1), Individual #210 (Priority 1), Individual #128 (Priority 2),	Noncompliance

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		Individual #333 (Priority 1), Individual #154 (Priority 1), Individual #206 (Priority 2), Individual #284 (Priority 1), Individual #123 (Priority 1), Individual #293 (Priority 1), Individual #278 (Priority 1), Individual #298 (Priority 2), Individual #281 (Priority 1), Individual #156 (Priority 1), Individual #15 (Priority 2), Individual #327 (Priority 2), Individual #323 (Priority 2), Individual #409 , (Priority 1) Individual #10 (Priority 1) , Individual #337 (Priority 2), and Individual #357 (Priority 1). Sixteen of the 20 individuals (80%) within this sample had AAC devices, including: Individual #355, Individual #210, Individual #333, Individual #154, Individual #284, Individual #123, Individual #293, Individual #409, Individual #10, Individual #278, Individual #323, Individual #298, Individual #281, Individual #156, Individual #337, and Individual #327. Positive developments with regard to the Facility's progress towards compliance with Section R.1 included the following: ▪ The Speech and Hearing Department was fully staffed. ▪ Caseload therapists (SLPs, OTs, and PTs) and PNMP Coordinators had been divided into therapy teams. Each therapy team was comprised of an OT, PT, SLP, and two PNMP Coordinators. The goal of the HT Department restructuring was to provide consistent HT presence at Unit meetings, PSP, and PSPA meetings. ▪ A review of Sample R.4 revealed SLP attendance at annual PSP meetings was 69%, which was an improvement from previous reviews. In some cases for which noncompliance was noted, documentation was not submitted (e.g. blank PSP signature sheets, no signature sheets, and two PSPS not available). ▪ SLPs had developed staff instructions for communication strategies and individual-specific AAC systems that were an extension of the PNMP. These instructions were to be present in an individual's Individual Notebook (I-Book). A review of some individuals' I-Books documented the presence of these instructions. <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> AUSSLC had five budgeted Speech Language Pathology (SLP) positions. These positions were filled. Based on the documentation provided, the following chart illustrates the caseloads and responsibilities of SLPs, which totaled to 352 individuals: **SLPs** | **Current Caseloads and Responsibilities** SLP #1 | Supported 91 individuals SLP #2 | Supported 65 individuals SLP #3 | Supported 97 individuals	

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SLP #4	Supported 99 individuals
SLP #5	PNMT Lead

Facility SLPs had attended State-sponsored webinars, including: Assessment of Technologies, Dietician's Role in the PNMT, GI/Dysphagia Issues in Individuals with Developmental Disabilities, Introduction to PNMT, and Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (Annual HT Conference). Documentation submitted included attendance rosters and certificates of completion. The attendance of therapists who were not PNMT members at PNMT-related training was important to build capacity within the HT Department for potential future PNMT membership, and to assist therapy staff in working with IDTs to develop and implement effective risk action plans. One SLP completed certification as a VitalStim Therapy Provider (i.e., FDA-cleared treatment approach that combines Neuromuscular Electrical Stimulation and traditional dysphagia techniques). The continuing education completed by the SLPs was appropriate.

Communicative Aides 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.
A list of individuals with AAC devices was provided that identified the individual's name, living unit, type of device and date received. Based on documentation provided, 70 of the 351 individuals (20%) living at AUSSLC had augmentative or alternative communication device(s). Communication Dictionaries had been developed for 207 of 351 individuals (59%). Twelve (12) of thirteen individuals (92%) in Sample R.4, who were ranked as Priority 1, were recommended and received AAC equipment. Four of the seven individuals (57%) in Sample R.4, who were ranked as Priority 2, were recommended and received AAC equipment.

None of the individuals (0%) in Sample R.1 received direct support from a SLP, although all these individuals had communication devices and dictionaries. Review of individuals in Sample R.1 substantiated that these individuals would have benefitted from receiving some form of direct and/or indirect SL services. The following concerns were noted:

- SL evaluation updates using the new format presented recommendations and outcomes for the use of AAC equipment, but in many cases, the objectives were not measurable. Measurable outcomes should include criteria that would enable the SLP and/or team members to assess and monitor the implementation of skill acquisition programs to ensure efficacy of the program.
- Multiple SLP assessments did not make recommendations regarding skill acquisition programs, nor did the PSPs integrate the use of prescribed AAC

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		systems into skill acquisition programs to promote utilization of these devices in different environments. Multiple assessments stated that the SLP: "will be available to provide in-service and assist in planning appropriate communication programming," but no recommendations were included for direct or indirect SL supports and/or skill acquisition programs. PST members need coaching, mentoring, and support from SLPs to understand how to integrate the use of AAC systems into skill acquisition programs, and through multiple opportunities for practice throughout the day. SLPs' recommendations for measurable objectives should be more prescriptive enabling PST members to integrate them into the PSP through skill acquisition programs. ▪ Recommendations, in many cases, were not individual-specific. Recommendations should be based on an individual's preferences, goals, strengths, and needs. The recommendations should support functional communication within the home, work, and leisure environments, including the community. ▪ Even though risk levels had been integrated into the revised SLP assessment and update formats, SL assessments did not consistently discuss risk action plans, and/or risk factors that might impact functional communication. No Facility policy existed to define the SLPs' role and responsibilities. The HT Department should develop and implement policies and procedures to define therapists' roles and responsibilities. An audit tool should be developed and implemented to assess compliance with these roles and responsibilities. AUSSLC was not in compliance with this provision of the Settlement Agreement, but progress had been made. Multiple individuals' SL assessments did not provide individual-specific recommendations to facilitate the use of AAC systems. Individuals with identified communication deficits who would have benefitted from SL services did not receive direct and/or indirect SL supports. There was an absence of the development and implementation of formal programs to provide opportunities to promote learning and use of AAC systems within multiple environments.	
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	<u>All individuals in need of AAC are identified as being in need of AAC.</u> The Presentation Book for Section R indicated that 224 of 352 individuals (63%) had received SL assessments. The following observations were noted: ▪ All of the 131 individuals (100%) ranked as Priority 1 (i.e., individuals with a PBSP and/or Autism who did not speak) were identified as having their assessments completed. According to the AUSSLC Individualized Communication Equipment List, only 43 of the 131 Priority 1 individuals (33%) had prescribed equipment. Seventeen of the 131 individuals were identified as verbal, although this was not a Priority 1 criterion. The remaining 114 of 131	Noncompliance

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	systems, including systems involving behavioral supports or interventions.	individuals were non-verbal. Assessments were completed for 70 of 93 individuals (75%) assigned as Priority 2 (i.e., with a PBSP and/or autism who speak). Ninety-two (92) of the 93 individuals were identified as non-verbal, which did not meet the criterion for Priority 2. Sixteen of the 93 individuals (17%) had an AAC system(s). SL assessments were completed for 25 of 68 individuals (37%) identified as Priority 3 (i.e., without a BSP and/or Autism who did not speak). Five of these 68 individuals (7%) had AAC systems. ▪ SLP assessments were finished for 11 of 66 individuals (16%) identified as Priority 4 (i.e., without a PBSP and/or autism who speak). Two of these 66 individuals (3%) received AAC systems. Twelve of thirteen individuals (92%) in Sample R.4, who were ranked as Priority 1, were recommended and received AAC equipment. Four of the seven individuals (57%) in Sample R.4, who ranked as Priority 2, were recommended and received AAC equipment. All of the individuals in Sample R.1 (100%) had one or more pieces of communication equipment. Unfortunately, AAC systems had not been consistently integrated into individuals' PSPs through direct and/or indirect therapy supports, development and implementation of formal programs, and/or integration of informal strategies for implementation throughout the day. This did not provide individuals with a foundation for optimal utilization of their systems and/or their staff's successful utilization of an AAC system. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> The Presentation Book for Section R indicated that the Speech Update template was revised, and was being piloted at AUSSLC. The State Office had not approved the template. The SL Evaluation Update Instructions, revised 8/22/11, provided guidance to the therapists for the following sections: risk levels, other services/supports, consultations/evaluations in past year, PNMP, eating/dining/swallowing, assistive equipment, recommendations, measurable objectives, and factors in community placement. The Monitoring Team's review of multiple SL assessments did not reflect the development of individual-specific recommendations for functional skill acquisition programs, nor did they set forth the outcomes expected from the implementation of plans or programs. The HT Department should continue to revise the SLP assessment template to provide adequate assessment data consistent with the revised PSP process. The assessment should identify the individual's strengths and potentials for improved health status, as well as skill performance and/or skill acquisition/learning. Therapists should use this information to assist teams to develop programs to support individuals in attaining functional outcomes in life skill areas, as well as maintaining or enhancing their health and wellness.	

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		Since the last review, two individuals had been admitted to AUSSLC. Based on a review of Sample R.2, these individuals had received a SLP assessment. One of these individuals (Individual #33) spoke in full simple and complex sentences to communicate, but she had difficulty with complex two-step commands. It was reported that she exhibited anxiety when completing tasks that she did not understand. The second individual was diagnosed with profound hearing impairment. However, none of the individuals (0%) in Sample R.2 with identified communication deficits were recommended for direct or indirect speech therapy supports, and/or skill acquisition programs. <u>Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.</u> None of the individuals (0%) in Samples R.1, R.2, or R.4 had formal plans and/or skill acquisition programs developed and implemented by SLPs. <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> Behavior Therapy Committee Meeting documentation was submitted for 12 meetings. Nine of 12 Behavior Therapy Committee Meeting agendas (75%) documented SLPs attendance. A review of individuals in Sample R.3 revealed the following: ▪ The SL assessment and/or update templates did not provide instructions to address an individual's behavior and/or PBSP. ▪ Multiple SL assessments for individuals with PBSPs did not discuss collaboration with a psychologist for integration of communication strategies in the PBSP (e.g., replacement behaviors). ▪ Multiple PBSPs highlighted communication strategies, but there was no documentation to support collaboration with a SLP. Documentation of attendance at a meeting is not sufficient. Documentation should describe the actual collaboration that occurred. In other words, how did the SLP and Psychologist work together? Who did what? What integration occurred between programs the SLP and Psychologist each developed for the individual? ▪ PBSPs were not co-signed by the SLP to document collaboration in the development of the PBSP. ▪ Outdated SL evaluation information was quoted in PBSPs, even though a current SL evaluation was available. This did not support effective collaboration between psychologists and SLPs (e.g., Individual #5, Individual #327, and Individual #154). ▪ PBSP staff instructions for replacement behaviors, and AAC system instructions were not consistent or compatible. To minimize staff confusion, these	

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		instructions should mirror each other. The SLPs and psychologists should consider co-authoring skill acquisition programs to reinforce collaboration between disciplines, as well as provide increased learning opportunities for functional communication. A positive observation included: ▪ Some PBSPs incorporated information from current SLP assessments and referenced the assessments (e.g., Individual #123 and Individual #156). Therapists' roles and responsibilities with psychologists in the development of PBSPs and/or co-authoring skill acquisition programs should be formalized in policy and/or procedures. <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> As stated in the previous report and above with regard to Section R.1, the Facility did not have a policy to address therapist's roles and responsibilities.	
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.	During the last two reviews, the Monitoring Team raised concerns related to the absence of resources for individuals who were deaf and/or significantly hearing impaired. This concern continued to be warranted. Individual #210 had been moved to a residence that did not have staff that were proficient in sign language, nor was a translator available. This continued to place this individual in a position of not being able to communicate to the best of his abilities with peers and/or staff. As recommended before, Facility Administration, in collaboration with the HT Department, should ensure the provision of essential supports related to communication to individuals on campus who are deaf and/or hearing impaired. A positive development with regard to the Facility's progress towards compliance with Section R.3 included the following: ▪ Significant progress had been made in the provision of competency-based training and check-offs for individuals with AAC systems. <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> None of the individuals (0%) in Samples R.1 with AAC systems had their systems fully integrated into PSP skill acquisition programs and/or daily schedules. These direct and indirect supports were necessary to integrate the use of these devices throughout the day in a variety of environments. <u>Rationales and description of interventions regarding use and benefit from AAC are</u>	Noncompliance

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		clearly integrated into the PSP. None of the individuals in Samples R.1 with AAC systems had these systems integrated throughout their PSPs through the provision of direct therapy services, formal skill acquisition programs, and/or strategies to reinforce their use in a variety of environments throughout their daily schedules. AAC devices are portable and functional in a variety of settings. The PNMPs of all 16 individuals with prescribed AAC devices (100%) in Sample R.4 provided communication strategies addressing their AAC devices. In addition, Communication Strategies were provided for each individual that provided additional instructions beyond the PNMP strategies. Staff instructions for AAC devices also were developed. These documents reinforced AAC devices being used in a variety of environments. The following are examples of staff instructions: ▪ Provide choices throughout the day using Picture Choice Board (Individual #293); ▪ Provide Picture Choice Board during all activities (Individual #123); ▪ Use Picture Schedule daily when changing from one activity to another (Individual #409); ▪ Use the Picture Schedule in the shower. Use the schedule each time she showers (Individual #298); ▪ Provide Picture Book during daily activities to clarify speech (Individual #337). The SLPs were to be commended for providing easily understood directions to staff to reinforce the use of AAC systems throughout the day in multiple environments. AAC devices are individualized and meaningful to the individual. Sixteen of the 16 individuals (100%) with AAC devices in Sample R.4 had individual-specific communication strategies and AAC device(s) instructions developed. Staff are trained in the use of the AAC device. The SLPs had developed and implemented competency check-off forms for communication, sign language board, picture communication board, picture choice board, picture schedule, video phone, single message speech generating device, expressive communication, receptive communication, Dynavox Eye Max System, Dynavox V Max System, Go Talk Pocket, Picture First-Then Board, Go Talk, Adaptive Switch, Blue Put'em Around, Cheap Talk, Clip Talk, Dozen Does It Board, Object Board, Object Ring, Hip Talk, Picture Communication Ring, Picture Exchange System, Picture Choice Board, Say It Sam, Talking Frame, dry ear precaution, and hearing aides. Sixteen of the 16 individuals' staff in Sample R.4 had received competency-based training and check-offs on their AAC device(s). The SLPs had made significant progress with	

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		implementing competency-based training and check-offs, and were to be commended for these initiatives. However, as noted below, it could not be determined if all staff working with all of these individuals had completed all of the required training. In addition, Communication Equipment List submitted for AAC devices did not identify all individuals with AAC devices. The Monitoring Team offers the following recommendations: ▪ The AUSSLC Communication Equipment List was not an accurate reflection of individuals' communication devices. Staff competency check-offs were completed for 14 individuals that were not present on the AUSSLC Communication List. The HT Department should ensure accuracy with documentation. ▪ The Monitoring Team was not able to discern from the competency-based training tracking sheet if there were additional staff that required competency-based training and check-offs. For example, 222 staff had completed check-offs for Individual #406, but Individual #262's staff had completed 20 competency check-offs. No data was presented to identify the total number of staff to be trained, number of staff trained, and the number of staff remaining to be trained. This data would provide compliance status for individual-specific competency-check offs. ▪ As discussed in Section O, the Facility should identify appropriate staff to assist the SLPs with competency-based training and check-offs. The Presentation Book for Section R indicated Speech and Hearing Services had completed 3203 check-offs. This total included new staff completing competency check-offs since October 1, 2011. SLPs need additional time to focus on providing PST members with coaching and mentoring, and in developing and implementing skill acquisition programs to reinforce functional communication. AUSSLC was not in compliance with this provision of the Settlement Agreement, but significant progress had been made with regard to competency-based training.	
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	<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> At the time of the previous review, the Communication Equipment Monitoring Spreadsheet had been developed, and was being refined to track and trend data collected from the communication equipment monitoring forms. The AUSSLC Communication Equipment Monitoring Tracking Sheet, dated 11/2/11, provided multiple fields that reflected the content of the Individual/Shared Communication Equipment form. Based on documentation, the monitoring spreadsheet was still being refined to provide an analysis of data collected. No tracking/trending data was presented to reflect staff	Noncompliance

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	communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	compliance with communication equipment. As discussed in Section O, the HT Department was in the process of piloting a universal monitoring form. The Facility and the HT Department should place a high priority on implementation of a monitoring system that will allow tracking and trending of data to support staff compliance with communication devices. The significant investment of time by SLPs to test staff competency should be reinforced through the implementation of a system to ensure that staff are implementing the programs, and assisting individuals to use the equipment. The communication equipment of 18 of the 18 individuals within Sample R.1 was monitored (100%). Based on a review of this documentation, the following observations were noted: ▪ Individual's communication equipment was not available in a variety of environments (e.g., workshop, Infirmary), because multiple monitoring forms documented individuals did not have their equipment available. Facility staff should ensure communication equipment follows the individual. ▪ Monitoring forms from month to month indicated that individual-specific communication equipment was not in use. The monitor would have staff demonstrate how to use the equipment, but communication equipment continued to be not in use on subsequent monitoring forms. SLPs reviewed monitoring forms, but there was no discussion and/or resolution for repeated instances of the equipment not being in use. ▪ Monitoring forms documented missing equipment for multiple individuals. Monitoring forms indicated that equipment was retrieved, but this was a systemic issue that required resolution. ▪ The majority of monitoring occurred in the individuals' residences. ▪ There did not appear to be a formal consistent monitoring schedule. Review of monitoring forms revealed monitoring occurred two times in a week, every two or three weeks, no monitoring for a month, monitoring only once a month, etc. As recommended in the previous report, the HT Department should formalize a monitoring policy and incorporate the following: ▪ Definition of monitoring process to ensure all communication equipment is available, functioning, and effective for the individual; ▪ 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 in a variety of environments; ▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; and ▪ Feedback loop extending beyond the HT Department to discuss deficiencies noted and to implement strategies to ameliorate deficiencies.	

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		Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home. As stated above, the monitoring policy should define the monitoring schedule to ensure monitoring will occur in a variety of environments (e.g., home, activity center, work sites, leisure activities, mealtimes, etc.). Validation checks are built into the monitoring process and conducted by the plan's author. There was no evidence that validation checks were built into the monitoring process and conducted by the plan's author. AUSSLC was not in compliance with this provision of the Settlement Agreement, but minimal progress had been made.	

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

1. SLP assessments should incorporate the following information:
    a. Measurable outcomes should include criteria that would enable the SLP and/or team members to assess and monitor the implementation of skill acquisition programs to ensure efficacy of the program.
    b. SLPs' recommended measurable objectives should be more prescriptive enabling PST members to integrate SLP recommendations and measurable objectives into the PSP through skill acquisition programs, or other programs or supports.
    c. Recommendations should be based on an individual's preferences and potentials. The recommendations should support functional communication within the home, work, and leisure environments, including the community.
    d. Assessments should address how the SLP will provide direct and indirect supports to the PST. (Section R.1)
2. The Facility should develop and implement a policy to address therapists' roles and responsibilities. An audit tool should be developed and implemented to assess compliance with these roles and responsibilities. (Section R.1 and Section R.2)
3. The SLPs and psychologists should consider co-authoring skill acquisition programs to reinforce collaboration between disciplines, as well as provide increased learning opportunities for functional communication. (Section R.2)
4. Therapists' roles and responsibilities with psychologists in the development of PBSPs and/or co-authoring skill acquisition programs should be formalized in policy and/or procedures. (Section R.2)
5. The HT Department should ensure accuracy with documentation (e.g., AUSSLC Communication Equipment List). (Section R.3)
6. The HT Department competency-based training tracking system should identify the total number of staff to be trained, number of staff trained and the number of staff remaining to be trained. This data should be used to determine compliance status for individual-specific competency-check offs. (Section R.3)
7. As discussed in Section O, the Facility, in collaboration with the HT Department, should identify appropriate staff to assist the SLPs with competency-based training and competency check-offs. (Section R.3)
8. The Facility and the HT Department should place a high priority on implementation of a monitoring system that includes tracking, trending, and analysis of data related to staff's implementation of the programs, and the assistance they provide to individuals to use the equipment. (Section R.4)

9. As recommended in the previous report, the HT Department should formalize a monitoring policy and incorporate the following:
    a. Definition of monitoring process to ensure all communication equipment is available, functioning, and effective for the individual;
    b. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    c. Formal schedule for monitoring to occur in a variety of environments;
    d. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues; and
    e. Feedback loop extending beyond the HT Department to discuss deficiencies noted and to implement strategies to ameliorate deficiencies. (Section R.4)
10. The Facility should focus on the identification of a relevant sample, and development of adequate instructions and criteria for the Section R audit tools. In addition, procedures should be developed and implemented to ensure inter-rater agreement. (Facility Self-Assessment)

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: Austin State Supported Living Center Plan of Improvement, dated 11/2/11; Settlement Agreement Cross Referenced with ICF-MR Standards monitoring tools; Total Outing and Activity Participation tracking tool, dated 11/8/11; Austin State Supported Living Center Trip Request Form with Attachment A; Training Rosters related to Trip Request Form; Training Rosters related to Activity Tote System; Objective Tracking Sheet and related Training Rosters; E-mail correspondence to Director of Active Treatment regarding removal of age-inappropriate materials from Castner and Timber Creek Units; Specific Program Objectives template, SPO Checklist, and samples; Active Treatment 2.0 Training Process, Power Point Presentation, Active Treatment Observation to Review During Presentation, Active Treatment Training Checklist, and Course Participation Report, dated 10/19/11; On Campus Jobs Plan Meeting Minutes, dated 7/11/11; Austin State School Employee Daily Log by Program, Employee, Date – Detail, dated 11/8/11; State Supported Living Centers Procedures – Vocational Assessment; Vocational Assessment State Supported Living Center, template and sample; Functional Skills Assessment, template and sample; Training Rosters, task analysis and SMART objectives; Sample Task Analyses; Writing Measurable Objectives Practice; and Power Point Presentations, Writing Measurable Objectives and Task Analysis; o Personal Focus Assessments for: Individual #183, Individual #351, Individual #353, Individual #325, Individual #246, Individual #30, Individual #199, Individual #97, Individual #326, Individual #380, Individual #194, Individual #33, and Individual #19; o Positive Assessment of Living Skills (PALS) for: Individual #325, Individual #326, Individual #140, and Individual #33; o Functional Skills Assessment (FSAs) for: Individual #353, Individual #246, Individual #277, Individual #159, Individual #194, Individual #19, and Individual #189; o Personal Support Plans for: Individual #183, Individual #351, Individual #353, Individual #429, Individual #325, Individual #374, Individual #78, Individual #421, Individual #30, Individual #23, Individual #277, Individual #283, Individual #199, Individual #97, Individual #326, Individual #380, Individual #395, Individual #159, Individual #77, Individual #118, Individual #60, Individual #194, Individual #33, Individual #405, Individual #367, Individual #74, Individual #344, Individual #360, Individual #195, Individual #189, Individual #56, and Individual #109; o Vocational Assessment SSLC for: Individual #355, Individual #210, Individual #163, Individual #335, Individual #326, Individual #77, Individual #60, Individual #26, Individual #19, Individual #442, Individual #360, and Individual #189; o Comprehensive Assessment Program Planning System for: Individual #183, Individual #325, Individual #194, and Individual #33;

	○ Individual Notebooks (I-Books) for: Individual #432, Individual #154, Individual #445, Individual #374, Individual #42, Individual #96, Individual #249, Individual #399, Individual #335, Individual #45, Individual #88, Individual #241, Individual #103, Individual #378, Individual #272, Individual #306, Individual #74, Individual #344, Individual #360, Individual #120, Individual #189, and Individual #439; ○ Specific Program Objectives (SPOs) for: Individual #183, Individual #353, Individual #325, Individual #427, Individual #97, Individual #326, Individual #380, Individual #140, Individual #159, Individual #194, Individual #33, and Individual #19; ○ Specific Program Objective Data Sheets for: Individual #183, Individual #351, Individual #353, Individual #325, Individual #78, Individual #284, Individual #30, Individual #427, Individual #199, Individual #97, Individual #326, Individual #380, Individual #140, Individual #159, Individual #118, Individual #194, Individual #33, Individual #405, Individual #389, Individual #19, and Individual #189; ○ Skill Acquisition Plan (SAP), template and three sample objectives; ○ Special Considerations for: Individual #183, Individual #406, Individual #246, Individual #284, Individual #96, Individual #448, Individual #427, Individual #149, Individual #395, Individual #103, Individual #299, Individual #74, Individual #120, Individual #219, and Individual #439; and ○ List of Individuals with Visual Impairment, dated 11/17/11. ▪ **Interviews with**: ○ Sarah Knowles, Director of Active Treatment, and Holly Lindsey, QDDP Coordinator, on 11/15/11. ▪ **Observations of**: ○ Residence 501, Residence 729, Residence 732 Eagle, Residence 772, Residence 779 Hummingbird, Residence 779 Phoenix, Residence 792 Roadrunner, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; ○ Workshops 503, 527, and 544; ○ Day Habilitation Centers 510, 512, 533, and 775; ○ Chapel; ○ Computer Lab; ○ Personal Focus Assessment meeting for Individual #73, on 11/15/11; and ○ Personal Support Plan meeting for Individual #357, on 11/16/11.
	Facility Self-Assessment: The Facility's Plan of Improvement, dated 11/2/11, indicated it was not in compliance with any areas addressed in Section S of the Settlement Agreement. The Monitoring Team is in agreement with this assessment. According to the narrative descriptions, and the action plans included in the POI, several steps had been taken in an effort to improve the development and implementation of habilitation training, education, and skill acquisition programming. A second class related to Active Treatment had been developed and

	implemented. Additionally, staff from the QDDP and Active Treatment departments were working with State Consultants to improve the design of skill acquisition plans. New assessments of adaptive behavior and vocational skills had been introduced since the last visit. These were expected to provide a more comprehensive assessment of the individual's strengths, needs, and areas of interest. Although based on interview, the Facility had completed monitoring of individual records, the Facility was not utilizing the monitoring tools correctly. For example, reviewers were aggregating information regarding groups of objectives, as opposed to rating each objective separately. The resulting data was meaningless. In addition, none of this information was incorporated into the Facility's POI. The Facility should use the results of monitoring, as well as review of other relevant data, to identify areas of strength, as well as areas needing improvement. Action plans should be developed and implemented as appropriate. Summary data, as well as descriptions of how the Facility used the data to improve the supports provided to individuals should be incorporated into the POI to substantiate the Facility's findings with regard to compliance and noncompliance.
	Summary of Monitor's Assessment: The Facility is commended for its introduction of new and expanded measures of adaptive behavior and vocational skills. It is also commended for the improvement in identifying personal preferences and interests, and for attention to risk factors. It is important to note that these initiatives were in the early stages of development, and initial implementation showed the need for continuing improvement. The challenge remained to ensure that comprehensive Personal Support Plans were developed based on objective assessment of an individual's needs. Training objectives remained quite limited in scope and were defined poorly. Teaching opportunities remained infrequent, methodologies were compromised by a lack of clarity and consistency, and data used to assess progress were below standard. The environments did not promote high expectations for growth and development. Activities available to individuals at the Facility were often of poor quality, not individual specific, and often without functional outcome or purpose. Residences remained areas where active engagement was very limited.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to	The Personal Support Plans for 32 individuals were reviewed. As noted in the last report, each began with a brief description of the individual's preferences and interests. This section also referenced assessments used to guide the PSP process. The remaining text of the plan included an identification of risk factors and necessary supports for the individual's optimal living vision. The last section identified action plans including training objectives, participation objectives, and service objectives to meet the individual's needs. Comments specific to each section are provided below. <u>Preferences and Interests:</u> All of the plans included a review of the individual's preferences and interests. Staff should consider carefully the information gathered, the	Noncompliance

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	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.	identification of the most important factors, and the development of corresponding goals. The following provide explanations of concerns noted and individual examples that exemplified issues noted across PSPs: ▪ It was not consistently clear that activities that were most important to the individual were prioritized, and, at times, activities listed as preferences were services or supports. For example, Individual #351 was noted to enjoy visits with his mother. This was not included as a preference that made him happiest, yet included on the list was self-administration of medication. A list of 12 preferences/interests was included on the PSP for Individual #60. When determining which of these were top priorities for the individual, the team identified self-administration of medication, reduction of disruptive behavior, and money management, none of which were included in the list. ▪ At time, it was not clear how a preference (s) had been determined. For example, the team for Individual #353 agreed that her "preference was to stay at her current home," although there was also a note that when asked about living choices, she "could not make a relevant response." ▪ Often, preferences and interests were not linked to training objectives or other supports and services, or were not addressed with adequate intensity. For example, the PSP for Individual #30 indicated that learning to prepare food and cook were a top priority for him, yet his PSP included only two objectives related to this goal, one to occur once monthly, the other to occur twice monthly. Similarly, learning to cook was identified as an interest of Individual #395 at her Personal Focus Meeting. There were no training objectives related to this interest. The content of the PSP for Individual #109 included an identified priority need of improving the individual's reading skills, and a note that the individual had expressed an interest in learning to cook. Neither of these skills was addressed as a training objective. <u>Assessments:</u> Assessments used to help develop the individual's PSP were identified by discipline or formal title. This was evident in all but four of the plans. Measures of adaptive behavior (e.g., PALS, ICAP, FSA) were identified in 21 of the 32 plans (66%). The date of the assessment of adaptive behavior was included in only six of these 21 plans (29%). As the PSP is the document used to identify the delivery of habilitation services for the year, it is essential that current assessments of adaptive behavior be used to guide its development. Whenever assessments are referenced, it is recommended that the date of completion be included. This will ensure continued timely assessment of an individual's needs. <u>Identified Risks:</u> Nineteen (59%) of the plans included a completed risk assessment in table format. The remaining 13 plans (41%) reviewed risks within the body of the plan. The table format offered a quick review of areas of concern and need. The following	

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		summarizes the concerns noted: ▪ Issues were noted with regard to the accuracy of the risk ratings for a number of individuals (e.g., Individual #183, Individual #351, Individual #353, Individual #277, Individual #360, and Individual #395). ▪ An additional concern was that risk ratings were not correctly referenced throughout individuals' PSPs (e.g., Individual #374). ▪ An individual's behavior was sometimes cited as an obstacle to moving to the community (e.g., Individual #380 and Individual #77). An individual's behavioral issues should not be viewed as an obstacle. With the right supports, individuals with significant behavioral issues successfully live in community settings. <u>Supports and Services:</u> Plans included a narrative describing supports and services provided to the individual at the time of the PSP meeting. Staff should ensure the accuracy of the narrative and to address concerns in a timely manner. Concerns were noted with regard to the appropriateness of supports provided (e.g., Individual #351's day programming that included the opportunity to listen to white noise), a lack of appropriate day program/vocational supports without adequate justification (e.g., Individual #353), a lack of immediate action to address significant concerns (e.g., Individual #326's need for another residential environment), lack of preventative supports and services (e.g., Individual #60's PBSP being implemented only when target behaviors were displayed), and the age-appropriateness of supports (e.g., Individual #74's use of an infant spoon to address fast eating pace). <u>Training Objectives:</u> In the 32 PSPs reviewed, a total of 486 training objectives were identified. These ranged from a low of six objectives for Individual #429 to a high of 29 objectives for Individual #74. The numbers can be deceiving however, because 16 of the plans included reduction of problem behavior in the training objectives. Similarly, there were numerous individuals for whom multiple training objectives addressed the same skill. Of the 486 objectives, only 266 (55%) were to be addressed at least five times each week. Specific concerns regarding training objectives are provided below. ▪ The schedule for training new objectives was often limited to a few days per week (e.g., Individual #429), one day per week (e.g., Individual #109), or only one day a month (e.g., Individual #344 and Individual #283). Lean training schedules result in very limited learning opportunities and likely will compromise the development of new skills. ▪ Other PSPs included specific program objectives for which no training schedule was provided (e.g., Individual #353, Individual #199, and Individual #60). ▪ Other individuals (e.g., Individual #374, Individual #30, Individual #395, Individual #77, and Individual #74) had multiple specific training objectives that addressed the same skill. Staff should avoid teaching an individual to respond	

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		only after repetitive verbal prompts have been provided as this is effectively teaching the individual to not respond to instruction. Effective prompts should result in the desired behavior. ▪ Individual #421 was to spend four months learning to identify the color blue, followed by learning the color brown, and then the color white. Similarly, she was to spend four months each learning to identify a circle, a square, and a triangle. The function of these skills is questionable, but if they were related to some purposeful activity, it would appear that learning to discriminate colors and shapes could be taught simultaneously. ▪ Individual #283 had 10 training objectives included in his PSP. Five of these addressed components of sending an e-mail message. As sending an email is one task with several steps, it would appear that all components of this skill could be taught simultaneously. Additional concerns are noted below: ▪ The PSP for Individual #429 was dated 10/5/10. Plans should be developed and revised annually. It was also noted that this individual had not attended any day programming since her placement at her current residence. Habilitation services should be ongoing regardless of movement within the Facility. ▪ The PSP for Individual #367 was dated 7/28/10. Again, plans should be updated annually to ensure appropriate needs are addressed. During the onsite review, this individual reported that she would like to learn to read. As this is not addressed on her current PSP, staff should address this reported interest and explore the possibility of helping the individual learn this skill. To ensure that PSPs are developed to promote the growth, development, and independence of the individuals served, the following guidelines are recommended: ▪ Ensure that all necessary assessments are completed prior to the PSP meeting. This includes an assessment of the individual's preferences, interests, and adaptive behavior. ▪ Include in the PSP the date of completion of assessments. ▪ Complete an assessment of risk based on objective data provided by the appropriate discipline. ▪ Based upon information gleaned through comprehensive assessment, design teaching objectives to meet the needs and preferences of the individual. Objectives should promote the growth and greater independence of the individual. A total of 44 Specific Program Objectives, representing 12 individuals (i.e., Individual #183, Individual #353, Individual #325, Individual #427, Individual #97, Individual #326, Individual #380, Individual #140, Individual #159, Individual #194, Individual	

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		#33, and Individual #19) were reviewed. Each was analyzed with regard to specifications outlined in the Settlement Agreement monitoring tool. The findings are summarized below: ▪ Where appropriate, a complete task analysis was present in only five of the objectives (13%). 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 might require a greater number of smaller teaching steps to master a complex skill. Others might learn the same skill when it is broken into fewer, but larger steps. ▪ All of the objectives (100%) noted a schedule for training and for data collection. Twenty-six (59%) of the objectives indicated that training would take place daily, or five days per week. 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 five of the 44 objectives (11%) 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. ▪ Five of the 44 objectives (11%) identified a discriminative stimulus related to the skill. The others provided no clear stimulus that would cue the individual to engage in the response. ▪ The consequence for correctly performing the identified skill was noted in 37 of the 44 objectives (84%). The identified reinforcer for correct performance of a skill was praise in 33 of these 37 objectives (89%). 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. The remaining four objectives in which a consequence was noted included: praise and a touch; praise and soda; and praise, star chart, and weekly paycheck (two objectives). ▪ Consequences for incorrect responding were identified in none of the objective (0%). In several plans, staff were advised to allow the individual to calm if he/she refused to participate or became agitated. An attempt to continue with the activity was advised once the individual was calm. ▪ None of the objectives (0%) included instructions for ensuring that maintenance and generalization of newly acquired skills occurred. A total of 152 Training Objective Data Sheets, across 21 individuals, were reviewed. Data sheets noted the objective, the materials needed, and the reinforcer to be applied for	

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		correct responding. Multiple concerns were raised during this review, including the following: ▪ Data often reflected an individual's refusal to participate, yet there was no indication that any action had been taken to address this active refusal. Examples included Individual #351 who refused to participate for one month when asked to turn his head when his name was called, and Individual #325 who refused to attend work for three consecutive months. ▪ For other individuals (e.g., Individual #353, Individual #78, Individual 118, and Individual #194), data reflected infrequent opportunities for training across consecutive months. Limited learning opportunities will impede the acquisition of new skills. ▪ Individual #353 was learning to lift her arms during dressing. In the reinforcement note, staff were advised to remind this individual that the more she worked, the more money she would earn. This same advice was included in an objective addressing dental care. As neither objective related to work activities, it is difficult to understand the relevance of this statement or this strategy. ▪ Individual #284 had two training objectives in the workshop area. Notes from five of the six data sheets provided indicated that she performed well and was a good worker. Staff should consider a revision of her work objectives to ensure that she continues to develop greater skills. ▪ Individual #199 was learning to choose between two items and to open his mouth when a suction toothbrush was used. In the first objective, task #1 was listed as "DSP will bring/present two different items…" Although this refers to staff behavior, data was recorded. In the second objective, data was recorded on the following: "Nursing staff will ask (individual) to open up his mouth." Data should be recorded on the observable behavior of the learner, not the teacher. ▪ It was not always clear what observable behavior was being measured, because no operational definition was provided of the identified skill. For example, Individual #97 and Individual #326 were both learning to "participate" in "sensory and magazine reading," and "turn taking," respectively. Participation was not described in observable and measurable terms. ▪ Individual #389 was learning to work for 30 minutes without prompting. There was no explanation provided as to whether pauses in working were acceptable, and although data was recorded for 30 minutes, data also was recorded for 40 and 60 minutes. With measures collected for longer work durations, the purpose of the objective was unclear. ▪ Similarly, Individual #19 had an objective designed to teach him to make a request 30 minutes prior to leaving work. Data was collected at 10, 15, 20, 25, and 30 minutes. It was unclear what behavior was being measured across these multiple intervals of time. This same data sheet often included two codes within	

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		one block of time. For example, at the 10-minute interval on 9/12/11, the codes for a verbal prompt and refusal were circled. Interpretation of this data was difficult. In general, objectives did not provide for a clear understanding of the observable behavior the individual was to exhibit, nor were there sufficient opportunities for learning to occur. At the time of the visit, there were no measures collected to ensure interobserver-agreement. In sum, it is important that training guidelines provide clear and comprehensive information that includes a clear description of the expected outcome, the conditions under which the skill will be learned, and the strategies that will be applied to ensure learning. Plans also should be included to ensure that the individual maintains newly acquired skills and learns to use these skills across all appropriate situations and environments. Graphic display of skill acquisition measures would help clearly identify progress or the lack thereof. When there is consistent refusal by the individual, a lack of progress, or skill regression, members of the team should investigate the reason, and, as appropriate provide staff with additional training and/or supervision, and/or revise the training objective to ensure that learning takes place. As necessary and appropriate, psychology staff should provide behavioral support during this process. The Facility was in the process of introducing a new format for developing Skill Acquisition Plans. The template and three samples were provided for review. The new format included: a) an operational definition of the behavior to be exhibited; b) a rationale for the identified goal; c) the source for identifying the goal; d) identification of the training location, both on and off campus; e) the schedule of training; f) materials needed; g) special instructions; h) teaching techniques, including consequences for correct and incorrect responding; i) staff responsible for training and data collection; j) instructions for data collection; and k) plans for maintenance and generalization of the newly learned skill. While the new format provided an improved version of a Skill Acquisition Plan, there are several areas for staff to consider, including; ▪ In the examples provided, the schedule of training remained quite lean. For the dressing example provided, training was to occur once daily. In the vending machine example, it was unclear whether the training would occur one time each day, or only on the three days that data was collected. For the third sample objective, the opportunity to shop in the community was limited to one time per month. It is suggested that such limited training opportunities will impede the acquisition of new skills. ▪ A clear discriminative stimulus was not identified in two of the samples. Staff	

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		were advised to talk to the individual who was learning to dress, and they were advised to ask the individual whether she wanted to go shopping. It is recommended that a specific instruction or some other discriminative stimulus be presented that will set the occasion for the behavior to occur. If the stimulus is presented in question format, staff must be prepared for the individual to decline participation. ▪ In the special instructions for the vending machine example, staff were advised to question the individual if she did not put enough coins in the machine to purchase a soda. One suggestion to help develop the individual's independence would be to teach her to refer to a stimulus card depicting the item and the corresponding coins needed to purchase the item. This would increase her ability to independently complete this activity. ▪ Under teaching techniques, reference is made to the learner showing competence. It will be important to ensure that "competence" is clearly defined in observable and measurable terms in each plan. ▪ Consequences for correct responding should include consideration of tangible items, as praise, particularly when delivered by unfamiliar or non-preferred staff, might not always function as a reinforcer. ▪ In one sample, consequences for incorrect responding referenced allowing the individual to calm. This behavior should be clearly defined for the specific individual in this specific situation. In the other two samples, direct support professionals were to repeat the trial and increase their level of assistance. ▪ In the dressing sample, staff were directed to conduct training in the morning when the individual prepared for the day. However, they were directed to record the data in the afternoon. Data should be recorded at the time the skill is demonstrated or shortly thereafter. Reliance on recall several hours later compromises the accuracy of the data recorded. ▪ While plans for maintenance and generalization were addressed in this new format, these did not include guidelines for data collection, nor did they provide a level of specificity regarding generalization settings and situations. Similar to past visits, 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 23 PLACHECKS were collected in the residential environments. Engagement ranged between 0% and 100%, with a mean of 33%. ▪ Nine PLACHECKS were collected in the workshop areas. Engagement ranged between 67% and 100%, with a mean of 81%.	

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		▪ Lastly, in the day habilitation settings, a total of 12 PLACHECKS were conducted. Engagement ranged between 33% and 100%, with a mean of 47%. Observations of appropriate engagement included the following: ▪ On three occasions, individuals were observed participating in domestic activity in their residences. Individual #406, Individual #99, and Individual #194 were all observed helping to set the table in preparation for mealtime. ▪ In the workshop areas, Individual #49 was shredding and bagging paper material, and Individual #194 was very attentive to her task as she prepared mailings. ▪ In one unit, a woman was participating in a physical workout as she watched a video of "chair exercises." Although she was the only one of 14 individuals who was actively engaged, she clearly seemed to be enjoying herself. ▪ Fifteen individuals were observed in the chapel as they engaged in choir practice. Engagement was quite high with positive affect displayed by those involved. As noted in the first two reports, several concerns were raised: ▪ The materials used in the workshop areas were often in poor condition. Individuals were observed in workshop areas bundling worn pamphlets, stuffing well-used envelopes, or packaging plastic silverware in old plastic bags. Many of the pamphlets were the same as what had been observed on previous visits. ▪ While stuffing envelopes, bundling materials, or assembling packages can all be purposeful work activities, individuals were often observed completing these tasks only to have their work disassembled in front of them. Individual #87 was observed removing a bundle from a bin, re-bundling a random number of pamphlets, and returning these to the same bin. This resulted in repetitive busy work without a clear beginning, end, or purpose. ▪ In another workshop, a staff member was observed tossing work materials (i.e., non-shank toothbrushes) to Individual #406 who was seated approximately five feet away. This was an inappropriate manner in which to present task materials. ▪ When efforts to teach were observed, teaching strategies were often applied inconsistently. For example, when trying to teach Individual #288 to learn a bundling/packaging task, the staff member handed the individual one pamphlet at a time and then completed the task for the individual. The individual was not seated squarely at the table, he was not required to look at the materials, and he was not learning to complete the task independently. As noted in the last report, many of these tasks can be taught as routines in which the individual learns to complete a task sequence by moving from left to right. 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	

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		reinforcement to ensure that the individual was appropriately motivated and rewarded for engaging in the activity. ▪ Observations of day habilitation programs revealed frequent use of arts and crafts materials to keep individuals busy. Staff were often completing most of the steps in the task, while prompting some participation from the individual. On two days in one day habilitation program, Individual #124 was observed crouched on the floor, tearing cardboard into pieces, and then shoving the pieces under a table. When staff were asked about this activity, they explained that this was what the individual liked to do. Clearly the staff had accepted this as behavior that should be allowed within the day habilitation setting. ▪ In one residence, Individual #219 was observed manipulating material. When the staff member was asked about this activity, he explained that the individual did not like to wear long sleeved shirts. As a result, staff cut the shirtsleeves and provided the individual with the remnants. The individual was observed placing the sleeve on top of his head, wrapping it around his hand, and using it to tie his arm to the chair. None of these were appropriate activities, yet the staff response indicated not only an attitude of acceptance, but also one of support as they provided the material. ▪ As noted previously, while visiting in the residences, individuals were often observed sitting idly, waiting for a meal or the next transition. ▪ In Residence 501, individuals were observed in the living area. A movie was playing on one television, an individual was banging his hands against another television that was tuned to a different show, and a staff member was tapping a tambourine in front of another individual. The competing noises created an uncomfortable environment that did not support skill development or meaningful activities. 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. During previous visits, the Director of Active Treatment provided a template for measuring engagement. During this onsite review, she explained that the QA Department was now collecting this data. It was unclear how this data was being used to help improve staff-to-individual interaction or the quality of activities available to the individuals. PLACHECKS can be a very useful tool for training staff. Although the data gathered can be a helpful tool for administrative staff to assess progress in providing appropriate supports and services to the individuals served, PLACHECKS can serve an even more useful purpose through staff training. When PLACHECKS are conducted, it is	

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		most helpful if immediate feedback is then provided to the staff who were observed working with the individuals served. Staff should receive specific praise when engagement is appropriate. By stating clearly what was working, there is a greater likelihood that this will be repeated in the future. When engagement scores are low, supervisory staff are afforded an opportunity to provide staff with feedback on specific steps to take to improve engagement. A review of 22 Individual Notebooks (I-Books) was completed on site in one day habilitation setting and across seven residences. In 15 of these books (68%), the PSP had been completed within the last 12-month period. Of the remaining seven books, five contained PSPS from 2010 and two had no PSP included. Sixteen of these 22 individuals were noted to have current PBSPs. The I-Books for 10 individuals (63%) contained plans developed within the previous 12 months. The remaining six books included three with plans from 2009, two with plans from 2010, and one in which the plan was missing. As noted previously, if I-Books are going to serve as a reference for staff to help with comprehensive and accurate implementation of habilitation and behavior support plans, it is essential that these be kept current. I-Books were not consistently available in day program sites and on at least one occasion, the I-Books were found in the residence although no individuals were present. As these books also contained data sheets for tracking skill acquisition and problem behavior, it is important that they accompany individuals as they move from environment to environment. The Active Treatment Department had developed an Activity Tote System designed to support the provision of active programming. This system allowed for the distribution of material to provide a range of activities for individuals in their residential environments. Materials included: DVDs, CDs, reading materials, colognes, exercise materials, various grooming items, massagers, and balls. Staff were provided guidelines for activities and were able to request replacement material as needed. While staff reported a very favorable response to this tote system, use of the materials was evident in only one residence during the onsite review. With 63 individuals, or 18% of the population of AUSSLC, identified with a severe visual impairment, it is recommended that the Facility either hire or contract with an orientation and mobility specialist, and/or teacher of the visually impaired to ensure that all staff are trained in appropriate supports for these individuals. While care is taken to address the needs of individuals who have physical disabilities or other sensory impairments through physical, occupational, and speech/language therapies, it appeared that no special considerations were provided for those who experienced blindness or limited vision. Specialized supports are appropriate and would contribute to ensuring that adequate habilitation services are provided to these individuals.	

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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.	A total of 12 Personal Focus Assessments (PFA) were reviewed. The format was designed to help understand the preferences of the individual across a range of environments and domains. While the tool can be useful in better understanding what will be necessary to meet the wants and needs of the individual, the sample reflected problems with its implementation. Specific concerns with individual examples are provided below: ▪ There was often a lack of clarity regarding supports that would be necessary to meet the individual's needs. For example, "Everything is already in place for Individual #183" was noted under environmental adaptations. Similarly, the PFA for Individual #353 noted that staff knew how to communicate with her. Neither gave clear details as to how best support the individual. ▪ For others, the information that was provided was limited to one word or very brief responses (e.g., Individual #325, Individual #30, and Individual #97). The PFA for Individual #326 was missing essential information related to OT/PT, Speech/Audiology, and Medical/Health. ▪ Identification of assessments necessary to identify the individual's strengths and needs was often limited or absent (e.g., Individual #30, Individual #97, and Individual #326). ▪ Notes for Individual #19 indicated that he wanted to learn to cook, he wanted to move to the community, and he did not like workshop. Although his preferences appeared to be clearly recognized, the related, necessary assessments were limited to kitchen skills, community participation, and vocational assessment respectively. Missing were assessments of food storage and preparation, community traffic safety and awareness, and occupational interest inventory. As noted, the Personal Focus Assessment covers a range of critical aspects of living. If these assessments were completed to ensure a comprehensive portrait of the individual and his/her wants and needs, these would be more useful in guiding an appropriate Personal Support Plan. Since the Monitoring Team's last visit, the State had identified for use a new assessment of adaptive behavior, the Functional Skills Assessment (FSA). As noted in the Facility's Plan of Improvement for Section S, training on the tool occurred in July of 2011. Implementation of this assessment began immediately afterwards. The FSA provides for an assessment of 13 areas, including: dressing skills, restroom skills, hygiene and grooming, communication, social skills, domestic skills, dining skills, academic skills, leisure, campus/community awareness, telephone skills, adaptive equipment, and community living. The individual's ability to perform identified adaptive behaviors is noted, along with the level of prompting needed to perform the skill. The code "other" is used if the person is too resistant to the task, if he/she cannot physically perform the task, if the skill cannot be safely assessed, or if necessary materials were unavailable.	Noncompliance

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		Once completed, a summary of strengths and needs is recorded with recommendations provided. A total of seven completed assessment were provided for review. Findings are outlined below: ▪ Six of the seven assessments (86%) were dated. It will be important to include the date the assessment was completed so that the individual's progress over time can be determined. ▪ Components of all 13 sections were completed for one of the seven individuals (14%). For the remaining six individuals, dining was not assessed for one individual who was fed through a g-tube, telephone skills were not assessed for four individuals, adaptive equipment was not assessed for three individuals, and community living was not assessed for two individuals. When skill areas are not assessed, it would be helpful if a reason for this omission were provided. ▪ A summary of strengths and needs was provided for only two of the seven individuals (29%). For Individual #353, the summary was difficult to read, because words were cut off in the printed copy of the assessment. For Individual #189, a very brief summary (e.g., requires total assistance, gestures) was provided for seven of the 11 areas assessed. No summary was provided for the other five individuals (71%). ▪ For none of the seven individuals (0%) were recommendations made regarding adaptive behavior needs. While this sample of Functional Skills Assessment proved to be more comprehensive than samples provided during previous visits, staff should ensure that assessments are used to guide the development of appropriate skill acquisition programs. Without a comprehensive summary of strengths and needs, with corresponding recommendations, the utility of the assessment process is severely limited. At the PSP meeting held for Individual #357 the week of the onsite review, the Monitoring Team observed a discussion regarding skills to teach the individual to help her become more independent. There was no reference to any assessment of her current adaptive behavior skills. Staff should ensure that completed and current assessments are reviewed at the individual's PSP meeting. Similar to the steps taken to improve the assessment of adaptive behavior, the State had identified a new assessment of vocational skills. In July 2011, the Facility had trained staff to use this new tool, Vocational Assessment – State Supported Living Center. Following training, it had been put into practice. The assessment began with an introductory summary regarding the individual's vision, preferences, work history, strengths, barriers, needed supports, ideas for the future, and recommendations. Eight areas were then assessed in greater detail, including: communication skills, physical characteristics, strengths and barriers, vocational characteristics, safety awareness/skills, work preferences, work history, and vocational exploration. Twelve	

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		completed assessments were reviewed. The depth of information provided varied across individuals, with the most comprehensive assessment being for those who had good verbal skills and could contribute to the information gathered. As staff at the Facility continue to complete these assessments, they should expand their recommendations to include a greater variety of work environments and activities, and to make an attempt to explore work options beyond the individual's current work placement.	
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	The physical environment observed during the onsite review did little to support the habilitation needs of the population served at AUSSLC. Other than the computer lab and the chapel, most environments were poorly furnished, poorly decorated, and often unclean. These environments reflected limited expectations for growth and development for those who resided at the Facility. Specific observations are described below. ▪ Observations in one residence revealed bedrooms with clothing piled in a corner on the floor, dirty windows, curtains tied in a knot, and doors that were difficult to close. ▪ Another residence revealed a closet containing broken sunglasses, empty plastic bottles, and a plastic bag. In this same residence, the curtain in one individual's bedroom was being held up with a clothes hanger. One of the bathrooms had no door. In one bathroom, the light flickered constantly and the fan emitted a loud sound. ▪ The kitchen of one residence revealed a dirty microwave oven, a cabinet with dead bugs, and an oven seal that was frayed. ▪ Two residences, 501 and 772, had been closed during past visits and should not have been re-opened as residences. Both were poorly designed and were not at all homelike. ▪ Another residence had the number painted on the door and the name of the unit written on the side of the building. Both looked more like graffiti than address labels. Because of the physical plant of the Facility, AUSSLC is clearly not the most integrated setting for the development of a range of skills, such as many of the independent living	Noncompliance

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		skills that would be taught in community programs, such as cooking, home and yard maintenance, community safety skills, interactions with neighbors, etc. However, there are changes that can be made to the environment to support individual habilitation. Living, working, and day habilitation settings should be designed to present a welcoming and supportive environment. Individuals should be provided access to a variety of materials and tasks that meet their interests and needs, and when appropriate, they should be encouraged to participate in all daily activities. The Facility had introduced two new assessment tools that should help ensure a more comprehensive understanding of strengths and needs specific to the individual. Staff should make every effort to ensure these are completed in full, with summaries of current performance levels and recommendations for programming provided. Based upon the review of the documents provided by the Facility, training objectives remained limited in scope. Programs were not written clearly, effective teaching interventions were not provided, and schedules did not allow for sufficient opportunities to master the identified skill. With only one individual working in an integrated community setting and no training occurring in the community (as reported by the Director of Active Treatment and the QDDP Coordinator), the Facility was not meeting its own policy of providing training in the most integrated setting. As noted previously, it will be important for the Facility to explore training opportunities beyond the boundaries of the campus. As noted in the last report, there is a need to balance an individual's right to freedom of choice with the Facility's responsibility to provide services and supports that will promote growth and greater independence. Although an individual might prefer engaging in repetitive, nonfunctional activities, it is the Facility's responsibility to ensure that continued efforts are made to teach the individual more interesting and meaningful leisure, work, and home skills. When individuals refuse to participate in self-care, habilitation, or work activities, it is the Facility's responsibility to design programs that will help motivate the individual to learn. The refusal might be due to lack of skills, lack of interest, or some other variable that must be addressed. 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. Based upon the Monitor's review of I-Books and Specific Program Objective data sheets, the implementation of skill acquisition plans was not adequate. When data was provided, it was limited to one trial. Due to missing data, limited opportunities for training, and participant refusal, habilitation training was not occurring on a regular basis.	

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	(b) Include to the degree practicable training opportunities in community settings.	As noted above, the Personal Support Plan for 32 individuals were reviewed. In only one case was community training identified. Individual #189 had two daily objectives related to shopping in the community. While documentation of trips to the community was provided, both the Active Treatment Coordinator and the QDDP Coordinator acknowledged that no training occurred in the community. Further, at the time of the visit, only one individual from the Facility worked in an integrated community setting.	Noncompliance

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

1. As the Personal Support Plan is the guiding document to ensure adequate habilitation services, it is essential that this be based on comprehensive and current assessment. The Personal Focus Assessment should be completed to ensure that the individual's strengths, preferences, and needs are clearly identified. (Sections S.1 and S.2)
2. To ensure that PSPs are developed to promote the growth, development, and independence of the individuals served, the following guidelines are recommended:
    a. Ensure that all necessary assessments are completed prior to the PSP meeting. This includes an assessment of the individual's preferences, interests, and adaptive behavior.
    b. Include in the PSP the date of completion of assessments.
    c. Complete an assessment of risk based on objective data provided by the appropriate discipline.
    d. Based upon information gleaned through comprehensive assessment, design teaching objectives to meet the needs and preferences of the individual. Objectives should promote the growth and greater independence of the individual. (Section S.1)
3. Skills identified for training following comprehensive assessment should be functional, age-appropriate, and matched to the individual's preferences. Skill development should span a range of adaptive behavior domains, including self-care skills, communication skills, social skills, domestic skills, leisure skills, academic skills, vocational skills, and community skills. (Section S.1)
4. Once training objectives are identified, programs should be written to include the following information:
    a. A behavioral objective that includes a description of the conditions under which the behavior is to occur, a description of the behavior in observable and measurable terms, and the criteria used to determine mastery;
    b. A schedule for training including the number of trials to be provided (ensure that the schedule provides sufficient opportunities for learning to occur);
    c. The setting in which training will take place;
    d. Specific materials needed;
    e. Guidelines for teaching, including the discriminative stimulus, prompting strategies, fading of prompts, task analysis where appropriate, and the implementation of shaping and chaining strategies;
    f. Identification of reinforcers, incorporating the results of formal preference assessments;
    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)
5. Preference assessments are recommended to ensure that potentially effective reinforcers are incorporated into all training objectives. (Section S.1)
6. 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)

7. When there is consistent refusal by the individual, a lack of progress, or skill regression, members of the team should investigate the reasons, and, as appropriate, provide staff additional training and/or supervision, and/or revise the training objective to ensure that learning takes place. Psychology staff should be involved to help design programs to improve participation be it through change in presentation, choice in activity, or something similar. (Sections S.1, S.2, and S.3)
8. To promote adequate habilitation and skills training, individuals should have access to materials that are of interest to them, that are in good condition, 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)
9. 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)
10. The Facility should take concrete steps to raise staff's level of expectation for the individuals served at AUSSLC. A review of the philosophy that all individuals have the ability to grow and develop, as well as the principles of normalization and social role valorization is strongly recommended. (Sections S.1 and Section S.3)
11. As recommended previously, staff should expand the variety of home, leisure, and vocational activities available to the individuals served. (Section S.1)
12. Administrative and support staff are encouraged to use PLACHECK measures to provide support and training to staff so that they are better able to teach and engage the individuals served. The provision of immediate, constructive is strongly recommended. (Section S.1)
13. Individual Books (I-Books) should be checked regularly to ensure that all necessary material is included and current. (Section S.1)
14. The Facility should expand its therapeutic services to include orientation and mobility services for those individuals who experience visual impairment. (Section S.1)
15. A plan should be developed to ensure inter-observer agreement measures are collected on all skill acquisition programs. (Section S.1)
16. The Facility should ensure that the new functional skills and vocational assessments are completed in full, including a summary outlining the individual's current level of performance and recommendations for future programming. (Sections S.1 and S.2)
17. 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)
18. With regard to its self-assessment, future monitoring should address individual training objectives and related documents. The Facility should use the results of monitoring, as well as review of other relevant data, to identify areas of strength, as well as areas needing improvement. Action plans should be developed and implemented as appropriate. Summary data, as well as descriptions of how the Facility used the data to improve the supports provided to individuals should be incorporated into the POI to substantiate the Facility's findings with regard to compliance and noncompliance. (Facility Self-Assessment)

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 current referrals for transition, dated 10/21/11; o List of individuals who have requested community placement, but have not been referred, dated 10/21/11; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed, since 5/16/11; o Since the last review, list of individuals who have not been referred for transition to community solely due to Legally Authorized Representative (LAR) preference, undated; o List of individuals who transferred to the community (excluding alternative placements), since 5/16/11; o List of alternate discharges, since 5/16/11; o List of individuals who transferred to other SSLCs, undated; o List of alleged offenders, undated; o Community Placement Report, dated 10/25/11; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o In the last 12 months, trainings/educational opportunities provided to individual, families, and LARs to enable them to make informed choices, undated; o Facility and MRA staff training curricula related to community living, transition and discharge, including training materials; o Since last onsite review, training/educational opportunities, resources provided, and documentation; o For the last 12 months, a list of individuals who have been assessed for placement, date of assessment, and resulting recommendations, undated; o A description of how the Facility assesses an individual for placement, 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 copy of the Community Placement Report; 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 #210, Individual #293, Individual #154, Individual #378, Individual #385, Individual #165, Individual #363, Individual #60, Individual #258, and Individual #368; o PSPs, Community Living Discharge Plans, sign-in sheets, and related assessments for: Individual #85, Individual #177, and Individual #320;

	o Community Living Discharge Plans, sign-in sheets, and related assessments for: Individual #339, and Individual #424; o In response to a request for, "For the three CLDPs submitted, the State Office review of these plans, the statement "None;" 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 #192, Individual #384, Individual #167, Individual #339, Individual #85, Individual #177, and Individual #320; o For the following individuals, discharge with reassignment (transfer summary): Individual #139, and Individual #217; o For the following individuals, drafts of CLDPs, and any related ISPAs: Individual #165, Individual #258, Individual #368, and Individual #74 (including the ISP and related assessments); 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 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 For the last one year period, list of individuals who have had police contact, psychiatric hospitalizations, unexpected Emergency Room (ER) visits or hospitalizations, unauthorized departures, transferred, died, and/or returned to the Facility, including brief synopsis of incident, from 10/1/10 to 10/1/11; o Draft ISP for Individual #50; o Training documentation for Individual #424's community provider staff; o Plan of Implementation for Section T; and o Presentation Book for Section T.

	▪ **Interviews with**: o Mary Birdsong, Admissions/Placement Coordinator; and o Sherrie Scarbrough, Post-Move Monitor. ▪ **Observations of**: o ISP annual review meeting for Individual #62; o Post-Move Monitoring Visits for Individual #424; and o Visits to various residences and day programs on campus.
	Facility Self-Assessment: Based on a review of the Facility's POI with regard to Section T of the Settlement Agreement, the Facility found that it remained out of compliance with the majority of the subsections. The five provisions that the Facility indicated it was in compliance with were T.1.c.3 (reviewing the CLDP with the individual and/or LAR), T.1.e (essential and nonessential services in CLDPs, and pre-move monitoring), T.1.h (submitting the Community Placement Report to the Monitor and DOJ), T.2 (post-move monitoring), and T.4 (alternate discharges). Although the Monitoring Team found compliance with Section T.1.h and T.1.c.3, it did not find compliance with the following: ▪ 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. None of the CLDPs included a comprehensive set of essential and nonessential supports. ▪ Section T.4, which requires the Facility to complete discharge planning for individuals with alternate discharges. The discharge/transfer summaries for individuals who transferred to other SSLCs were not of adequate quality. ▪ Section T.2, which addresses post-move monitoring. The Monitoring Team found concerns related to both the quality of the reviews, and the follow-up activities. Moreover, it was unclear why the Facility did not self-identify compliance with Section T.1.c.2. This required CLDPs to identify the staff responsible and dates for completion of action items in the CLDPs. Based on a review of the CLDPs developed since the last monitoring visit, the Facility was including this information consistently. The Facility's self-assessment processes should have included a review of this component of the Settlement Agreement. It should be noted that the POI included extremely minimal monitoring data, or other objective measures. 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. The POI also included three action plans for Section T. These addressed a tracking system for 45-day assessments, the development and implementation of policies for Section T, and implementation of the obstacles identification and analysis processes. All of these were in the implementation phases, and a number of the action steps were listed as "not started."
	Summary of Monitor's Assessment: Individuals' ISPs had begun to include determinations by professionals with regard to whether community placement was appropriate. Each assessor was now

	expected to include a specific recommendation regarding whether or not the individual could be supported in a less restrictive setting. Some assessments included such statements, but many did not. However, professional members of teams had begun to have these discussions, make recommendations to the individual and his/her guardian, and document the results in the ISPs. Since the last review, six individuals had transitioned to the community. At the time of the review, 18 additional individuals had been referred for transition to the community. As has been a consistent finding in all of the Monitoring Team's previous reports, individuals' ISPs 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 ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. IDTs 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. However, teams still did not consistently identify the full array of essential and nonessential supports that individuals needed to transition safely to the community. This placed individuals at risk, and jeopardized their successful transitions. However, improvement was seen in the measurability of the supports. Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. Efforts 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. However, issues were noted with regard to both the quality of the reviews, and the follow-up activities necessary to ensure that supports and services were provided.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take	As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification	Noncompliance

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	action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any individual's move to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's ISP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. 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. Once an individual's team referred him/her for community placement, transitions generally 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 t the time of the review, at AUSSLC, three individuals had exceeded this timeframe, one by only a few days. The remaining two had significant behavioral concerns that required careful planning, and identification of a community provider who could offer supports to ensure the individuals' safety, as well as their growth and development. As is discussed in further detail with regard to Section T.1.g, although obstacles to individuals' transition to community settings had not been fully identified and analyzed on a systemic level, anecdotally, the availability of community providers who could support individuals with complex behavioral needs appeared to be an issue. The Monitoring Team agrees wholeheartedly with the teams' decisions not to transition individuals until an appropriate configuration of supports and services was identified. However, this likely is an area in which more systemic attention is needed from DADS State Office. At the time of the review, some assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community. In addition, individuals' some ISPs generally included a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate. Based on a review of 10 ISPs (including those for Individual #210, Individual #293, Individual #154, Individual #378, Individual #385, Individual #165, Individual #363, Individual #60, Individual #258, and Individual #368), for four of the 10 PSPs reviewed (40%) (i.e., Individual #165, Individual #210, Individual #258, and Individual #293), the team had documented a determination of the professionals regarding whether or not transition to the community was recommended. Within the overall sample of 10, two individuals' teams had referred them for transition to the community without delineating the professional team members' joint recommendation (i.e., Individual #154, and Individual #368).	

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		With regard to the requirement that "the transfer is not opposed by the individual or the individual's LAR," for two individuals (i.e., Individual #210, and Individual #293), the professionals on the team jointly agreed that the individual could be supported in a less restrictive environment. However, the individuals' guardians were reluctant/opposed, so a referral was not made. Since the last review, six individuals had transitioned to the community. At the time of the review, 18 additional individuals had been referred for transition to the community.	
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, but rather a statement that: "In process not completed." In its POI, the Facility indicated that as of 7/28/11: "Three sections of the facility policy have been modified and updated in accordance with the state policy on Most Integrated Setting." However, no policies were submitted for review. It was anticipated that DADS would issue a revised policy on Most Integrated Setting soon. Several months ago, 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 will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs	In a review of 10 recently developed ISPs, a number of different formats were used. However, the ISP formats generally included a section entitled the "Living Options," or "Optimistic Living Vision for…" This section included discussion regarding the individual's and his/her LAR's awareness of community options, their preferences for a specific living option, obstacles that the IDT identified, and the supports and services the individual needed in various areas. The findings related to the review of 10 ISPs are discussed below with regard to the two requirements included in this provision, including: 1) the identification in the ISP of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles. <u>Identification in ISPs of Needed Protections, Services, and Supports</u> As was discussed with regard to Section F of the Settlement Agreement, individuals' ISPs	Noncompliance

#	Provision	Assessment of Status	Compliance
	and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	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. Some of these issues were due to the fact that thorough and adequate assessments were not being completed (e.g., nursing, psychiatry, functional skills, physical and nutritional management, communication, vocational, etc.), services and supports were not being adequately integrated with one another (e.g., psychology and psychiatry, and psychology and dental/medical, etc.), and/or adequate plans were not being developed to address individuals' preferences, strengths, and needs (e.g., nursing, psychiatry, psychology and habilitation, physical and nutritional supports, and communication). As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services. This is important for three reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them, as well as potential providers, to have a clear idea about what protections, supports, and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; 2) given the extensive histories of many individuals the Facility serves, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that 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. When all of the necessary protections, supports, and services are not outlined in the ISP, it is much more difficult to ensure the individual's safe transition. Based on a review of 10 ISPs, none of the plans reviewed (0%) included a comprehensive list of the protections, supports, and services needed to support the individual. Often this appeared to be due to staff's assumptions that supports were being provided at the SSLC, and that they did not need to be spelled out in detail. In other instances, the continuing deficits in assessments from various disciplines appeared to stymie the teams' ability to create a comprehensive list. In other instances, the lack of integration across disciplines and lack of incorporation of the various plans (e.g. PBSPs, PNMTs, health care plans, psychiatric treatment plans, communication plans, etc.) continued to result in incomplete ISPs. Previous reports have provided detailed examples of concerns related to ISPs. The Facility is encouraged to review the Monitoring Team's previous reports in relation to Sections F and T of the Settlement Agreement, as well as to critically analyze recent transitions to the community, and identify supports that were missing from ISPs and CLDPs.	

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		Identification of and Plans to Overcome Obstacles to Transition to Community As noted above, the ISP format included a section on obstacles that the IDT identified. In addition, the State Office had standardized a list of obstacles/barriers to community transition to assist in the analysis of information collected from IDTs throughout the SSLC system. The State Office had issued the list in April 2011. According to the Admissions Placement Coordinator and documentation provided, on July 29, 2011, IDT members were provided training on the Obstacles List. In reviewing the sample of 10 ISPs, teams had discussed some obstacles. Of the 10 ISPs reviewed, six should have had obstacles defined, because four of the individuals had been referred to the community. Of the six plans, one (17%%) included an adequate list of obstacles (i.e., Individual #210). The problems associated with the obstacles in the plans included the following: ▪ They did not conform with the State Office's standardized list (e.g., for Individual #293, Individual #385, and Individual #378, the narrative identified guardian reluctance, but this was not formally identified as an obstacle; and for Individual #363, "at-risk" issues was listed as the obstacle); and ▪ When guardians or individuals objected, adequate inquiry did not occur with regard to specifically what their concerns were. Moreover, action plans to overcome the obstacles identified generally were not present, and, when they teams had developed them, they were not adequate. Of the six ISPs, one (17%) included an action plan to overcome obstacles identified. The ISP for Individual #210 cited his LAR's reluctance to have him transition to the community as the obstacle, and further defined this as her concerns related to his behaviors. The team listed implementation of his behavior plan, including the Safety Plan as the plan to overcome the obstacle. The team did not include further research of options that might meet his needs, or education of his mother of options available for supporting individuals with complex behavior needs. The Monitoring Team has provided numerous examples in previous reports regarding the concerns related to the identification of obstacles, and the lack of plans to overcome them. The Facility is encouraged to review the previous reports. Compliance with 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. As is discussed with regard to Section F, efforts were underway to improve the ISP process. However, at the time of this most recent review, minimal improvement was seen in these areas. The Facility remained out of compliance with this provision.	

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	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 (LA), 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. This event was discussed in detail in the last report. ▪ On 7/19/11, the Local Authorities provided training to IDT members. By informing staff more about community options, IDTs had the potential to provide additional information to individuals, their LARs, and families. ▪ The Local Authorities had developed a picture book especially for individuals living at AUSSLC. This book was used to help individuals understand more about community living. ▪ 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. ▪ 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 at times, individuals shared their personal experiences with visits to community programs, or transition processes. As discussed in previous reports, the most challenging area with regard to education of individuals and families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. The Optimistic Living Vision section of the 10 PSPs was reviewed, and for six, no referrals were made. In none of the plans (0%) was the need for further education identified, or an adequate written action plan included. Generally, the problems included: ▪ As noted above, narratives of the plans often listed guardian resistance as an obstacle. However, the reasons for this were not explored, and, as a result, no actions were developed to individualize information provided to attempt to	Noncompliance

#	Provision	Assessment of Status	Compliance
		specifically address guardian concerns. ▪ Even when specific concerns related to an individual or guardian's resistance were noted, no action plans were developed to provide further individualized education or support (i.e., for Individual #210). 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. As the Admissions Placement Coordinator mentioned, it would be helpful to assist individuals at the Facility to maintain relationships, and, as appropriate, visit friends who have moved to community settings. 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 Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	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 a list of individuals who had been referred for transition to the community. In response to request for: "A description of how the facility assesses an individual for placement," a statement was submitted that read: "There is no assessment for transition to the community. At the individual's annual PSP meeting or at PSPAs called especially to review living options for that individual, the PST determines what supports and services are needed to assist that individual to achieve or move closer to their optimal vision for life." This document went on to describe the requirement that two statements be added to the assessments/summaries completed by each discipline prior to each annual ISP. They included: ▪ Based on the identified needs of the individual, a statement regarding whether or not the assessor/author believed that such supports and services could be provided in a less restrictive setting. ▪ A statement that: "In my professional opinion, I feel that (name of individual) can/cannot be served in a less restrictive setting." If the answer to either of these questions was that the individual could not be served in a less restrictive setting, further information needed to be provided regarding the reasons why not.	Noncompliance

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		As is discussed above with regard to Section T.1.a of the Settlement Agreement, for four of the 10 PSPs reviewed (40%) (i.e., Individual #165, Individual #210, Individual #258, and Individual #293), the team had documented a determination of the professionals regarding whether or not transition to the community was recommended. Of note: ▪ In reviewing the related assessments, many of the assessments, even for those ISPs for which the professionals had documented their overall recommendation, did not include the statements that State Office was requiring. ▪ Within the overall sample of 10, four individuals had been referred for transitions, and two of these four individuals' teams had referred them without specifically delineating the professional team members' joint recommendation (i.e., Individual #154, and Individual #368). ▪ For two individuals (i.e., Individual #210, and Individual #293), the professionals on the team jointly agreed that the individual could be supported in a less restrictive environment. However, the individuals' guardians were reluctant/opposed, so a referral was not made. Although improvement was seen with regard to this provision, the Facility remained out of compliance.	
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:	At the time of the last review, AUSSLC was in the initial stages of implementing the new Community Living Discharge Plan process. Since then, the Facility had continued to use the new format. Although progress had been made, particularly with regard to documentation related to the selection of appropriate community providers, the CLDPs continued to need significant improvement. In the previous compliance report, the Monitoring Team made a number of recommendations regarding the revised CLDP format. Based on discussions with State Office staff, it appeared that the State Office, working in conjunction with the SSLCs, was in the process of making additional changes to the format. The recommendations previously made will not be repeated here, but can be referenced in the last report. Community Living Discharge Plans were reviewed for five individuals (i.e., for Individual #424, Individual #339, Individual #85, Individual #177, and Individual #320). This represented all of the CLDPs that had been finalized since the last review. In addition, the Monitoring Team reviewed the draft CLDPs for four additional individuals (i.e., Individual #165, Individual #258, Individual #368, and Individual #74). These were in the very initial stages of development. With regard to the timeliness of the Community Living Discharge Plans, five (100%) included documentation to show that they were developed sufficiently prior to the individual's transition. This was determined based on the narrative, and the information	Noncompliance

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		included in the CLDP regarding the team's deliberations and discussions, for example, regarding essential supports. Based on this information, it appeared the five individuals' planning had occurred over a sufficient period of time. As noted previously, noting the various dates on which the team revises a CLDP either on the first page or in the footer of the document would be beneficial. Documentation, either in the CLDPs or in ISPAs, also should be maintained to show the details of the ongoing development of the CLDPs between the time of referral and the individual's transition. It was noted in reviewing the four draft plans that the teams had done minimal work in listing essential and non-essential supports. One of the benefits of a lengthier CLDP development process should be to better define these supports on an ongoing basis. Although some of the teams had begun to list supports, the drafts continued to show a lack of understanding of the extent of and detail with which support needed to be defined. As is discussed in greater detail below, the essential and non-essential supports continued to be inadequate. The Facility should begin using the pre-transition time to more effectively define these supports. With regard to the timeliness of the development of CLDPs, the Facility had made significant progress. However, as is detailed in further detail below, the Facility was not yet in compliance with developing and implementing adequate CLDPs.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individual to the community. However, none of the five plans reviewed (0%) clearly identified a comprehensive set of specific and measurable steps that Facility staff would take to ensure a smooth and safe transition. When such steps were identified, they often were not sufficiently detailed or measurable. Some examples of the general concerns noted included: ▪ The plans sometimes identified the need for training for community provider staff. However, they did not define which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or what level of mastery of the information was required (e.g., classroom training, demonstration of competence, etc.). ▪ Although Individual #339's and Individual #424's CLDPs made some attempt to do this (i.e., related to the need for staff to demonstrate competence), generally, the plans did not specify the method of training, for example, if it would be necessary for community provider staff to shadow AUSSLC staff, and/or show competency in actually implementing a plan, such as a PBSP, nursing care plans, etc. For some individuals, specific components of their ISPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an essential support), or, at a minimum, evidence should be	Noncompliance

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		required that the community provider staff have the competencies necessary to safely support the individual. The plans that had attempted to address this issue did not provide sufficient detail regarding the specific competencies to be demonstrated and/or the methodologies. In other words to say that: "Provider staff should be trained on the CLDP, BSP, and Special Considerations… Training should be competency-based and indicate how competency was demonstrated" is too subjective. A significant amount of information is included in the CLDP, for example, and as a result, such a statement makes it unclear to which competencies the action step is referring and/or what the expectations would be with regard to "competency-based" training. It also should not be left to the community provider to determine the appropriate competency measure. The IDT should define the measure(s). As requested, the Facility provided an example of training documentation for Individual #424's community provider staff that had been described as competency-based training. Based on the documentation, no evidence was found of competency-based training. The training rosters generally showed that staff had sat through training sessions, and then were asked to sign the sign-in sheets confirming that they understood the material, and had had the opportunity to ask any questions. For a couple of items (e.g., level of supervision, choir participation, exercise program, and Special Considerations), the sign-in sheets indicated staff provided verbal confirmation of their understanding. Although many of the topics covered in the training should have required staff to demonstrate their skills and/or knowledge, no indication was provided of this level of competency-based training. ▪ Missing from the plans was any requirement that collaboration occur between the Facility clinicians currently working with the individual and the community clinicians who would assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, psychiatrists, etc.). For many individuals, this would be necessary to ensure ongoing coordination of care. ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff. ▪ The plans did not describe AUSSLC's staff's involvement in evaluating potential sites at which individual would be served. Examples of this depending on the needs of the individual would include Habilitation Therapies staff ensuring adequate accessibility and/or equipment, Behavioral Services Department staff determining if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment. ▪ The plans did not address any role that AUSSLC staff or community provider staff might play in assisting the individual to make the transition. For example, it	

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		was unclear if consideration had been given to the need for AUSSLC staff to follow the individual into the community for any period of time (e.g., the first day or longer), or to check in by telephone or in-person on occasion. Likewise, action steps might need to be included in the CLDPs for community provider staff to visit the individual at AUSSLC. Different individuals have different reactions to transitions. However, teams should be cognizant of the stress that transition can cause, and should build mechanisms into CLDPs to reduce this to the extent possible. The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. 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. The Facility remained out of compliance with this provision.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	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 and/or title (e.g., for direct support professionals) in five out of five 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/or their guardians prior to discharge. For five of the five plans reviewed (100%), sign-in sheets were provided that confirmed the presence of the individual and his/her guardian. As discussed above, the new CLDP format requires that teams meet multiple times to complete various portions of the transition process. This is a positive development. To ensure continued compliance with this provision, it is recommended that the Facility maintain with the CLDP document sign-in sheets that show the attendance at the various meetings held.	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	This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessment. Although the Facility had made progress with regard to obtaining timely assessments, the quality (i.e., comprehensiveness) of the assessments was significantly lacking.	Noncompliance

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	individual's leaving.	Brief updates often were included to supplement full assessments or evaluations that had been completed as part of an earlier ISP process, and assessors were asked to include these updates on a form compatible with the CLDP format. Often times, these appeared to consist largely of information cut and pasted from previous assessments, and, at times, it was unclear if information had been updated, or new assessments and evaluations completed, as appropriate. For the five individuals' CLDPs reviewed, it appeared that the majority of the assessments had been updated within the 45-day timeframe. However, some assessments were missing. For example, dental assessments frequently were not included, and in some cases medical assessments were missing. In addition, the quality of these assessments was lacking. None of the five CLDPs reviewed (0%) were based on adequate assessments. In particular: ▪ Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. Such a summary should contain an analysis of information, not merely a listing of dates, times, occurrences/lab results, etc. ▪ In addition, assessments frequently were inadequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. They did not describe or recommend the protections, treatments, and supports that needed to be provided (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), and/or the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.). ▪ Moreover, assessments did not identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. For example, nursing assessments for individuals who had nursing care/health management plans at the Facility should include recommendations about their continuation and/or any modifications that need to be made to accommodate community settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments should identify differences (e.g., environmental, staffing, training of staff on protective holds, etc.) that could impact the implementation of the PBSP in place at the Facility, and/or make recommendations about needed modifications. ▪ In addition to specific issues related to transition, as is discussed in other	

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		sections of this report, the underlying assessments were not of adequate quality. ▪ Finally, as has been recommended in previous reports, a process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information. It also should be noted that frequently the assessments were not signed or dated. It is essential that documents used for transition purposes include the correct date, and the signature of the person who completed them. The Facility remained out of compliance with this provision of the Settlement Agreement. A focus on improving the quality of assessments is necessary.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The CLDPs reviewed included essential and non-essential supports. Since the baseline review, progress definitely was being made, but the Facility continued to struggle with this process. On a positive note, efforts were underway to improve ISPs to more effectively describe individuals' needs for supports, and define how such supports were to be provided at the Facility. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. Given the current inadequacies of ISPs, teams had to identify these supports after the individual was referred for transition, which made it more difficult due to the generally short timeframes from referral to transition. At the time of the current review, teams still were not consistently identifying all the essential supports that the individuals needed to transition safely to the community, nor did teams consistently adequately define the essential supports in measurable ways. However, it should be noted that improvements were being seen with the measurability of supports included in the plans. The plans did not consistently identify preferences of the individuals that might affect the success of the transition. This made it difficult to ensure individuals' successful transitions, and for thorough and meaningful monitoring to occur prior to and after the individuals' transitions to the community. Likewise, teams did not consistently identify non-essential supports. In none of the five plans reviewed (0%) was a comprehensive set of essential and non-essential supports identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. The following summarizes the general concerns noted:	Noncompliance

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		▪ Generally, teams had not visualized the individual with no supports at all, and then identified each and every support that was needed to assist the individual to be successful in a particular community environment(s). Due to the current inadequacies of the ISPs, teams needed to start at the beginning, and describe the full array of supports the individual needed and wanted. Once these were listed, the CLDPs needed to identify how they would be provided in the community, by whom, when, with what frequency, and for how long. This could only be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they did for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built. ▪ Although some clinical services (e.g., psychology/behavior, psychiatry, dietary, etc.) were now referenced in the CLDPs reviewed, the intensity of the supports was not identified, nor were the qualifications or the roles of clinicians clearly defined. Supports defined as "contract or agreement with behavior analyst," "opportunities to attend individual or group counseling," or "establish services with a dietician" were inadequate. Teams were not clearly identifying what these supports entailed for the individual at AUSSLC, and then defining in the CLDP how functionally equivalent supports could be provided in the community. ▪ In addition, clinical supports that AUSSLC was providing, based on assessment information, were not included in the CLDPs, and no justification was provided for not identifying a functionally equivalent support. For example, nursing care/health management plans often were not referenced in the CLDPs reviewed. Likewise, individuals who were receiving habilitation therapies supports at AUSSLC did not have functionally equivalent supports identified in their CLDPs. ▪ Of significant concern, for individuals who had been identified as being at risk through the Facility's at-risk screening process, the risk action plans that the Facility had begun to develop, albeit still inadequate, were not reflected in action plans included in the CLDPs reviewed. As is discussed with regard to Section I of the Settlement Agreement, plans for individuals whose teams identify them as being at-risk should be of adequate clinical intensity to address the level of risk. Similarly, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. ▪ In removing any support that the individual utilized at the Facility from the array of supports that would be provided in the community, teams should justify why the support is not needed in the community. If the individual had health care plans to monitor weight, for example, these should not be left out of the CLDP without adequate justification. ▪ It was positive that the CLDPs sometimes required that community staff be	

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		trained on existing plans. As noted above, concerns existed with regard to the lack of expectations for the quality or outcomes of this training. ▪ The CLDPs often did not identify as an essential or nonessential support for a number of different types of treatment plans to be implemented (e.g., nursing care plans, health management plans, PNMPs, use of communication techniques/dictionaries, etc.). ▪ Although it appeared that the individuals reviewed had specific health care indicators that needed to be monitored and reported (e.g., input/output, meal refusals, seizures, psychiatric symptoms, etc.), few, if any supports were included in the CLDPs to ensure that specific staff were responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff. ▪ Although one of the essential supports listed for Individual #320 was the development of a crisis intervention program, the CLDPs often did not identify crisis intervention plans, and/or how the current methods for dealing with crises at the Facility needed to be modified in a community setting. Likewise, for individuals for whom physical restraint was contraindicated (e.g., Individual #85), CLDPs should specifically have addressed this in the action plan section, but did not. ▪ Direct support staffing ratios and requirements were not specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). ▪ In reviewing assessments, albeit incomplete, many recommendations were not specifically addressed in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.). ▪ Generally, day and vocational supports were not well defined. ▪ Supports that needed to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) were not included as part of the day/vocational component. ▪ It appeared that teams often were identifying due dates for critical supports that were not reflective of what the individual needed, but rather dependent on issues related to the conversion of individuals' Medicaid from institutional to community Medicaid. Not having such supports available at the time of transition, or shortly, thereafter potentially compromised individuals' successful transition. As one of many examples, Individual #320 had complex behavioral needs. The CLDP did not specify when a community psychologist needed to	

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		begin providing supports (i.e., as an essential support, it only required documentation that a psychologist would accept the individual as a new Medicaid patient), and gave the provider close to two months to review and make revisions to her PBSP. Within a month of her transition, she was hospitalized due to behavioral issues, and moved to a new community program. No indication was provided that a community psychologist was involved to assist the individual and community provider through the initial transition period. For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle. Since the last review, minimal improvement was noted with regard to the comprehensiveness of essential and non-essential supports. Of the seven individuals who the Facility was conducting follow-up since the Monitoring Team's last review (i.e., Individual #192, Individual #384, Individual #167, Individual #339, Individual #85, Individual #177, and Individual #320), three (43%) had experienced significant adverse outcomes within the first 90 days of transition (i.e., Individual #192, Individual #167, and Individual #320). All three had experienced police contact due to behavioral issues that the community providers were unable to address; one had been psychiatrically hospitalized, and remained hospitalized for over six months; and two had required a change in placement due to the original placement being unwilling or unable to meet their needs. Based on a review of the CLDPs for these individuals during either this or the previous review, as well as the post-move monitoring information, significant concerns were noted with regard to the transition plans, as well as the quality of supports community providers offered to these individuals. The Facility is strongly encouraged to conduct reviews of any significant adverse outcome for any individual who transitions to the community. Such reviews should be conducted in the spirit of identifying ways in which improvements can be made to prevent negative outcomes in the future. As was discussed in some detail while at the Facility, good transition planning requires the commitment of the entire IDT, as well as those tasked with primary responsibility for developing the CLDPs. The entire team should be involved in critical, but constructive reviews of issues that individuals have experienced once they transitioned to the community. As previously reported, with regard to Monitoring by the MRA or other means to ensure essential supports were in place prior to an individual's transition, the MRA's review appeared to be a general safety assessment as opposed to an individualized assessment	

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		based on the essential supports identified by the team. The only assurances that the MRA staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the essential supports were in place appeared based on a "meeting with the site administrator/manager." The form included two related questions, including: 1) "Did the site administrator/manager have a copy of the consumer's draft Community Living Discharge Plan and know the outcomes important to the consumer or legally authorized representative"; and 2) "Did the site administrator/manager verify services and supports could be provided that are necessary to assist the consumer in achieving the outcomes?" (Emphasis added.) Responses to these questions did not represent adequate proof that the essential services required by the CLDPs were in place. However, the Facility had begun to implement the process of having the Post Move Monitor conduct a pre-move site visit designed specifically to determine if the essential supports were in place. A review was conducted of five individuals' pre-move site visit documentation (i.e., Individual #167, Individual #339, Individual #85, Individual #177, and Individual #320). Four of the five (80%) appeared thorough, and included each essential support listed in the individual's CLDP. They included a description of the evidence that had been reviewed to determine that the essential support was in place. They had been completed in a timely manner, often a few days before the individual's transition to allow time for changes to be made. A number of them noted issues that required correction, and provided follow-up notes related to these concerns. The pre-move monitoring documentation for which concerns were noted was for Individual #320. It did not appear to have included a qualitative review of the supports listed (e.g., training of staff or development of a crisis intervention plan). It merely cited the presence of the items with no indication regarding the quality of the supports. For example, the CLDP required "thorough" training of staff, but the reviewer simply noted "materials used and training roster." It was unclear what this meant. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress was noted with regard to the pre-move confirmation of essential supports, substantial work was still needed in adequately delineating the essential and non-essential supports in individuals' CLDPs.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is	Since the previous review, no progress had been made with regard to this provision. Areas in which concerns were noted included: ▪ At the time of the last review, AUSSLC had begun to use revised monitoring tools to evaluate its compliance with Section T of the Settlement Agreement. However, based on the POI and other documentation, due to staffing changes in the Admissions Placement Office, minimal monitoring had been completed. ▪ In addition, n relation to Section E of the Settlement Agreement regarding	Noncompliance

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	responsible, consistent with the provisions of this Section T.	quality assurance efforts, the Monitoring Team asked for aggregate monitoring data summaries or trend reports. Although AUSSLC provided some information, none related to Section T. Based on this lack of information, it did not appear that any trending or analysis of information had yet occurred in relation to these requirements of the Settlement Agreement. ▪ As noted above, minimal amounts of the data was being incorporated into the Facility's self-assessment/POI. ▪ Inter-rater reliability had not yet been established, nor had the accuracy of the monitoring data. As is discussed with regard to Section E, the procedures being used to establish inter-rater reliability needed modification. A standard inter-rater reliability methodology should be used statewide, and focus should be placed on ensuring that not only are the results of the monitoring similar, but also that they are accurate. In other words, if both auditors were incorrect in their assessment of an indicator, high inter-rater reliability would be present, but the data still would not be valid. ▪ As detailed in the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team continues to have concerns about the adequacy of the guidelines provided to reviewers. Efforts to improve these are necessary to ensure accuracy in monitoring as well. The Facility should expand its monitoring activities in this area, including modifying, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In addition, the analysis of data will be an important next step, as well as the development and implementation of corrective action plans, as appropriate.	
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 ISPs and interviews with staff, AUSSLC continued to be in the initial stages of identifying obstacles to transition on an individual basis. Teams' role in this process is discussed in further detail with regard to Section T.1.b.1. In addition, according to the Admissions Placement Coordinator, a meeting was to be scheduled with the QDDP Coordinator, and a Facility staff member with expertise on the database. The goal of this meeting would be to discuss the process for entering the data. As a result of teams not adequately identifying obstacles, as well as a data system not yet being in use to capture the results of team deliberations, full and reliable data was not available for analysis. The limited progress that had been made included: ▪ The State had developed a list of standard obstacles that teams would be asked to utilize. On 5/16/11, the Monitoring Panel provided the State Office with	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.	comments on the draft revised Most Integrated Setting policy, including the list of obstacles. In general, though, this list should assist in standardizing the data collected, which in turn should provide the State Office with better information about protections, supports, and services that should be enhanced in the community, as well as concerns that individuals and LARs have regarding transition to the community. ▪ AUSSLC had drafted an action plan to address Section T.1.g. It set forth a plan for complying with this provision, albeit not very detailed, and the Facility had begun to implement it. For example, the Facility provided documentation of training on the new obstacles categories that the Admissions Placement Coordinator had provided to IDT members. It is noteworthy that this training occurred approximately three months after State Office issued the standard list of obstacles, which delayed its implementation. Based on review of a limited number of ISPs, it was unclear if the training was successful. The Facility should carefully monitor implementation, and, as necessary, provide further training and/or technical assistance. As have been detailed in previous reports, 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 continued to discuss with Facility staff the patterns regarding recent admissions and referrals to the Facility, which were also indicative of concerns in the community system, resulting in individuals requiring placement in more restrictive settings. These issues had not changed, and additional information on them can be located in the Monitoring Team's previous report for AUSSLC. Although AUSSLC remained out of compliance with this provision, some activities were underway to achieve compliance. It will be essential for IDTs to be provided ongoing training and/or technical assistance on the proper identification of obstacles in order for these efforts to be successful.	
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	In response to a document request, the Facility submitted to the Monitoring Team a Community Living Placement Report, for the period between 10/25/10 and 10/25/11. The report listed: ▪ Current Referrals: This included individuals who had been referred by their teams for community placement and had an open referral, including the individual's name, the date of referral, and the status of the referral. Nineteen individuals were included on this list. However, since the list had been generated one of these individuals recently had transitioned to the community.	Substantial Compliance

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	ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	▪ Community Placements: This included individuals who had transitioned to the community, including their name, date of referral, and date on which their transition to the community occurred. This included 12 individuals, including five since the last review. As noted above, another individual recently had transitioned to the community. 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 that each of the Facilities uses. For these categories, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included the name of one individual with the date of the meeting at which the decision not to refer was made. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included one individual, including the date of the meeting and a brief description of the reason for the referral not being made. For the one individual, the reason was noted as "Behavior/Psychiatric." ▪ 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 had begun to make independent recommendations regarding the appropriateness of an individual for community placement. However, the State indicated that 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. The Facility was in compliance with this provision.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		

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T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Timeliness of Checklists: Post-move monitoring documentation was reviewed for seven individuals, including Individual #192, Individual #384, Individual #167, Individual #339, Individual #85, Individual #177, and Individual #320. Of the 15 required visits, 15 (100%) had been documented as having been completed on time. The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was clearly documented in the reports. For all of the 15 reports reviewed (100%), as applicable, the Post Move Monitor or designee had visited the individual at his/her home, as well as day/vocational site. Content of Checklists With regard to the content of the checklists, since the previous review, AUSSLC had begun to use the new format that the State Office had developed for post-move monitoring activities, which had been modified a second time in May 2011. Some of the sample of post-move monitoring documentation had been completed using this revised format. 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. For three out of the seven individuals (43%), thorough reviews were documented. For those for which thorough reviews had not been completed, the following summarizes the issues noted: ▪ Although due dates had passed for completion of specific action steps, the reviewers had not completed some items on some of the checklists (e.g., 90-day review for Individual #167, and 90-day review for Individual #339). As a result, it could not be determined if community providers had completed these action steps. ▪ At times, it was unclear whether or not adequate reviews had been conducted, because the descriptions of the actions taken were incomplete, inadequate, or missing (e.g., 90-day review for Individual #167, and seven-day and 45-day reviews for Individual #85). ▪ At times, documentation was not present to show review of essential supports that were of an ongoing nature (e.g., training of staff that would need to be updated if new staff were hired). ▪ For Individual #320, it appeared that a number of action steps included in the CLDP were not included on the monitoring form, and, as a result, monitoring of these items had not occurred. Use of Facility's Best Efforts to Ensure Supports Are Implemented The primary reasons for conducting post-move monitoring are to identify if any	Noncompliance

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		protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the seven individuals reviewed, all of them (100%) had needs identified for which follow-up was necessary to ensure supports were implemented. ▪ Of the seven individuals for whom follow-up was indicated, documentation was present to show that for two individuals (29%), adequate follow up had occurred (i.e., Individual #192, and Individual #167). In some instances, the Facility had worked diligently to follow-up in relation to concerns identified (e.g., Individual #192, and Individual #320). However, a number of issues regarding the adequacy of follow-up were noted for a number of individuals. The following summarizes the concerns noted: o At times, even when the PMM identified the need for the individual's AUSSLC IDT to review and make recommendations about specific issues identified during the post-move monitoring visits, this was not consistently done or documented (e.g., Individual #384, Individual #177, and Individual #85), or the review was significantly delayed (e.g., Individual #339 for whom significant concerns were noted regarding the requirement for a pica-safe environment). o At times, issues were noted, but no follow-up or plan for follow-up was documented (e.g., Individual #339 re: appointments not kept and incomplete data sheets). o The expectations for community providers were sometimes less stringent than they should have been (e.g., for Individual #320, Facility staff accepted the provider's assertion that appointments had not been made/kept, because the individual's Medicaid had not converted, as opposed to requiring the provider to show efforts to work with community medical and therapy providers to understand that the Medicaid funding was active, and services could be billed retrospectively). Based on the Monitoring Team's review, issues were identified with regard to both the quality of the post-move monitoring activities, as well as the Facility's efforts to ensure supports were implemented. The Monitoring Team recognizes that during the review period, the Post-Move Monitor position was in transition due to staffing changes. However, the Facility was out of compliance with this provision.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on monitoring visits to Individual #424's day program and home. The Post-Move Monitor followed the format, asked many good questions, reviewed	Noncompliance

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	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.	documentation, and conducted observations. However, although the Monitoring Team requested all post-move monitoring reports that the Facility had completed since the original documents were produced, a copy of the report for these monitoring visits was not included. Therefore, the "accuracy of the Facility's monitoring" could not be determined. As a result, this provision was rated as noncompliance.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the	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. Since the previous review, under this revised definition, two individuals had had alternate discharges (i.e., were transferred to other SSLCs). The discharge packages for	Noncompliance

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	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.	Individual #139, and Individual #217 were requested for review. Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause: Based on the information provided, in two out of the two records reviewed (100%), good cause was identified in the discharge summaries (i.e., court commitment to another SSLC, and a family's request for the individual to live closer to them). ▪ The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): For one individual, this was not applicable, due to the court's involvement. For the remaining individual, no information was included in the discharge summary to allow a determination to be made regarding whether or not adequate time was available for the discharge process to occur. As a result, the Facility was not in compliance with this indicator. ▪ At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: Although the final summaries included each of these components, for none of the two individuals (0%) was the information adequate. Concerns included: o Adequate summaries were not provided of the individuals' overall stay at AUSSLC. o Incomplete historical and current status information was provided (e.g., details were not included about Individual #217's behavior leading to an arrest, which was the cause for his transfer; Individual #139's summary provided minimal information overall, with significant lapses in information with regard to developmental, psychological/behavioral information, and medical/nursing information). o Generally, little information was provided about the supports the individuals were receiving, and no analysis was provided regarding what supports had assisted the individuals versus those that had not been effective to assist the receiving facility to develop an appropriate treatment plan. o Both individuals had significant psychiatric issues. However, neither summary provided adequate information about their diagnoses, current treatments, or history with successful or unsuccessful treatment. ▪ With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies: For one of the two individuals (50%), AUSSLC provided documentation as requested to show that a copy of the discharge summary and related assessments had been provided to the receiving facility.	

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		▪ The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Transfer Discharge Reassignment Summaries, the IDTs for none of the two individuals (0%) adequately described the key supports that the individuals would need in their new settings. For one individual, the team wrote under "Referrals and/or Necessary Services in New Environment" that the individual "will require 24 hour awake staff due to her dangerous behavior, self-injurious behavior, unauthorized departure, impulsive behavior and lack of pedestrian skills." This was not an adequate "post discharge plan of care to assist the individual to adjust to her new environment." Similarly, for the second individual, the team included a short list of not well-defined supports, such as "Structured Environment," and "Counseling Referral." In addition to providing inadequate details to allow the receiving IDT to develop an appropriate plan, the list was missing significant supports, including but not limited to psychiatric supports, day/vocational supports, staffing requirements, or any specifics about nursing or medical supports. Due to the inadequacies of the discharge/transfer summaries, AUSSLC was not in compliance with this provision.	

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. 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)
3. 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. (Sections T.1.b.1 and T.1.g)
4. 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)
5. 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)

6. 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' ISPs, as appropriate, and implemented. (Section T.1.b.2)
7. 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. (Section T.1.c)
    b. The Facility should begin using the pre-transition time to more effectively define the essential and non-essential supports. (Section T.1.c)
    c. 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. (Section T.1.c.3)
8. Essential and non-essential supports should be better defined in Community Living Discharge Plans. More specifically:
    a. The role of the Facility and community provider staff in the transition and discharge process should be defined better. This should include, but not be limited to defining:
        i. Which community provider staff need to complete which training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or for each component of training, what level of mastery of the information is required (e.g., demonstration of competence);
        ii. The method of training, for example, if it would be necessary for community provider staff to shadow AUSSLC staff, and/or show competency in actually implementing a plan, such as a PBSP, PNMP, etc. For some individuals, specific components of their ISPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an essential support), or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual;
        iii. Collaboration between the Facility clinicians currently working with the individual and the community clinicians who will assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.);
        iv. Coordination between current and future residential or day/vocational staff;
        v. AUSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Behavioral Services Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment); and
        vi. The role AUSSLC staff or community provider staff might play in assisting the individual to make the transition;
    b. Due to the current inadequacies of the ISPs, teams should start at the beginning, and describe the full array of supports the individual needs and prefers. Once these are listed, the CLDPs should identify how the necessary supports will be provided in the community, by whom, when, with what frequency, and for how long. This can be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they do for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built;
    c. With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians;

d. Clinical supports that AUSSLC is providing should be included in the CLDPs, or adequate justification for not identifying a functionally equivalent support should be documented in the CLDP;
e. For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible;
f. In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community;
g. Teams should factor in modifications that need to be made to current programs or plans, and write such modifications into the essential or nonessential supports;
h. As appropriate, teams should identify as an essential or nonessential support the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications might need to be made to the methodology for providing these supports, with the end result being the individual's need for the support being met;
i. For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), teams should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff;
j. As appropriate, crisis intervention plans should be developed, and/or essential and non-essential supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting;
k. Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.);
l. Recommendations in assessments should be addressed specifically in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.), and justification provided for any recommendation not included as an essential or non-essential support;
m. As recommended previously, CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community;
n. Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component;
o. For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle; and
p. Focused effort should be placed on ensuring each of the supports identified is measurable. (Sections T.1.c.1 and T.1.e)

9. In addition to addressing recommendations related to assessments in other sections of this report to improve the overall quality of assessments used in developing CLDPs, modifications should be made to assessments to:
    a. Provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of,

for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility;

b. Assist teams in developing a comprehensive list of protections, supports, and services in a community setting. Assessments should describe or recommend the protections, treatments, and supports that an individual requires (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), as well as the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.); and

c. Identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. (Section T.1.d)

10. A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This should be comprehensive, and not just include general medical information, but also specialists' involvement with individuals. This would facilitate the transition of this information to community medical care providers. (Section T.1.d)
11. 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 and T.1.e)
12. With regard to monitoring activities related to the Facility's performance with this section of the Settlement Agreement, the Facility should:
    a. Expand its monitoring activities in this area;
    b. Modify, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors;
    c. Provide staff responsible for conducting audits with competency-based training;
    d. Ensure the reviews accurately evaluate quality, as well as the presence or absence of items;
    e. Establish inter-rater reliability; and
    f. 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. For individuals undergoing alternate discharges, the discharge/transfer summaries should include:
    a. Clear descriptions of when the referrals were made, when the discharge planning process began and ended, and the level of involvement of the individual and his/her guardian or family;
    b. Summaries of relevant historical and current status information, including as appropriate applicable data;
    c. To assist the receiving Facility to develop an appropriate treatment plan, analysis regarding what supports had assisted the individual versus those that had not been effective;
    d. Medical information, including summaries from specialists (e.g., psychiatry, neurology, etc.); and
    e. Adequate post-discharge plans of care that comprehensively describe the key supports that the individual would need in his/her new setting(s). (Section T.4)
14. As the Facility expands its self-assessment activities, the POI should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The POI also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions. (Facility Self-Assessment)

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Individual without Guardians, with the note "but we have not completed process of prioritization," dated 10/24/11; o List of individuals for whom a Legally Authorized Representative (LAR) has been obtained, undated; o Guardianship Committee meeting minutes, dated 7/29/11, and 9/22/11; o Correspondence with Travis County Probate Court, dated 8/10/11; o Summary of Probate Court Visit, dated 9/29/11; o Email correspondence between AUSSLC Human Rights Officer and Special Counsel for System Support of the Health and Human Services Commission, dated 10/20/11; o Presentation Book for Section U; o Draft State Supported Living Centers Statewide Policy and Procedures: Guardianship, with attachments, undated; o AUSSLC Plan of Improvement for Section U, dated 11/2/11; o List of Guardianship Committee members, undated; o Draft Guardianship Priority Rating Tool, undated; and o In response to request for curricula for training on the instruments or processes used to determine functional capacity, and any instruments or processes used to prioritize the needs of the individuals, the response: "Does not exist." ▪ **Interviews with**: o JoAnn Villasana, Human Rights Officer; o Nicole Hinajosa, Social Worker; and o Kenneth Eck, DADS State Office.
	Facility Self-Assessment: The Facility self-assessment showed that it continued to be in noncompliance with the two provisions of Section U of the Settlement Agreement. This was consistent with the findings of the Monitoring Team. The POI included narrative descriptions of steps being taken to attain compliance. However, no data from reviews or self-audits, or other data sources (e.g., numbers of individuals with guardians or those needing guardians, or those for whom guardians had been obtained) were included. Although during the last review, it appeared that AUSSLC had begun to use the monitoring tools that State Office had issued for Section U, during this review, no evidence was presented to show that these tools were still in use. Once screening and assessment process are in place, it will be important to show, based on data from audits, whether or not teams are accurately determining individuals' functional capacity, whether individuals' needs for guardians are being prioritized appropriately, and whether or not adequate efforts are being made to identify needed supports. In addition to providing narrative descriptions of activities, the POI should include analyses of the audit results.

	The Facility included two action plans in the POI, including one related to the maintenance of a prioritized list of individuals needing guardians, and the other related to identifying guardians for individuals who needed them. Because State Office had not yet issued policies for Section U, it was unclear if the action steps included were consistent with what would be required once the policies were finalized. Likely, once this guidance is issued, AUSSLC will need to revise its action plans.
	Summary of Monitor's Assessment: At the time of the review, DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of these Settlement Agreement requirements. AUSSLC had no instrument or process to determine individuals' functional decision-making capacity. It was anticipated that the State Office policy would provide guidance with regard to this issue. Although the Facility did not have a formal process yet to determine which individuals did not have decision-making capacity or had limits to their decision-making ability, at the time of the review, 114 of the 351 individuals the Facility served (32%) did not have guardians. As noted in the previous report, 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 that 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. Since the last review, the Facility's Social Workers had begun to complete draft tools for each of the individuals on their caseloads. The next step would be sharing the drafts with the individuals' teams, and finalizing the tools with input from the teams. It was unclear if the State Office had reviewed or approved the tool the Facility was using. As the Monitoring Team reported in previous reports, Facility staff made ongoing attempts to obtain guardians for individuals. For example: ▪ Since the baseline review, a total of 11 individuals had obtained guardians. Three of these guardianships had been ordered since the last review. ▪ AUSSLC continued to make referrals to a private, nonprofit guardianship agency called Family Eldercare. Unfortunately, the waiting list for this program was long. ▪ The Facility had formed a Guardianship Committee that currently was composed of eight Facility staff, with plans to expand the membership to include community members. ▪ Members of the Committee met with the local Travis County Probate Court to discuss the 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. Based on these recent conversations, it was hoped that a number of guardianship hearings would be held before the end of 2011. A position had been approved for a Guardianship Coordinator position to assist with all of the tasks related

	to ensuring individuals had adequate supports related to decision-making. It was anticipated that this position would be posted soon.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	At the time of the review, DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of these Settlement Agreement requirements. The Facility had a copy of the draft policy on Guardianship. Based on interview with staff, it was anticipated that this policy would be finalized soon. A second policy on consent remained in the development phase. The State is encouraged to finalize these policies, because they should assist the Facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. AUSSLC had no instrument or process to determine individuals' functional decision-making capacity. However, at the time of the review, the Facility had identified those individuals without a guardian. Based on the list provided, 114 of the 351 individuals the Facility served (32%) did not have guardians. The Facility recognized that implementation of the policies the State Office was developing was expected to require significant effort and changes to a number of practices at the Facility, including more intense involvement of individuals' PSTs in assessing individuals' "functional capacity to render a decision" and provide informed consent. It was anticipated that the State Office policy on consent would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area. In order to assist with the work that this would entail, the Facility Director had approved a new position for a Guardianship Coordinator. Staff indicated that the primary focus of the staff person in this position would be to ensure that individuals who are unable to make decisions on their own are provided the supports they need. At the time of the review, it was anticipated that the position would be posted soon. At the time of the review, AUSSLC was not maintaining a prioritized list of individuals needing guardians. However, it had identified those individuals without guardians, and had begun the process of reviewing factors related to the need for decision-making. As noted in the last report, AUSSLC had developed a draft document entitled: "Guardianship Priority Rating Tool." At the time of the most recent review, it was unclear if the State Office had reviewed or approved it. As indicated in the last report, 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	Noncompliance

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		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. Since the last review, the three Social Workers at the Facility had completed drafts of the tool for each of the individuals on their caseloads that did not have guardians. Reportedly, the next step was sharing these drafts with individuals' teams, obtaining input from the teams, and finalizing the documents. Although it remained unclear if this process would meet the State Office's expectations, it was positive that teams were beginning to review each individual's needs for decisions to be made regarding potentially invasive or restrictive procedures, as well as determining whether or not the individual had potential guardianship resources. As discussed during the onsite review, in addition to continuing these efforts, efforts also should be made to identify other supports that might assist individuals to make decisions. Facility staff indicated that these types of supports recently had been discussed at a Consumer Rights Conference, and could be incorporated into training that AUSSLC was developing for the PSTs. These alternatives include, but are not limited to developing information in formats that are more easily understood, such as utilizing simpler language, or formats with pictures (e.g., similar to what the State Office was beginning to develop with regard to psychotropic medication); expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). The Human Rights Officer had been in contact with a speaker from the Consumer Rights Conference who had expertise with guardianship, as well as its alternatives. Discussions were underway to have this expert speak as part of a panel discussion at AUSSLC in the spring. Particularly as more efforts related to supporting individuals who need assistance with decision-making begin to occur on campus, this would be a positive addition to other educational activities. The Facility remained out of compliance with this provision of the Settlement Agreement. However, AUSSLC continued to make progress in identifying individuals without guardians, and reviewing factors that should help to prioritize those with a greater need for assistance with decision-making. This proactive approach of beginning to have teams think about individuals' needs in relation to decision-making, as well as their potential	

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		guardianship resources should assist the Facility to more quickly implement the State policy once it is finalized.	
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.	Since the previous review, the Facility had made some limited progress with regard to this subsection of the Settlement Agreement. At the time the last report was issued, a total of eight individuals had obtained guardians since monitoring began. Since the previous compliance review, three additional individuals had obtained guardians, bringing the total to 11 individuals. As the Monitoring Team reported in previous reports, Facility staff made ongoing attempts to obtain guardians for individuals. For example: ▪ Since the last review, a Guardianship Committee had been formed, and met twice. This Committee was developed in response to the State Office's draft policy. At the time of the review, the Committee only consisted of Facility staff, but efforts were underway to include some community members. ▪ Although the State Office policy did not clearly articulate that one of the roles of this group should be to assist in identifying and/or developing guardianship resources, based on the meeting minutes, it appeared the group was assisting with some of these efforts. For example, some of the barriers to obtaining guardianships were the funding for legal fees and court costs, and the need for assistance in navigating the legal system. As noted in previous reports, 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. However, due to staffing changes, this program had experienced some delays. Since the last review, the Guardianship Committee had followed through on plans to meet with staff from the Probate Court to facilitate guardianship proceedings for some individuals. Based on these discussions, the Facility was working with the Court to ensure the completion of up-to-date certificates of medical examinations, because some of them had lapsed. Through these efforts, it was hoped that some guardianship hearings would be held before the end of 2011. ▪ As has been discussed in previous reports, as appropriate, AUSSLC continued to make referrals to a private, nonprofit guardianship agency called Family Eldercare. Criteria for acceptance by Family Eldercare included no family involvement, or family who had clearly stated that they had no interest in ever becoming the individual's guardian. The waiting list for services with this agency was fairly long. ▪ The Guardianship Committee also was looking at options to address lapsed guardianships. Each year, the current guardian was required to submit an annual report to the Court. The Committee was working on setting up a system	Noncompliance

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		to closely track these dates. In doing so, the Facility would be able to offer assistance to guardians, as needed, to complete the annual report, thereby ensuring that the guardianship did not lapse. Members of the Committee also had inquired with the Probate Court regarding any policy on lapsed guardianships. 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 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 policies on guardianship and consent, and implement them as soon as possible. In doing so, it should consider including the following in the policies:
    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)
2. Once the State policies are finalized, the State should provide key Facility staff with training on their implementation. (Section U.1)
3. Once the State policies are finalized, AUSSLC should develop policies on guardianship and consent to reflect the State policies, and individualize them to the extent necessary for implementation at the Facility. (Section U.1)

4. Once the State identifies the tools and processes to be used to assess individuals' decision-making capacity, teams should screen/assess all individuals served by the Facility who do not currently have guardians. (Section U.1)
5. Based on any additional information provided in the State policy regarding prioritization for guardianship and/or the State Office's review of the current draft tool the Facility is using to assist in the prioritization process, AUSSLC should modify its process, as appropriate. (Section U.1)
6. Efforts should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures (e.g., similar to what the State Office was beginning to develop with regard to psychotropic medication); expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). (Section U.1)
7. 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)
8. 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)
9. As the processes for assessing individuals' capacities to make decisions are implemented, it will be important for the Facility to conduct audits to ensure that teams are correctly identifying individuals who might need guardians or other assistance in making decisions, that individuals are appropriately prioritized on the list, and that adequate efforts are being made to identify needed supports. In addition to providing narrative descriptions of activities, the POI should include analyses of the audit results, as well as other relevant data. (Facility Self-Assessment)

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 and 10/20/11; o AUSSLC Master Record Order, Volume I, II, and III, revised 3/15/11; o Individual Notebook and Guidelines; revised 9/20/11; 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 "Getting a Grippa on HIPAA" video and handout; o In response to document request TX-AU-1111.2, statement that: "Client Records will be picking up labs and consults to be filed from medical area as of 9/01/11, instead of being routed through nurse case managers…"; o In response to document request TX-AU-1111.9, statement that: "A copy of the audit done is provided to the clerk and discussed if there are problems with filing;" o In response to document request TX-AU-1111.9.a, statement that: "Training is done on an individual basis based on audit results and training rosters;" o In response to document request TX-AU-1111.9.b, statement that: "This is done verbally;" o Sample AUSSLC Submission and Filing Tracking form; o Email related to mandatory training for checking out active records, dated 8/6/11; and o AUSSLC Active Records Check-Out Process: The Process of Using a Special Binder in Each Chart Area, revised July 25, 2011. ▪ **Interviews with**: o Leann Boyd, Client Records Coordinator; o Sherry Weir, Unified Records Clerk; o Kimberly Quarry, Unified Records Clerk; 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 subsections of Section V of the Settlement Agreement. 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. Based on interview and record review, 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 establishment of inter-rater reliability, analysis of audit results, and development and implementation of corrective action plans, is necessary to ensure that the Facility is able to conduct an adequate self-assessment. Also, as noted in the previous report, 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. Similarly, the only action plan included in the POI for Section V was for subsection V.2. It included some important action steps, but none of them related to Section V.2. Rather, they related to Sections V.1, and V.4
	Summary of Monitor's Assessment: Since the last review, for the Active Records, substantial improvement was noted. Except for a few documents, documents generally appeared to be in the records. The Facility had taken some specific steps to address the issues related to the timely availability of documents in the Active Records. Medical documents, such as lab reports and consultations, were sent directly to the Records Department, as opposed to being sent first to nursing. In addition, a tracking system was set up to log the submission of documents through to when they were filed in the records. AUSSLC also had addressed the issue of the security of records, particularly ensuring that the whereabouts of records was known. Specifically, a procedure had been developed, staff training, and implementation begun of a sign-out process. Other than for other sections of this report, the Facility did not provide the information the Monitoring Team requested related to policy development. However, 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. Because of the lack of information provided, no evidence was found to show that new policies were being disseminated. In addition, a system was not yet in place to track the training provided. However, based on staff interview, a system was not yet in place to ensure staff had the necessary knowledge and skills to implement the policies. Audits were being completed of records. No action plans had been developed yet to address issues related to records.

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V1	Commencing within six months of	Progress had been made and/or sustained with regard to the establishment and	Noncompliance

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	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.	maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included: ▪ Since the Monitoring Team's last review, a new Client Records Coordinator had been hired. The Facility also had two Unified Records Coordinators, and six File Clerks assigned to the Quality Assurance Department. Their primary responsibilities related to the maintenance of records. At the time of the review, two vacancies existed for File Clerks. Interviews had occurred, and final decisions were being made. ▪ In previous reports since the baseline review, the Monitoring Team made findings regarding the numerous documents that were not in the records and had to be obtained from the units. During this review, for the Active Records, substantial improvement was noted. Except for a few documents, documents generally appeared to be in the records. Based on interview and documents provided, the Facility had taken a number of steps to address this issue. These included: o A survey had been completed to determine what some of the issues various departments had with regard to records. This information was utilized to develop corrective actions. o Beginning on 9/1/11, a new process was implemented to prevent important documentation from sitting on staff's desks, and not being filed. All laboratory reports, x-rays, and consultation reports that previously had been sent to nursing staff before being filed was now sent directly to the Records Department for filing. This appeared to have significantly improved the availability of such information. o To assist with tracking the status of information sent for filing, a system was set up on the Facility's shared drive. QDDPs and clinical staff had access to this system, and could log in the information they were sending to the Records Department. Then, the File Clerks used it to log when they received information, and document the date it was filed. This system was fairly new at the time of the review, but should help to increase accountability. ▪ On 7/25/11, a revised check-out process policy/procedure was issued. It required staff to sign-out the records, and sign them back in. Some minor issues with the procedures are discussed below. However, based on interview, a significant decrease already had been seen in the number of records that could not be found on campus for periods of time (i.e., sometimes up to a week). ▪ In August 2011, mandatory training was required of all staff to address a number of issues. These included security of the records, including checking them in and out, as well as the importance of accurate and complete observation notes, and the consistent recording of dates, times, and signatures. Given the number of staff who required training, this was a significant endeavor.	

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		▪ At the time of the review, staff reported that each individual had an Active Record, a Master Record, and an Individual Notebook. The Active Record was organized according to the Table of Contents the State Office had developed, with some modifications specifically for AUSSLC. The last update to the Table of Contents was completed in October 2011. Many of the changes made resulted from feedback obtained through the survey mentioned above. ▪ An Active Records Committee had been established. The membership represented disciplines across campus. In meetings held every other month, the group reviewed record-related issues, such as forms that were proposed for addition, the retention schedule, the order of the records, etc. Based on review of the minutes, the Committee appeared to provide a valuable forum for obtaining input and making decisions related to the records. ▪ The Unified Records Coordinators were providing ongoing training and technical assistance to the Record Clerks, as issues were identified in the records. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, it was positive that a check-out policy/procedure had been implemented. To ensure that staff's responsibilities clearly were defined in the policy, as discussed on site, modifications should be made. Specifically, parameters for how long a record can be signed out (i.e., until the end of the staff person's shift) should be explicitly stated, and consideration should be given to making the File Clerks or other staff member (e.g., Shift Supervisor) responsible to check on a regular basis (e.g., end of each week) to ensure all records that were signed out have been returned. ▪ With the implementation of the check-out procedures, important steps had been taken to ensure the security of the records. The Monitoring Team asked for copies of regular training provided to staff regarding confidentiality, including confidentiality of records. A copy of training materials was provided. However, a note indicated that the training requested was "not required training and the content is very outdated. HIPPA (sic) for SSLC employees is included in the Rights of Consumers course." What the Monitoring Team requested was the module that during interviews with staff was identified as the regular training staff underwent on this topic. The Monitoring Team will need to request copies of the training modules actually currently in use during the next review. However, ongoing training for all staff on maintaining the confidentiality and security of records is essential. If this is not currently a part of annual, or at least biannual training, it should be. ▪ As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. This is discussed in further detail with regard to Section V.3. However, some of the issues that staff verbally identified included adequacy/thoroughness of the information included	

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		(e.g. completeness of observations notes), legibility, gaps in records, and the inclusion of the most current information in the record (e.g., ISPs). During the onsite review, the Client Records Coordinator and Unified Records Coordinators discussed a number of ideas to address these issues, such as regular training for staff. ▪ In the last report, issues were discussed regarding the Individual Notebooks (I-Books). Similar issues were identified during this review. As noted with regard to Section S.1, a review of 22 Individual Notebooks was completed on site in one day habilitation setting and across seven residences. In 15 of these books (68%), the PSP had been completed within the last 12-month period. Of the remaining seven books, five contained PSPs from 2010, and two had no PSP included. Sixteen of these 22 individuals were noted to have current PBSPs. The I-Books for 10 individuals (63%) contained plans developed within the previous 12 months. The remaining six books included three with plans from 2009, two with plans from 2010, and one in which the plan was missing. As noted previously, if I-Books are going to serve as a reference for staff to help with comprehensive and accurate implementation of habilitation and behavior support plans, it is essential that these be kept current. I-Books were not consistently available in day program sites and on at least one occasion, the I-Books were found in the residence although no individuals were present. As these books also contained data sheets for tracking skill acquisition and problem behavior, it is important that they accompany individuals as they move from environment to environment. As the I-Books are intended to serve as guides for staff and as the repository for essential data, it is essential that required documents are current and complete. While the Facility had continued to make progress with regard to the quality of the active records, it was not yet in compliance with this provision of the Settlement Agreement. AUSSLC should continue to address issues related to the quality of the records.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. 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 only information provided was related to training on the new policy/procedure on checking-out records. As with the last review, it appeared there was a misunderstanding about the breadth of this Settlement Agreement requirement, which addresses all of the policies related to Part II of the Settlement Agreement (i.e.,	Noncompliance

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		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. Based on interview with the QE Director, the process AUSSLC used to review policies was initial review by the QE Director, who disseminated them to relevant people for comment. The Facility Director provided final approval. However, beginning on 1/1/12, it was anticipated that policy review would become part of the QA/QI Committee process. Facility staff identified the need to conduct more training, and often, competency-based training on new policies. During the interview with the Monitoring Team, staff indicated that at the current time, often, supervisors merely handed new policies to staff to sign. They recognized that this was inadequate. Staff indicated that for the revised community outing policy, a train-the-trainer model was used. The Monitoring Team requested documentation of this training, but the Facility provided nothing in response to this request. It is recommended that the Facility define in policy or procedure the process that will be used to ensure training on policies occurs. It should incorporate mechanisms for communicating the issuance of new policies, as well as who requires training on such policies, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided. In addition, for each policy approved, consideration should be given to having the QA/QI Committee define who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility. Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP training). Based on documentation provided, it appeared a system was available to track which staff had completed which training, and to run exception reports showing who still required training. Incorporation into this system of the training on policies would appear necessary and appropriate. The Facility was making progress in updating and/or developing policies to address the various requirements of the Settlement Agreement. However, it was not yet in compliance with this provision. In addition to continuing to develop and revise policies	

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		in concert with the issuance of State Office policies, the Facility also should develop standardized processes for training of staff on new or revised policy requirements.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ 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. Based on interview, a total of 20 audits were done each month, for a total of 15 records. ▪ To conduct the audits, the monitors were completing the Active Record Order Guidelines Audit Tool, and then the information collected was used to complete the monitoring tool entitled "Settlement Agreement Cross Referenced with ICF/MR Standards – Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4." ▪ In addition, an individual's team for one record review that each of the Unified Records Coordinators completed was selected for completion of the State Office's interview tool designed to solicit information specifically about Section V.4, which requires the Facility to routinely utilize individuals' records in making care, medical treatment and training decisions. ▪ Issues identified through the monitoring process with regard to individual records were addressed with the specific File Clerks. Individualized training or technical assistance was provided. Some sample sign-in sheets were provided. Areas in which improvements should be made in order to achieve compliance, included: ▪ It is important to note that based on knowledge gained from internal auditing and surveys, as well as information that the Monitoring Team provided, the Facility had taken steps to correct issues related to the timely filing of information in records, as well as the security of records. However, no evidence was presented to show that the audit data had been analyzed thoroughly to identify trends and determine the other underlying issues, and/or action plans developed to address such issues. The Facility recognized that this was the next step in the process. ▪ The Facility also recognized the need to close the loop with regard to the feedback provided to File Clerks regarding specific records. In other words, a process was not yet in place to ensure that needed corrections had been made. Although the Facility continued to complete some of the tasks that required with regard to this provision of the Settlement Agreement, AUSSLC had not begun to aggregate and analyze results of monitoring data, and/or develop, and implement actions necessary to correct deficiencies identified systemically.	Noncompliance

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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.	Progress had been made and/or sustained with regard to the Facility's use of such records in making care, medical treatment, and training decisions. Positive developments included: ▪ As discussed above, to address issues related to the timely filing of information needed to make decisions, modifications were made to the process through which lab and medical consultation documents were submitted, and a tracking process was set up for the submission and filing of documents. Although these new processes were in the early stages of implementation, both staff's perception, as well as the Monitoring Team's experience with the records during the onsite review indicated that improvements had been made with regard to the availability of needed documents. During the review, the following issues were noted with regard to the availability and quality of the records, and the impact on the ability of staff to utilize records in making medical treatment and training decisions: ▪ As noted above, from a limited review of records while on site, it was noted that very few documents were missing from the active records. However, it could not be determined if missing documents from the Monitoring Teams' documentation requests were due to the documents not being completed, not being available in the active records, or inadvertently not included in the requested packets. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. ▪ Observation of individual planning meetings showed mixed results with regard to staff's use of information in the records to make care, medical treatment, and training decisions. ▪ 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 clear that staff were not consistently and timely documenting data, and processes were just beginning to be developed and implemented to ensure data reliability. This was further complicated by I-Books not containing up-to-date data sheets on a regular basis. The Facility had begun to implement the State Office tool for monitoring this component of the Settlement Agreement. Although this was a positive development, additional monitoring methodologies will be necessary to substantiate compliance with this provision. It will require a number of different methodologies, including, for example,	Noncompliance

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		observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, PSP meetings, etc.), reviewing Integrated Progress Notes and other 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. Modifications should be made to the check-out policy for Active Records. Specifically, parameters for how long a record can be signed out (i.e., until the end of the staff person's shift) should be explicitly stated, and consideration should be given to making the File Clerks or other staff member (e.g., Shift Supervisor) responsible to check on a regular basis (e.g., end of each week) to ensure all records that were signed out have been returned. (Section V.1)
2. If ongoing training for all staff on maintaining the confidentiality and security of records is not currently a part of annual, or at least biannual training, it should be. (Section V.1)
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. 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)
6. The Facility should develop a standardized system to train staff, and ensure staff have the necessary knowledge and skills to implement the new or revised policies. To accomplish this, the Facility should define in policy or procedure the process that will be used to ensure this occurs. In developing such a policy, the following should be considered:
    a. It should incorporate mechanisms to communicate the issuance of new policies and training requirements, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job categories to whom training should be provided.
    b. In addition, for each policy approved, consideration should be given to having the QA/QI Committee define who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility.
    c. Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training).
    d. Based on documentation provided, it appeared a system was available to track which staff had completed which training, and to run exception reports showing who still required training. Incorporation into this system of the training on policies would appear necessary and appropriate. (Section V.2)
7. Monitoring of records should result in analysis of data, and development and implementation of 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. As is specified in other sections of this report, improvements should be made with regard to the quality of the data and other information that is entered into individuals' records. (Section V.4)
9. The Facility's POI should provide an analysis of the Facility's overall policy development. (Facility Self-Assessment, and Section V.2)
10. 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)
11. Further refinement of the internal auditing process should occur, including establishment of inter-rater reliability, analysis of audit results, and development and implementation of corrective action plans. (Facility Self-Assessment)

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
AMA	Annual Medical Assessment
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
DPN	Dental Progress Note
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
FAIF	Functional Assessment Interview Form
FAST	Functional Assessment Screening Tool
FBA	Functional Behavior Assessment
FDA	Federal Drug Administration
FNP	Family Nurse Practitioner
FSA	Functional Skills Assessment
FTE	Full-time Equivalent
GE	Gastroesophageal
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-J	Gastrojejunostomy
gm	Grams
G-tube	Gastrostomy Tube

HCG	Health Care Guidelines
Hgb	Hemoglobin
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
HT	Habilitation Therapy
I and O	Intake and Output
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
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IPN	Integrated Progress Notes
IV	Intravenous
J-tube	Jejunostomy Tube
L	Liters
LA	Local Authority
LAR	Legally Authorized Representative
LBSSLC	Lubbock State Supported Living Center
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
MDRO	Multi-drug resistant organism
mg	Milligrams
MH	Mental Health
MHMR	Mental Health Mental Retardation
ml	Milliliters
MMC	Mealtime Management Committee
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
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
PE	Physical Examination
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
QABF	Questions About Behavioral Function
QDDP	Qualified Developmental Disability Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement

QID	Four times a day
QMRP	Qualified Mental Retardation Professional
REACT	Respiration, Energy, Alertness, Circulation, and Temperature
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
SAP	Skill Acquisition Program
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
VPA	Valproic Acid
VNS	Vagus Nerve Stimulators
VRE	Vancomycin-Resistant Enterococci
VRI	Viral Respiratory Infection
VS	Vital Signs