United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

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Submitted By: Maria Laurence, MPA

Monitoring Team: Elizabeth Jones, MS
Victoria Lund, Ph.D., MSN, ARNP, BC
Edwin J. Mikkelsen, MD
Susan Thibadeau, Ph.D., BCBA-D
Nancy Waglow, MS, MEd
Wayne Zwick, MD

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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. Substantial Compliance Ratings and Progress

Across the State's 13 Facilities, there is variability in the progress being made by each Facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation of the parties who crafted the Settlement Agreement was for the State to make systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the Facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a Facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report to identify the Facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the Facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity. Some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, Section L.1 addresses the total system of the provision of medical care at the Facility. This is in contrast with Section T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each Facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the Facility will obtain substantial compliance with 25% of the provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement. This is due to the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the Facility (as was the intent of the parties).

V. Executive Summary

The Monitoring Team's last compliance review was completed in November 2011. At that time, serious concerns were noted. In fact, in that report, the Monitor noted: "it was surprising and concerning that, as a whole, Austin State Supported Living Center (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." The findings from this most recent review were very different, and much more positive. When the Monitoring Team visited AUSSLC for an abbreviated review in the May 2012, the beginnings

of change were evident. However, during this review, the entire Monitoring Team saw some changes that are essential to eventual compliance with the Settlement Agreement, and most importantly, improving the lives of and supports provided to the individuals who live here. Some of these changes included:

- A real sense of teamwork. Disciplines were not only working together, but also recognizing the strengths that one another brought to the table.
- A focus on the contributions of direct support professionals, and commitment to ensuring they have the skills they need to support individuals.
- Training that had gone beyond classroom training to more competency-based models and side-by-side mentoring had been another key to success.

Although this report identifies a number of areas in which improvements are needed, there had been progress in a number of areas and in others some of the basic staffing and structures had been put in place to allow needed progress to be made. In just about every meeting the Monitoring Team had during its onsite review, staff were able to identify areas in which progress had been made, but importantly set forth the areas still needing improvement and a plan for next steps. Importantly, these changes had already begun to be evident in more meaningful interactions between staff and individuals that live at AUSSLC, and some improved supports, protections, and services.

At the beginning of the week, the management team showed the Monitoring Team a video demonstrating how the integrated approach to delivering supports had the ability to change lives. This was an example of how everyone came together with their various knowledge and experience to build a different configuration of supports and work side-by-side with the staff responsible for directly supporting the individual. The Monitoring Team believes that with the same enthusiasm and collaborative effort, along with more targeted side-by-side training and mentoring, AUSSLC should be able to continue to move in positive directions for individuals as well as in attaining substantial compliance.

As with previous reviews, the Monitoring Team would like to thank the management team, all of the staff, and the individuals who live at AUSSLC for their assistance during the onsite visit, as well as in preparation before the visit, and the production of many documents after the visit. Everyone with whom the Monitoring Team spent time during the onsite review was helpful in providing valuable information to assist the Monitoring Team in reviewing the Facility's status with regard to the Settlement Agreement.

The following is a brief summary of Austin State Supported Living Center's status with regard to relevant sections of the Settlement Agreement:

Restraints

- Although substantial work still needed to be completed before AUSSLC reached substantial compliance with the provisions of Section C, during this site visit, there was evidence of greater focus on and organization of the tasks related to the Settlement Agreement and the overall policy directives issued by the State Office. For example, the Director of Behavioral Services had taken steps to retrain monitors who were found to be inconsistent in completing restraint documentation. Restraint use was beginning to be examined through a number of varied methods and continued to receive priority attention at the daily Incident Management Review Team meetings attended by the Facility's leadership. In particular, observation of the assigned Skill Acquisition Specialists provided evidence of the positive effects of individualized attention and more meaningful habilitation activities. This was particularly noteworthy in the observation of one individual with a high rate of restraint use. Direct support professionals in the residential units with a reduced census, including one residence with seven individuals, commented to the Monitoring Team about the positive behavioral effects of that change, effects experienced by both the individuals and the staff.
- Review of restraint documentation highlighted the need to continue concentrating attention not only on the accurate and timely completion of the forms, but also on the events leading up to the use of restraint. There was scant evidence of the environmental and social factors possibly influencing an individual's behavior and relatively little description of any alternatives to restraint use. It was not evident from the restraint checklists that there was consistency among the staff working with the individuals with challenging behaviors. The database did not include all occurrences of restraint, and monthly progress reports for several individuals continued to reference programmed restraint. Efforts to reduce the use of restraint and/or sedation for dental and medical procedures remained a very slow process. Only one Skill Acquisition Plan had been developed to address this matter. The adequacy of the Facility's response to repeated restraint remained inconsistent across individuals.

Abuse, Neglect and Incident Management

- The leadership of AUSSLC is to be commended for the significant improvements noted with regard to its adherence to the protection from harm requirements included in Section D. The investigation reports reviewed were much stronger in their organization and substantive content. Many of the problems noted in past reviews of investigations, such as the lack of timeliness and the lack of evidence of supervision had been largely corrected. The commitment to zero tolerance of abuse, neglect, and exploitation was evident in the disciplinary actions taken, including the actions taken against employees who failed to report. The failure to report incidents of such transgressions as improper lifting, which resulted in a fractured arm, or intimidating staff behavior was documented in the sample of investigations reviewed for this report. Employees found to have abused or neglected the individuals under their care were dismissed. Recommendations for improved staff performance and, occasionally, for active treatment were more frequently included in the investigation reports issued by both DFPS and AUSSLC. Recommendations were now tracked daily and there was an up-to-date tracking log

provided to the Monitoring Team. The forums for discussing and assessing the Facility's performance, including the Quality Assurance/Quality Improvement Council and the daily Incident Management Review Team meetings, had been reconvened with a more streamlined format.

- The investigations indicated the continuing need to enforce the requirements for timely reporting. Although efforts had been made to develop tracking and trending reports, these initiatives required further refinement in order to provide the information that would be most useful.
- Since the Monitoring Team's last visit, the Director of Risk Management/Incident Management had begun to implement systematic methods for data collection and analysis. She was working closely with the Director of Quality Assurance and the Executive Leadership Team to reduce risk in the living environments. The addition of Skill Acquisition Specialists permitted a greater focus on individualized approaches to habilitation. The individuals and staff who lived/worked in the houses with fewer people commented positively on this change.
- Although the Facility was not in substantial compliance with all of the provisions of Section D, the Facility's progress and improvement were recognized.

<u>Quality Assurance</u>

- Although compliance with the provisions of Section E had not been reached, there was clear evidence of energy, initiative, and resolve to reach that goal. In partnership with the Facility's executive leadership team, the Director of Quality Assurance and his staff had formulated a clear framework for the quality assurance process at AUSSLC and were in the early stages of its implementation. There was a commendable focus on ensuring habilitation and person-centered supports for the individuals residing at the Facility. For example, the 5 x 5 Key Elements Audit was designed to ensure that attention was directed to the most visible individuals at AUSSLC in order to reduce the use of restraint and the occurrence of undesired behaviors, injuries, etc. It will be important to continue to analyze and disseminate the findings from such qualitative approaches. At the same time, there was a realistic assessment of the potential barriers to achieving compliance with the Facility's goals and the concurrent goals of the Settlement Agreement. As a result, there were significant efforts underway to establish collaboration with the clinical departments in order to strengthen monitoring processes and the evaluation of the outcomes. The results of this collaboration should be evident during the next visit.
- One of the primary concerns noted during the onsite visit continued to be the lack of established key indicators and/or outcome measures. According to information obtained during the review, the State Office assumed responsibility for the determination of the final set of key indicators and/or outcome measures. However, this work had not been finalized, but the Facility had made a conscientious effort to move forward to the degree possible. It is essential that the State Office resolve this issue as soon as possible so the structure of the monitoring process and the requirements for the review of critical outcome data can be finalized.
- In July 2012, the Facility reconvened the Quality Assurance/Quality Improvement Council. It was scheduled to meet twice a month. Review of its monthly minutes and attendance at one of its meetings continued to demonstrate the importance and effectiveness of this organizational structure. The agendas consistently

focused on achievement of compliance with the provisions of the Settlement Agreement. Corrective Action Plans (CAPs) were beginning to be identified, refined, and tracked.

- The Facility had instituted a CAP Tracking System to review the CAPs submitted to the Quality Assurance Department. For the quarter following the Monitoring Team's visit, the Facility had noted its intent to prioritize the monitoring and reporting of the CAPs and the comprehensive CAP review. Without such reporting and analysis, it would be difficult to determine whether the CAPs were addressing the cited concerns in a reliable and sustainable manner.

Integrated Protections, Services, Treatments and Supports

- In May 2012, DADS State Office had revised Policy #004.1: Individual Support Plan (ISP) Process, and had provided the Monitoring Teams with a draft copy. A number of changes had been made to the ISP format/template and process. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was developed to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. At the time of the review, AUSSLC staff had not undergone the full training on the new ISP process, including the new Integrated Risk Rating Form (IRRF) and the Integrated Health Care Plan (IHCP) process. Although teams had begun to use some of the new forms and processes, they were awaiting further training from State Office.
- At the time of the Monitoring Team's last compliance review in November 2011, a number of factors were identified that 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. Since then, although not all of these problems had been remedied, some important work had been done to address these issues, and progress was being made. In addition to some assessments beginning to show some improvements, based on the Monitoring Team's observations during the week of the review, team members were more meaningfully participating in team meetings, and information was sought and provided by team members, including direct support professionals. These were extremely important shifts, and were illustrative of the greater teamwork that was seen across campus during this review.
- Although issues with the timeliness and quality of assessments prepared for ISP meetings continued to require improvement, as noted in other sections of this report, some improvements were being seen. For example, psychiatric, Occupational Therapy/Physical Therapy, and speech assessments all showed some improvements. In addition, based on observation of a newer format ISP meeting while the Monitoring Team was on site, as well as a video Facility staff shared of an individual with a visual impairment whose team had worked together to revise the supports provided to her, teams had begun to use assessment findings and recommendations in a more integrated fashion. For example, the video presented an example of good use of the recommendations from a specialized assessment from an orientation and mobility specialist in combination with the knowledge

and information others at the Facility had of the individual to significantly improve the individual's day-to-day life. Similarly, during an ISP meeting, one individual's team demonstrated use of information from a variety of assessments to creatively develop some plans to address health risks as well as to assist the individual to become more independent. It is the Monitoring Team's hope that teams throughout the Facility will replicate similar practices.

- Although more work was needed, it was clear that teams were trying to expand action plans to include more of the protections, supports, and services individuals required. In addition, based on limited documentation review, it appeared that efforts were being made to make goals and objectives more measurable and functional. In addition, efforts were being made to better define the role of the direct support professionals in ISPs.
- The Facility recognized that monthly review reports were an area requiring improvement, and Facility staff were working with a group State Office was leading to address this issue. However, as noted in a number of portions of this report, teams were not consistently identifying and addressing individuals' changes in status.
- Some improvements were seen with the timeliness of ISP meetings. However continuing concerns were noted with the timely completion of the final documents to allow implementation to occur. AUSSLC had begun to offer QDDPs two days after an ISP meeting during which someone else covered their other duties to provide time to finalize the draft ISP. This had been welcomed as a potential solution to the long delays.
- 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 conducted limited monitoring, and the QA Department also had just begun to conduct monitoring. The Facility recognized that it was not yet collecting adequate data, aggregating and analyzing it, using it to identify issues, and develop plans to correct them.

<u>Integrated Clinical Services</u>

- The medical morning meeting minutes were thorough and reflected interdisciplinary discussions, providing some evidence of integrated clinical services. However, the minutes were a resource that was underutilized. An analysis of the minutes over time would provide documentation of the activities of the group, the number of closure items identified, the number closed each month, the number outstanding at the end of the month and at 30 days, etc. Although the Facility's Self-Assessment indicated that departmental attendance was tracked, evidence of this was not submitted. This would be an additional valuable area for providing evidence of integrated clinical care.
- Criteria needed to be established to determine the quality of the ISPAs developed to address hospitalizations, with a focus on preventive aspects of care, and not only addressing the individual's immediate transition needs back to the Infirmary or residence. Timelines should be established for related activities, including timelines from the time the morning meeting group makes a referral to an individual's team, the team conducts the ISPA meeting and returns documentation to the morning meeting group, and the morning medical group reviews the ISPA. The Settlement Agreement's requirement of five days for changes health status should be followed.

- Tracking of PNMT recommendations also needed to occur. The Medical Department had identified this need, but not further pursued it.
- The consultant tracking monitoring tool template had been developed, but the Medical Department had not implemented this monitoring tool. There was a tracking tool utilized for on and offsite appointments, which also included missed and refused appointments, but it did not appear to generate referrals to the IDT to address missed appointments. This information also should be processed back to the morning meeting.
- In the previous six months, the Medical Department had begun the process of creating a systems approach for compliance with integrated clinical services. The momentum had provided evidence of considerable steps forward. However, much remained to be accomplished, such as the completion of databases, analysis of data, and periodic summaries, and implementation of monitoring tools. The Facility remained noncompliant with Section G.

Minimum Common Elements of Clinical Care

- The Medical Department had continued to make strides in implementing systems to ensure minimum common elements of clinical care were provided efficiently, and were of adequate quality. One of the limiting factors was development of data management systems and lack of ability to track information and progress steps, as well as lack of a summary document to allow effective review of the information. For areas for which there was information, challenges still remained. The timeliness of medical annual assessments and Quarterly Drug Regiment Reviews (QDRRs) required improvement. Dental annual assessments were timely. This section also should reflect timely assessment and monitoring of assessment of all clinical disciplines and related departments, such as Physical Therapy (PT), Occupational Therapy (OT), speech, audiology, dietary, nursing, psychology, and psychiatry.
- More specific to the Medical Department, the diagnoses on the active problem list needed further review. The criteria/evidence provided was not always sufficient to determine the accuracy of the diagnoses. Although improvements were seen with the justifications for psychiatric diagnoses, some issues were still noted, but processes were in place to address them.
- In the past, for one of the residences, a clinic log had been developed that recorded a number of parameters useful to track timeliness of assessment and quality of treatment. If updated and continued, this could be used to provide valuable information concerning the residences' identification of and primary care practitioners' (PCPs') timely response to health status change, as well as provide a source of information to review the quality of care.
- Clinical indicators separate from the audit measurement tools used in the external medical and medical management audits had been developed, but had not reached implementation phase.

At-Risk Individuals

- Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that

were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that would be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition (APEN) was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status.

- At the time of the review, the Facility had not yet received the necessary training regarding the revised At-Risk and ISP process. However, the Monitoring Team found a significant number of problematic issues in the existing At-Risk system, which if not addressed, could be transferred to the revised system. The Facility indicated that the massive technical issues related to restoring the gas and water at the Facility along with numerous staffing challenges, necessary responses related to regulatory reviews, and changes in key leadership positions had essentially prevented progress from being made in several areas, including Section I. Thus, at the time of the onsite review, most of the activities and monitoring outlined in the Self-Assessment to determine compliance scores had not been implemented. While the Monitoring Team agreed that changes to the At-Risk system needed to occur in order for the Facility to achieve substantial compliance, the overall lack of clear documentation included in the ISPs, Integrated Risk Rating Forms, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or changes in health status, and the lack of specific supporting documentation addressing actions and completion of action plans made it difficult for the Monitoring Team to determine a clear sequence of events in response to risk issues. The lack of progress in the existing At-Risk system was troubling at this juncture of the compliance process.

<u>Psychiatric Care and Services</u>

- The Facility had continued to make progress in a number of areas related to psychiatric care. At the time of the Monitoring Team's November 2011 review, the detailed, Quarterly Review format was still in the process of being implemented consistently for all individuals prescribed psychotropic medication. As of the current review, these comprehensive documents were being consistently implemented.
- The Quarterly Review documentation and the comprehensive psychiatric evaluations (CPEs) collectively addressed 10 of the 15 provisions of the Settlement Agreement. The Department's spreadsheet indicated that, currently, 63 CPEs had been completed, which would equate to 47% of the 135 individuals receiving psychiatric medications. However, only 39 of these had been completed or updated within the past year (29%). The Psychiatry Team expressed confidence they would have CPEs completed and updated for all of the individuals prescribed psychotropic medication by the first quarter of 2013.
- The Psychiatrists had begun to attend the ISPs of the individuals prescribed psychotropic medication. However, the documentation in the ISPs did not reflect the necessary information described in the Settlement Agreement.

In addition to the completion of the CPEs, the Psychiatry Department also will need to ensure that the Psychiatrist's contribution to the ISP meetings is clearly documented in the ISP. This is particularly relevant to the risk-benefit discussions related to the use of psychotropic medication, and the successful integration between the Departments of Psychiatry and Psychology.

- The Settlement Agreement is clear that if the individual's psychotropic medications can be justified, their continued use is acceptable. The Department had compiled the necessary evidence to support the utility of the prescription of multiple psychotropic medications for a significant number of the individuals whose regimens met the criteria for polypharmacy.
- The Psychiatry Department, working in conjunction with the Psychology Department had made considerable progress toward rectifying the previously identified problem of the dual description of the behaviors as both being present on a behavioral basis and being listed as a target behavior of the psychotropic medication.
- In summary, AUSSLC had made progress in a number of areas, and appeared to have viable plans to address the areas that required further improvement.

<u>Psychological Care and Services</u>

- At the time of the visit, the Department of Behavioral Services had a full complement of Associate Psychologists and was soon to have all Psychology Assistant positions filled. Although the Department had lost one Board Certified Behavior Analyst (BCBA) level practitioner, the remaining staff continued to make progress toward certification.
- Psychology Assistant staff had worked with direct support professionals to develop a new data system that was just being introduced campus-wide. However, this new system was in the initial stages of implementation, and some problems persisted. For example, based on the Monitoring Team's review, important behavioral data still was not being routinely recorded. In addition, the new data collection system needed to be individualized to meet the needs of individuals with high intensity behaviors, for example. The Department also was introducing a system to check for inter-observer agreement.
- Peer review continued through the Behavior Therapy Committee and monthly conference calls with professional staff from other State Supported Living Centers. However, external peer review did not consistently result in monthly review of AUSSLC plans or assessments, and although internal peer review was occurring regularly and a number of recommendations for improvements were made, frequent delays of more than 30 days occurred in staff responding to the recommendations. On a positive note, weekly consultation with one BCBA level Associate Psychologist had begun in an effort to address ongoing review of individual cases.
- Although improvements were seen with regard to monthly reports, further work was necessary to improve graphing to allow for easier analysis of information, as well as to ensure that when monthly reviews showed issues with either implementation of plans or the plans themselves, appropriate corrective action was taken.
- Positive Behavior Support Plans had been streamlined, resulting in quicker access for staff to critical information related to preventative and reactive strategies. Staff training on PBSPs also had been expanded to

include more individual-specific training with time allowed to become familiar with the plan and the individual. Although in its initial stages of implementation, an introduction of on-the-job competency-based training was a significant addition to staff training.

- Psychology staff also had begun conducting monitoring of PSBP implementation. Observations were conducted of staff as they worked with individuals focusing on critical components of the PBSP. Although some improvements were needed, this provided a forum for written positive feedback and constructive criticism followed with recommendations for future performance.
- In general, there were many positive changes observed during this most recent onsite review of the Facility.

Medical Care

- In the six months prior to the Monitoring Team's most recent onsite review, progress had been made in numerous areas of medical care and oversight. The medical morning meeting had become a well-developed structure that processed changes in health status promptly. These meetings included quality interdisciplinary discussion that was documented. The PCPs provided current and detailed information on acute care issues, with succinct follow-up plans. The Hospital Liaison Nurse also provided updated information that assisted the morning meeting attendees to discuss current issues in a timely manner. The meeting was facilitated efficiently. However, there was need for more delegation of follow-up activities either through assignment of tasks to a meeting attendee, identification of the need for an open record review, or referral of a specific request to the IDT for response. In addition, focus on preventive aspects of care was needed at both the medical morning meeting, and when teams met to discuss ISPAs to address referrals from the medical morning meeting. Time lines to closure needed to be tracked, with most items closed by the end of the month, unless initiated in the last week of the month.
- The medical quarterly reviews appeared to use varied templates, were often incomplete, and did not have dates of completion. It was not clear how the medical quarterly reviews were being used at a practical level, despite the amount of time and effort in producing these documents. The purpose and templates should be reviewed.
- Missed appointment were another area requiring attention, including identification of the reasons for the missed appointments, and actions to address preventable causes of missed appointment to the extent possible.
- Acute care PCPs provided appeared appropriate. However, there was need to begin to monitor specific diagnoses for assessment and treatment, using the clinical guidelines or other national standards as a basis for review.
- The Ethics Committee was well developed, and had the necessary components to make a decision based on regulatory standards, required documentation, and input from family/guardian and Facility personnel. Attendance was taken and minutes were recorded. Follow-up assignments from the Ethics Committee required improved documentation to closure. In addition, for some individuals, diagnoses justifying the use of a Do Not Resuscitate Order had not been documented.

- One area for which too many conflicting databases existed was pneumonia. Accurate information from these various databases should be condensed into one database to ensure completeness and uniformity.
- The QA Department did not have a presence in the oversight of the quality of medical care, despite established expectations for QA Department follow-up of external and internal medical peer review audit recommendations. Tracking of corrective action plans did not appear to have a QA component.
- Overall, there were many new and innovative steps being taken to develop a system of quality medical care and oversight, as well as a quality interdisciplinary system response to acute and chronic needs of the individual. However, the Medical Department was in the initial stages of this complex endeavor, but appeared to have the vision and skill to continue making progress toward these goals. The Facility remained noncompliant with Section L.

Nursing Care

- Since the last review, AUSSLC's Nursing Department experienced an increase in staff turnover as well as in the key leadership roles. Due to these staffing issues, the Facility had suspended the auditing processes for most of the nursing monitoring tools and only recently had implemented some monitoring at the time of this review. Although the Facility had experienced not only an increase in staff turnover as well as significant changes in key nursing leadership positions, at the time of the review, the overall nursing staffing issues had begun to stabilize at AUSSLC.
- On a very positive note, the Monitoring Team's observations of nursing staff demonstrating emergency equipment checks in the Infirmary, and Residences 729 and 795 found that all staff were familiar with the use and operation of the emergency equipment. This was a significant improvement from previous reviews.
- Also since the last review, the Medication Variance Committee was reinstated and was meeting monthly. From discussions with the CNE and the Director of Pharmacy, the Facility has taken a positive step forward by beginning to critically review a number of the systems addressing medication administration and medication variances. In addition, although considerably more work was needed, the Monitoring Team noted considerable improvement regarding medication administration from the previous reviews regarding telling the individuals the medications they were receiving, providing privacy during medication administration, and listening to lung sounds before and after medication administration, as appropriate.
- Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, and the unreliable systems regarding medication variance data were very concerning at this juncture in the review process.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department continued to put into place systems to monitor the quality of pharmacy services. They were able to demonstrate to the Monitoring Team a rigorous new order system to ensure safe dispensing.

When requested, additional needed information was readily available, but was not inclusive of all five categories for new orders.

- The ADR system was efficient and effective. Training has been completed for the residential staff as well as the professional clinical staff. The next challenge will be development of a refresher course due by May 2013.
- The DUEs had had a positive effect on the clinical practices of the PCPs.
- The timely completion of QDRRs could not be verified. The Facility's Self-Assessment indicated a 96.7% compliance rate, but two separate reviews by the Monitoring Team indicated compliance at 54 to 75%, indicating need for improvement. QDRR content continued to improve. The format was user-friendly. The more recent QDRRs appeared to be more detailed and complete. The internal pharmacy monitoring of the content was an important step, but might not be sensitive enough to capture quality concerns. The Facility also needed to confirm in writing the acceptable timeline between the pharmacy completion of the QDRR and the review date of the psychiatrist. This had been done for the PCPs.
- There was continued inconsistency in the chemical restraint documentation system between departments, and the review of the administration of emergency medication appeared to need improvement. Development of an e-med list updated daily should assist with this process. Concerns included lack of documentation of drug-drug interactions between the prescribed drug and the current drug regimen. Documentation by the psychiatrist appeared to need review to improve the content and value of that section.
- Medication variances remained a challenge. Internally to the Pharmacy, there remained need for improvement, including reduction in the rate of errors. That any errors would leave the pharmacy, and leave the pharmacy and not be captured by nursing indicates a need for a review of the current safety mechanisms in place. Focus on assisting the Nursing Department in resolving the numbers of unexplained returned medications also was needed, and the Pharmacy Department needed to demonstrate it had a system to track all medications to determine the cause of returned medications.

<u>Physical and Nutritional Supports</u>

- The Facility was continuing the process of rebuilding the Physical and Nutritional Management Team (PNMT). Since the last review, the PNMT membership from May to September 2012 consisted of a Qualified Developmental Disabilities Professional and a Physical and Nutritional Management Plan (PNMP) Coordinator. At the time of the review, the PNMT dedicated members were an OT, PT, QDDP, and PNMP Coordinator. A Facility Registered Dietician, Speech Language Pathologist (SLP), and RN were appointed as backup staff to assist the PNMT until dedicated staff was hired. Positions had been posted for a Nurse and Speech Language Pathologist.
- The PNMT Lead/OT attended the daily morning provider meetings. This provided opportunity to update clinical staff on the status of individuals on the PNMT caseload, as well as present systemic issues for discussion and resolution. In addition, the newly formed PNMT identified systemic issues during individuals' assessments and worked to resolve these concerns.

- Although a number of elements required further attention, the first assessment completed by the newly formed PNMT showed great promise. For this individual, the PNMT collected and analyzed relevant data to understand the cause and correlations of the individual's physical and nutritional management (PNM) concerns. However, a review of previous PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans.
- Lists the Facility presented to identify individuals having physical and nutritional management problems were not accurate (e.g., individuals who required mealtime assistance, individuals at high and medium risk for PNM concerns, individuals who had difficulty swallowing). The Director of Habilitation Therapies (HT) acknowledged there were no Facility policies and/or procedures to maintain, update, and sustain these lists. As a result, it was not clear if all individuals with PNM needs had the supports they required.
- Since the last review, the therapists were completing self-audits using the PNMP Audit tool. PNMP content was improved since the last review, but additional work needed to be done to ensure all essential components were present. In addition, a review of the list of individuals without PNMPs and their risk ratings showed that some additional individuals needed a PNMP.
- The Monitoring Team and members of the PNMT team completed direct observations of the implementation of PNMP strategies in residences for individuals on the PNMT caseload. These observations revealed that some staff were, but others were not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, the Facility's monitoring did not identify similar problems.
- The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' Risk Action Plans did not generate individual-specific clinical data to substantiate an individual's progress or to assess if the individual was better or worse, monthly progress notes were not completed to report on the effectiveness of an individual's supports and services, individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis.
- The Facility was scheduled to receive training in the new Aspiration Pneumonia Enteral Nutrition (APEN) process in conjunction with the new ISP process. Consequently, the ISPs did not yet provide justification for the continued use of feeding tubes as medically necessary, or identify the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

<u>Physical and Occupational Therapy</u>

- Individuals' OT/PT assessments were significantly improved from the last review. However, the assessments were still missing some essential components. A positive practice was the development of an OT/PT assessment audit tool, but the tool had not been implemented.

- OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of effectiveness review of the individual's progress with direct and/or indirect OT/PT supports.
- Individuals with PNMPs and dining plans were not monitored at an established frequency with an emphasis on enhanced monitoring for individuals at high risk for PNM concerns. The monitoring also did not address the status of their identified occupational and physical therapy needs, and the effectiveness of their OT and PT therapy programs. Furthermore, all prescribed adaptive equipment was not assessed for its condition, availability, and effectiveness.

Dental Services

- The Dental Department continued to make progress in providing quality and comprehensive care. The timely completion rate of the annual dental exams was 97%. Suction tooth brushing was beginning to be offered to additional individuals that would benefit from this procedure. A pilot project for improving oral hygiene in one residence was being developed. A new process for desensitization that was interdisciplinary had developed individual-specific plans that had potential for positive impact.
- Concerns remained in that 53% of the campus had poor oral hygiene ratings. Although there were two Dental Assistants and two Dental Hygienists, limited time appeared to have been assigned for training and teaching in all residences in which individuals had poor dental hygiene. Considerable efforts had been made to train individuals and staff during in-home exams or at the dental clinic, but no information was available regarding whether the training was competency-based, or whether follow-up occurred to determine if this training was effective.
- The Dentist did not appear to consistently document follow-up to procedures completed using oral sedation and total intravenous anesthesia (TIVA) to verify a recovery without complications. Given the number of injuries within 24 hours of TIVA, follow-up with documentation might be necessary after 24 hours to ensure no injuries occurred to the oral cavity and/or to determine if release from the Infirmary was premature.
- The State Office should review the definition of a dental emergency for documentation purposes. At AUSSLC, acute care visits were not entered into the emergency log, making it difficult to track the timeliness of notification of the Dental Office and treatment.
- State Office review of the definition of a missed appointment was also needed. AUSSLC had narrowed down the definition, and in the process, removed data that should have been included and reviewed. It is important to record all reasons for missed appointments in order to track the percentage of appointments affected by delay in evaluation and treatment, as well as ensure follow-up care is provided.
- Desensitization efforts continued at a slow pace. At the time of the review, 10 desensitization plans using a revised format had been created. Although they held potential for success, they had not yet been piloted.
- Much progress had been made in the Dental Department. However, there were many challenges that remained. The Facility remained out of compliance with this section.

Communication

- Individuals' Speech and Language assessments were significantly improved from the last review. However, the assessments were missing some essential components.
- Fifteen competency performance check-offs had been developed for new employees. The communication performance check-offs were adequate to assess new employees' competencies for providing communication supports to individuals. A plan was being developed to provide communication competency-based training and performance check-offs for current staff.
- Some staff had been provided with individual-specific competency-based training and performance check-offs to demonstrate their competency in supporting individuals in the use of their alternative and augmentative communication (AAC) systems. However, the Monitoring Team was not able to discern if the total number of staff providing supports to these individuals had been trained. In addition, the competency performance check-offs provided did not include staff training for all of an individual's AAC devices.
- The monitoring of AAC devices was occurring for some individuals. However, based on documentation provided the monitoring was not adequate. The Facility did not have a policy defining the process for monitoring individuals' AAC equipment or its use.

Habilitation, Training, Education, and Skill Acquisition Programs

- Several promising developments were presented during the week of the onsite review. The Facility was holding meetings three months prior to the Individual Support Plan meeting to ensure that all needed assessments were identified and scheduled for completion. Active Treatment Coordinators had been trained to competency in completing the Functional Skills Assessments, and they had received side-by-side training from consultants in developing and writing Skill Acquisition Plans. The Facility had developed individual activity cards to serve as a quick reference to the individual's preferences and special considerations. Skill Engagement Specialists had been introduced to help facilitate a greater range of activities in the home, on campus, and off campus. Each of the three units was assigned two specialists whose schedules of 11:00 a.m. to 7:00 p.m. allowed for assistance and support across two shifts. The workshops had adjusted their hours of operation to better accommodate the needs and schedules of the individuals served. Three new positions had been added to habilitation services. These included one Job Procurement Specialist whose responsibilities included expanding the contract work available on campus and two Community Coordinators to help facilitate involvement in community-based activities. Plans were underway to develop cooking classes, a literacy program, and training in using community-based transportation services.
- Although steps had been taken to improve the habilitation services offered to the individuals at AUSSLC, problems remained related to comprehensive assessment and program planning, skill acquisition plan development and implementation, and integration in the community environment. The Monitoring Team found the Facility out of compliance with all provisions of Section S.

Most Integrated Setting

- Prior to annual ISP meetings, each assessor was now expected to include a specific recommendation regarding whether or not the individual could be supported in a less restrictive setting. Most assessments now included such statements, but some did not. Individuals' ISPs generally included determinations by professionals with regard to whether community placement was appropriate. Unfortunately, in about half of the ISPs reviewed, teams had not provided adequate justifications for the recommendations they made to individuals and their guardians. For example, although statements in assessments indicated that supports could be provided in a less restrictive setting to meet the individuals' needs, professionals on teams then concluded that the individual would not benefit from a transition to the community. Teams did not reconcile the statements in the assessments with their final recommendations.
- Since the May 1, 2012, 13 individuals had transitioned to the community. At the time of the review, 35 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 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.
- The State had developed a list of standard obstacles to referral that teams had begun to utilize as part of the ISP process. However, IDTs had made little progress in accurately and completely identifying obstacles to referral, and/or developing plans to overcome them. AUSSLC had not yet begun to systematically collect data on obstacles to transition. Although the data could not yet be considered valid, the Facility would soon be submitting its annual report to the State, which should include an analysis of data collected thus far. In developing such a report, it will be important for the Facility to incorporate staff's knowledge of issues that potentially impede transition. Actions the Facility can take locally or with which Transition Specialists can assist, as well as those that fall more into the realm of DADS State Office should be incorporated into the report.
- The Community Living Discharge Plans (CLDPs) reviewed included pre-move and post-move required supports. However, teams still did not consistently identify the full array of pre-move and post-move required 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.
- Based on the documentation provided, it could not be determined if post-move monitoring had been completed in a timely manner for a number of individuals who had transitioned to the community. With regard to the content of the post-move monitoring checklists, each of the items on the checklists had been addressed. However, a number of concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals. In addition, the post-move monitoring identified some issues with regard to the provision of services at the community sites. Although the Facility had taken some important steps to correct issues,

documentation was not submitted to show what the role of individuals' teams was in this process. Although some important improvements were reported as having occurred in recent months, concerns were noted in the documentation reviewed with regard to the timeliness as well as the urgency with which staff addressed some significant concerns for individuals.

Consent

- On 3/7/12, DADS State Office issued Policy #019: Guardianship. The Facility had not yet developed a local policy, and the Facility was in the initial or planning stages of implementing many of the requirements of the State Office policy. A second policy on consent remained in the development phase. The State is encouraged to finalize this policy, because it should assist the Facilities in moving forward 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, 80 of the 321 individuals the Facility served (25%) did not have guardians. In addition, 64 individuals had lapsed guardianships. It was positive that the Facility had reduced this from the approximately 150 individuals originally identified as having lapsed guardians, but this remained a significant number. Courts had found that these individuals lacked the capacity to make decisions when they appointed guardians, and in some cases, the guardianships had lapsed months or even more than a year ago.
- As noted in the report for the Monitoring Team's visit in November 2011, AUSSLC had developed a document entitled: "Guardianship Priority Rating Tool." However, the Facility had made a reasonable determination that prioritization of individuals in need of guardians should not occur until an adequate process had been implemented to assess individuals' functional decision-making capacity.
- As the Monitoring Team reported in previous reports, Facility staff made ongoing attempts to obtain guardians for individuals. Since the baseline review, a total of 30 individuals had obtained guardians, 19 of which had been appointed since April 2012. An additional five individuals had had hearings, but paperwork was pending. Three additional individuals had guardianship applications pending. The majority of new guardians were family members. For some of the individuals for whom hearings had been held, it was anticipated that the local nonprofit guardianship agency would be appointed as guardian.

Recordkeeping and General Plan Implementation

- At the time of the review, staff reported that each individual had an Active Record, a Master Record, and an Individual Notebook.
- In the Monitoring Team's report based on its onsite review in November 2011, a number of issues were noted with regard to the Individual Notebooks. Since then, a workgroup had met, and developed a revised Table of Contents for the Individual Notebooks. The Notebooks had been revised to the new format. However, only the File Clerks had been trained and further training was being planned for all staff that would have responsibility for the Individual Notebooks.

- In March 2012, a revised Active Records checkout process began. The Administrative Assistants were supposed to check weekly to ensure all records were in the residences. This partially addressed the issue of security of the records. The Facility recognized more work was needed in this area.
- At the time of the review, as required by the Settlement Agreement, at least five audits were being completed of records each month. These audits were identifying problems with the records, and some follow-up was occurring on an individual record basis. The next step would be aggregating and analyzing information gained through record audits in more depth to determine if more systemic or targeted corrective action was needed.
- The Facility was making progress in updating and/or developing policies to address the various requirements of the Settlement Agreement. In addition, the Facility had developed what appeared to be a viable process for identifying the training needs for various policies, providing the training, and tracking the training's completion.
- Based on observations of team meetings, teams were more consistently using data, and other information contained within individuals' records, to make care, treatment, and training decisions. However, improvements in this regard were still necessary. In addition, issues related to the completeness of the records, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability.

VI. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints

Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.

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

- **Review of Following Documents**:
  - For Sample #C.1, eight individuals with a total of 30 restraints were selected from lists the Director of Behavioral Services provided. Restraint records were requested, including Restraint Checklists, Face-to-Face Assessments, Debriefing and Reviews for Crisis Intervention Restraint forms, PBSPs, and for each restraint, the documentation of any and all reviews of this restraint information for the following individuals on the following dates and times:

Individual	Date of Restraint	Time of Restraint
Individual #74	7/6/12	6:02 p.m.
	7/12/12	12:53 p.m.
	7/14/12	8:22 a.m.
	7/26/12	7:55 p.m.
Individual #406	5/6/12	12:30 p.m.
	5/7/12	7:30 a.m.
	5/25/12	10:37 a.m.
	5/27/12	6:20 a.m.
	5/27/12	6:50 a.m.
	8/6/12	3:45 a.m.
	8/6/12	3:55 a.m.
	8/12/12	2:03 p.m.
	8/19/12	6:50 p.m.
	10/5/12	8:00 a.m.
	10/12/12	2:45 p.m.
	10/13/12	8:25 p.m.
	10/27/12	10:25 a.m.
Individual #421	8/2/12	5:50 p.m.
	8/2/12	6:43 p.m.
	8/3/12	1:08 p.m.
	8/4/12	2:33 p.m.
	8/6/12	9:42 a.m.
	8/17/12	10:10 a.m.
Individual #445	5/2/12	8:35 a.m.
	5/12/12	6:11 p.m.
	5/17/12	12:32 p.m.
Individual #288	5/8/12	10:10 a.m.

Individual #303	9/25/12	11:50 p.m.
Individual #364	10/30/12	1:20 p.m.
Individual #374	7/16/12	12:24 p.m.

- For Sample #C.2, the following documentation was requested for a sample of 30 staff: the names of staff with their start dates, and the dates on which they were determined to be competent with regard to the required restraint-related topics;
- Presentation Book for Section C;
- DADS Policy: "Use of Restraint," approved 4/12, and staff training materials related to the new policy;
- AUSSLC Policy: "Use of Restraint," dated 5/12;
- FY 11-12 Restraint Reports for AUSSLC;
- Restraint Log, dated 5/1/12 to 11/5/12;
- Restraint documentation forms;
- "Do Not Restrain" List, undated;
- Monthly Restraint Notes by the Director of Behavioral Services, dated 5/12 through 9/12;
- Restraint monitoring surveys completed for Individual #74, Individual #341, Individual #344, Individual #380, Individual #406, and Individual #421;
- Self-Assessment for Section C, 10/22/12;
- For the restraint episodes for the individuals for the sample for Section C.7:
  - Crisis Intervention Restraint Checklist, and Face-to-Face Assessment and Debriefing Form for Individual #445, on 5/12/12 at 6:11 p.m.;
  - Crisis Intervention Restraint Checklists for Individual #445, on 5/2/12 at 8:35 a.m., 5/17/12 at 12:32 p.m., 5/22/12 at 8:44 a.m., and 5/22/12 at 11:12 a.m.;
  - Crisis Intervention Restraint Checklist, and Face-to-Face Assessment and Debriefing Forms for Individual #406, on 5/6/12 at 12:30 p.m., 5/7/12 at 7:30 a.m., 8/6/12 at 3:45 p.m., 8/6/12 at 3:55 p.m., 8/19/12 at 6:00 p.m., 10/5/12 at 8:00 a.m., 10/12/12 at 2:45 p.m., 10/13/12 at 8:25 p.m., and 10/27/12 at 10:25 a.m.;
  - Avatar Report, and Face-to-Face Assessment and Debriefing Forms for Individual #406, on 5/25/12 at 10:37 a.m., 5/27/12 at 6:20 a.m., and 5/27/12 at 6:50 a.m.;
  - Avatar Report for Individual #406, on 8/12/12 at 2:33 p.m.;
  - Crisis Intervention Restraint Checklist, and Face-to-Face Assessment and Debriefing Forms for Individual #421, on 8/2/12 at 5:50 p.m., 8/2/12 at 6:43 and 6:53 p.m., 8/4/12 at 2:33 p.m., 8/6/12 at 9:42 a.m., and 8/17/12 at 10:10 a.m.;
  - Face-to-Face Assessment and Debriefing Form for Individual #421, on 8/3/12 at 1:08 p.m.;
  - Crisis Intervention Restraint Checklist, and Face-to-Face Assessment and Debriefing Forms for Individual #74, on 7/6/12 at 6:02 p.m., 7/12/12 at 12:53 p.m., 7/14/12 at 8:22 a.m., and 7/26/12 at 7:55 p.m.;
  - Administration of Chemical Restraint, Consult and Reviews for Individual #74, on 7/12/12 at 1:52 p.m., and 7/26/12 at 8:20 p.m.;

	o Positive Behavior Support Plan Progress Notes and Psychiatry Clinic Monthly Reviews for: Individual #175, Individual #154, Individual #435, Individual #123, Individual #335, Individual #16, Individual #220, Individual #4, Individual #389, Individual #341, and Individual #382; o Pretreatment Sedation Committee Meeting minutes, dated 7/11/12, 8/2/12, 9/7/12, and 10/22/12; o Dental Task Analysis report, dated 9/14/12; o Dental Desensitization Plans for: Individual #417, Individual #248, Individual #61, Individual #226, Individual #292, Individual #57, Individual #190, Individual #200, and Individual #169; o Skill Acquisition Plan (dental) for Individual #274; o In response for a request for a copy of the 10 most recently developed and approved medical or dental desensitization plans, the following: Dental: Individual #332, Individual #381, Individual #363, and Individual #327; Medical: Individual #123, Individual #394, Individual #202, Individual #414, and Individual #98 – note that only nine individuals were included on this list; o List of individuals with medical or dental desensitization plans in place, including the date on which the plan was developed; o Power Point presentation on the use of restraint, approved 4/12; o Restraint Policy Notes for Nursing; o Restraint Policy Training – QDDPs; o Revised Restraint Policy – Direct Support Staff; o Protective Mechanical Restraint for Self-Injurious Behavior Checklist (4/12) and Key (5/1/12); o Medical/Dental Restraint Checklist (4/12) and Key; o Crisis Intervention Restraint Checklist (4/12) and Key; o List of individuals restrained more than three times in a rolling 30-day period between May and October 2012; o Psychological Evaluations for: Individual #445, Individual #406, Individual #421, and Individual #74; o Functional Skills Assessments for: Individual #445, Individual #406, Individual #421, and Individual #74; o Preferences and Strengths Inventories for: Individual #445 and Individual #74; o Individual Support Plans for: Individual #445, Individual #406, Individual #421, and Individual #74; o Individual Support Plan Addenda: Individual #445, Individual #406, Individual #421, and Individual #74; o Monthly Reviews by QDDP for: Individual #406, Individual #421, and Individual #74; o Positive Behavior Support Plans for: Individual #445, Individual #406, Individual #421, and Individual #74; o Crisis Intervention Restraint Instructions for: Individual #445, Individual #406, Individual #421, and Individual #74;

	○ Antecedent- Behavior-Consequence (ABC) Data Sheets for: Individual #445, Individual #406, Individual #421, and Individual #74; ○ Positive Behavior Support Plans, Safety Plan for Crisis Intervention Progress Notes, and Psychiatry Clinic Monthly Reviews (from 6/12 to 9/12), for: Individual #445, Individual #406, Individual #421, and Individual #74; ○ Restraint Reduction Committee Meeting minutes, dated 5/24/12, 6/28/12, 7/26/12, 8/9/12, and 9/13/12; ○ Presentation of Section C at entrance meeting, on 11/5/12; ○ Restraint documentation completed by nursing staff for the following restraint episodes: Individual #397, on 10/13/12 at 8:35 a.m.; Individual #210, on 10/22/12 at 7:02 a.m., and 10/25/12 at 1:45 p.m.; Individual #358, on 7/30/12 at 2:50 p.m.; Individual #406, on 10/5/12 at 8:00 a.m., and 10/27/12 at 10:25 a.m.; Individual #421, on 8/2/12 at 6:43 p.m., 9/19/12 at 3:07 p.m., and 10/1/12 at 3:20 p.m.; Individual #30, on 8/24/12 at 2:22 p.m., 9/3/12 at 5:27 p.m., and 10/27/12 at 3:36 p.m.; Individual #303, on 9/25/12 at 11:50 a.m.; Individual #380 on 10/26/12 at 3:17 p.m.; Individual #74, on 7/6/12 at 6:02 p.m., 8/2/12 at 8:17 p.m., and 9/24/12 at 7:10 p.m.; Individual #344, on 9/19/12 at 11:05 a.m., and 10/4/12 at 7:55 a.m.; Individual #56, on 9/5/12 at 11:23 a.m., and 10/26/12 at 1:16 p.m.; Individual #98 on 9/30/12 at 12:30 p.m.; and Individual #109 on 10/12/12 at 10:30 p.m.; ○ Minutes of the Quality Assurance/Quality Improvement Committee, dated 7/11/12 to 10/3/12; ○ Executive Leadership Team meeting minutes, dated from 4/30/12 to 10/15/12; and ○ Avatar Workgroup meeting minutes, dated 10/31/12. ▪ **Interviews with** ○ Andy Maher, Assistant Director of Programs; ○ Jose Levy, Director of Behavioral Services; ○ Curtis Walters, Director of Quality Assurance; ○ Jennifer Russell, Director of Risk Management/Incident Management; ○ Derrick Bunton, Director of Residential Services; ○ Michele Head-Blalack, RN, Chief Nurse Executive (CNE); ○ Kimberly Testa, Associate Psychologist V; ○ Robert Wayman, Unit Director, Castner Estates; ○ Diana Kennedy, Unit Director, Sunrise; ○ Charmaine Jones, Unit Director, Wood Hollow; and ○ Informal interviews/conversations with staff and individuals. ▪ **Observations of**: ○ Incident Management Review Team meetings, on 11/5/12, 11/6/12, and 11/8/12; ○ Quality Assurance/Quality Improvement Committee meeting, on 11/8/12; ○ Human Rights Committee (HRC) meeting, on 11/8/12; ○ Self-Advocacy Group meeting, on 11/7/12; ○ Restraint Reduction Committee meeting, on 11/7/12; ○ Pre-Treatment Sedation Committee Meeting, on 11/7/12; and

	o Site visits to residences and the workshop/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 submitted a Self-Assessment for Section C, dated 10/22/12. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section C, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, as well as interviews with staff: o The monitoring/audit tool the Facility used to conduct its self-assessment consisted of a template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section C - Protection from Harm-Restraints." The Director of Behavioral Services also reviewed and analyzed the restraint checklists using a list of the requirements for completion of the restraint checklist included in the Settlement Agreement. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tools was consistent with the provision of the Settlement Agreement. o The monitoring tools included adequate methodologies, such as the review of documentation. In addition, other sources, including video camera footage, were occasionally employed. The primary sources of information were the restraint checklists and debriefing forms. o The Self-Assessment identified the sample(s) sizes. However, it did not consistently, include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). For example, the Facility provided the total number of individuals (eight individuals for the period from May to September 2012) that had had more than three restraints in 30 days, and then identified the sample reviewed. However, this was not the case for most of the other sections. o The monitoring/audit tools provided did not include instructions/guidelines. Therefore, the adequacy of the guidance to ensure consistency in monitoring and the validity of results could not be evaluated. o The following staff/positions were responsible for completing the audit tools: the Program Auditors from the Quality Assurance Department worked collaboratively with the Behavioral Services Department staff to conduct the audits. Department staff positions were not identified in the documentation reviewed. During the site visit, interviews with the Director of Behavioral Services confirmed the role he played in monitoring restraint use.

	- It could not be determined from the information provided whether all staff persons responsible for conducting the audits were competent in the use of the tools and whether they were clinically/programmatically competent in the relevant area(s). Clearly, the Director of Behavioral Services possessed the requisite expertise. - For Section C, no information was provided regarding inter-rater reliability. It could not be determined whether adequate inter-rater reliability had been consistently established between the various Facility staff responsible for the completion of the tools. The establishment of inter-rater reliability was cited as the next priority for the Facility. - The Facility did use some relevant data sources and/or key indicators/outcome measures. For example, in addition to conducting audits, the Facility used data sources such as its training database. However, key indicators of performance or outcome measures were not specifically cited. Topics for key indicators could be such things as the average length of time in restraint, the number of people restrained, the number of injury reports that are filed as a result of restraint use, the number of serious injuries that occur while an individual is in restraint, the number of people restrained off campus, number of individuals for whom restraint use has declined, etc. To develop key indicators, baselines and goals would need to be established, as well as methodologies and timeframes for collecting valid data. The Facility needs to decide what data they have and how to use it to provide an outcome measure(s) of their use of restraints. The point is that the Facility should not rely solely on data from audits, but include the analysis of outcome data in its Self-Assessment as well. - The Facility presented some of the data in a meaningful/useful way. Specifically, the Facility's Self Assessment: - Generally presented findings based on specific, measurable indicators. - Did not consistently measure the quality as well as presence of items. For example, for Section C.8, the Facility looked at the timeliness of reviews of restraint, but not the quality. - Did not distinguish data collected by the Quality Assurance Department versus the program/discipline. - The Facility rated itself as being in noncompliance with each of the subsections of Section C. - The Facility data identified some areas in need of improvement. However, the Facility Self-Assessment did not provide a thorough analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. In fact, the Self-Assessment acknowledged that no action plans had been developed for several subsections, including C.1, C.3, and C.4.
	Summary of Monitor's Assessment: Although substantial work still needed to be completed before AUSSLC reached substantial compliance with the provisions of Section C, during this site visit, there was evidence of greater focus on and organization of the tasks related to the Settlement Agreement and the overall policy directives issued by the State Office. For example, the Director of Behavioral Services had taken steps to retrain monitors who were found to be inconsistent in completing restraint documentation. Restraint use was beginning to be examined through a number of varied methods and continued to receive priority attention at the daily Incident Management Review Team meetings attended by the Facility's

	leadership. In particular, observation of the assigned Skill Acquisition Specialists provided evidence of the positive effects of individualized attention and more meaningful habilitation activities. This was particularly noteworthy in the observation of one individual with a high rate of restraint use. Direct support professionals in the residential units with a reduced census, including one residence with seven individuals, commented to the Monitoring Team about the positive behavioral effects of that change, effects experienced by both the individuals and the staff. Review of restraint documentation highlighted the need to continue concentrating attention not only on the accurate and timely completion of the forms, but also on the events leading up to the use of restraint. There was scant evidence of the environmental and social factors possibly influencing an individual's behavior and relatively little description of any alternatives to restraint use. It was not evident from the restraint checklists that there was consistency among the staff working with the individuals with challenging behaviors. The database did not include all occurrences of restraint, and monthly progress reports for several individuals continued to reference programmed restraint. Efforts to reduce the use of restraint and/or sedation for dental and medical procedures remained a very slow process. Only one Skill Acquisition Plan had been developed to address this matter. The adequacy of the Facility's response to repeated restraint remained inconsistent across individuals.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>The Department of Justice has indicated an interest in certain statistics. In response to this request, the Monitoring Team has included some such numbers in this report, such as the following information related to numbers of restraints. The Monitoring Team is not in a position to verify these numbers, or provide in-depth analysis of these numbers. Clearly, it is the Facility's responsibility to conduct such analyses, and as these analyses have been made available to the Monitoring Team, they are discussed as appropriate with regard to the sections of the Settlement Agreement to which they apply. The following numbers are provided for informational purposes only, and are based on data available from the Facility at the time of the review.

The extent of restraint use was documented in the AUSSLC Behavioral Restraint Reports for 7/12 through 8/12. These were the only aggregate reports provided during the site visit. Although lists of restraints were provided, a numerical summary of the data was not provided in response to a document request for the last six months of such data. The monthly notes compiled by the Director of Behavioral Services were handwritten and were not consistently legible. According to the reports for 7/12 through 8/12, the crisis intervention restraint use included:

<table>
<tr><th>Type of restraint</th><th>2/1/12 to 6/30/12</th><th>7/1/12 to 8/31/12</th></tr>
<tr><td>Physical</td><td>Not Available</td><td>43</td></tr>
<tr><td>Chemical</td><td>Not Available</td><td>3</td></tr>
<tr><td>Mechanical</td><td>Not available</td><td>5</td></tr>
</table>
</td><td>Noncompliance</td></tr>
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		In the two months referenced above, there were twenty individuals restrained (twelve in July and eight in August, with some of the same individuals being restrained in both months). The summary provided by the Director of Behavioral Services documented that restraint use, when controlled for census, had declined by 72% over the last three fiscal years. (The census had decreased from 339 to 331 during this timeframe.) The most recent restraint information, for October 2012, was presented and discussed at the Restraint Reduction Committee meeting held during the week of the Monitoring Team's visit. The oral report documented 26 instances of restraint, including one episode of chemical restraint. The type of non-chemical restraint used was not described. However, it was noted that 10 of the 26 restraints were for Individual #210 and Individual #406. Teams for both of these individuals met to discuss restraint use. For Individual #210, it was reported that he wanted to leave AUSSLC, but that his guardian objected. The Team, including his psychiatrist, had met twice to discuss the individual's wishes, but recommendations had not been resolved. During this meeting, it also was indicated that two CAPs had been developed regarding the entry of restraint data into Avatar in a pilot home and the completion of medical/dental restraint checklists. As described above, a sample, referred to as Sample #C.1, was selected. The eight individuals in Sample #C.1 included: Individual #74, Individual #406, Individual #421, Individual #445, Individual #288, Individual #303, Individual #364, and Individual #374. <u>Prone Restraint</u> As stated in previous reports, based on the review of Facility policy as well as discussion with the Director of Behavioral Services, prone restraint was prohibited at AUSSLC. According to information received from the Director of Behavioral Services during the recent site visit, based on restraint documentation also reviewed at the Incident Management meetings, there had not been any prone crisis intervention restraints during the past six months. If staff were unable to hold an individual in the proper position during a restraint episode, they were instructed to release the restraint hold. The review of checklists did not reveal any evidence of prone restraint. Based on informal interviews with 10 direct support staff, all had been trained regarding the prohibition on prone restraint.	

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		Other Restraint Requirements Based on document review, AUSSLC's policies stated that restraints could only be used if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. The restraint records for the episodes in Sample #C.1 were reviewed, including the available restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ In 29 out of 30 records (97%), there was documentation stating that the individual posed an immediate and serious threat to self or to others. This did not appear to be case for the episode involving Individual #303 who was restrained when he refused to leave the staff office. ▪ However, in all but three checklists reviewed (10%), there was no description of environmental and psychosocial factors that might provoke behavioral disturbances and minimal descriptions of less intrusive interventions. ▪ For the 30 restraint episodes (100%) reviewed, there was no specific evidence that restraint was used as a punishment or for the convenience of staff. Of note, for 21 of the 30 occurrences of restraint (70%), the Facility provided both the Crisis Intervention Restraint Checklist and the Face-to-Face Assessment and Debriefing Form. In the other nine restraint occurrences, either the checklist or assessment was available only, or the Facility provided a report from their database (Avatar) regarding the restraint. The Facility should make every effort to ensure that required documentation is completed for each occurrence of restraint. The Facility is commended for the Keys developed for the following Checklists: Protective Mechanical Restraint for Self-Injurious Behavior, Medical/Dental Restraint, and Crisis Intervention Restraint. These provide clear guidelines for completing each of these checklists. It may be helpful to also provide a sample of completed checklists. A review was completed of the Positive Behavior Support Plan for the four individuals in this sample. General comments regarding PBSPs are provided with regard to Section K.9 of the Settlement Agreement. Comments specific to these four individuals, all of whom experienced more than three restraints in any rolling 30-day period, are provided in Section C.7.e below. The Facility remained out of compliance due to the lack of adequate documentation to determine if less restrictive interventions had been employed appropriately.	

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C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The use of Safety Plans was discontinued on 5/7/12 as part of the phasing in of the revised State Office restraint policy and procedures. Crisis Intervention Restraint Plans had been implemented for five individuals as of 9/14/12. These individuals included: Individual #56, Individual #74, Individual #344, Individual #406, and Individual #445. A Crisis Intervention Restraint Plan was defined as "a component of the ISP action plan that provides instructions for staff on how to effectively and safely use restraint procedures, as long as they are needed to prevent imminent physical harm in a behavioral crisis when less restrictive prevention/de-escalation procedures have failed and the individual's behavior continues." A review of restraint checklists documented: ▪ In five out of 30 episodes (17%), restraint ended when the staff member was unable to sustain the restraint hold. In addition, one episode (7/6/12) for Individual #74 was coded as a release for physical distress. However, there was no elaboration of this code. ▪ In the remaining 24 restraint records reviewed, all (100) included documentation to show that the individual was released when no longer a danger to self or to others. The Facility was found to be in substantial compliance with this provision.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and	On 7/12/12, the State issued a revised policy entitled: "Limitation of Restraint," governing the use of restraint. This policy defined approved restraints and required that staff use only such approved interventions. Direct support professional and clinical staff were trained on this new policy, beginning in May and continuing through September 2012. At the time of the Monitoring Team's visit, the Facility policy had been updated but had not yet been approved. Staff training was focused on the State policy. The State Office provided a comprehensive set of training materials. The above policy continued to mandate competency-based training for each staff person whose work responsibilities involved direct contact with individuals. This training must be completed before beginning work with any individuals, and it must be repeated annually as a refresher course. Review of the Facility's 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

#	Provision	Assessment of Status	Compliance
	redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Documentation submitted by the Facility, dated 10/4/12, showed that there was 95% compliance with PMAB training requirements. For Sample #C.2, the Monitoring Team requested the following documentation for a sample of 30 staff: the names of staff with their start dates, and the dates on which they were determined to be competent with regard to the required topics. Review of documentation indicated that 27 of the 30 staff worked directly with individuals and were required to demonstrate competency in PMAB techniques. Of the group of 27, 24 (89%) were documented as current with this training requirement. On 10/6/12, the Director of Behavioral Services indicated that he had submitted a report on staff delinquent in restraint-related training for follow-up by the Unit Directors. Given the safety issues that a lack of updated training on the use of restraint potentially presents, it is essential that staff remain up-to-date with this training requirement. Based on discussions with 10 direct support and clinical professionals, all were able to describe their training regarding the use of restraint, and all reported they were current with their training requirements. As noted above with regard to Section C.1, 3% 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. Based on the documentation provided during the site visit, the Facility remained in noncompliance with this provision of the Settlement Agreement. This provision of the Settlement Agreement specifically requires: "A restraint used must be the least restrictive intervention necessary to manage behaviors." As noted above, concerns continued to exist with regard to the use of restraint only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care	Based on a review of 30 restraint records (Sample #C.1), in 29 out of 30 (97%) there was evidence documented that restraint was used as a crisis intervention. As discussed above, there was one episode for Individual #303 that did not appear to meet that criterion, based on the information provided in the restraint checklist. There was no evidence that any of the 53 individuals on the Do Not Restrain list were restrained. In review of 46 Behavior Support Plans (42 for Section K.9 and four for Section C.7), in all cases (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of	Noncompliance

#	Provision	Assessment of Status	Compliance
	for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	programmatic restraint. In addition, Facility policy did not allow for the use of restraint for reasons other than crisis intervention. However, the Facility should review the template used for monthly reporting of an individual's progress on their Positive Behavior Support Plan. Monthly reviews of progress analyzed for Section K.4 of this report revealed 11 of 42 individuals with a header for programmed restraint listed on the first page of the report. While only two of these individuals (Individual #435 and Individual #389) had specific restraints listed, any reference to programmed restraint should be removed from all documentation. Minutes from the meetings of the Pretreatment Sedation Committee were reviewed from 7/11/12, 8/2/12, 9/7/12, and 10/22/12. Additionally, during the week of the onsite review, the Monitoring Team attended the committee meeting. Also reviewed were the notes of dental task analyses completed for 10 individuals residing in Residence 785. The report on this pilot project, dated 9/14/12, outlined a three-part plan in which 10 individuals' oral hygiene and cooperation level were first assessed, a task analysis related to dental appointments was completed for each individual, and finally the hygienist visited Residence 785 to observe tooth-brushing for each individual. The task analysis noted the individual's response to being informed about an appointment, transitioning to the clinic, waiting for at least five minutes, transitioning to the exam room, sitting in the dental chair, and cooperation with simple steps in the intraoral exam. This 12-step analysis provided general information about the individual's cooperation during the dental appointment. When reviewing completed task analyses, the comments did not always correspond to the cooperative/uncooperative (i.e., yes/no) ratings. For example, Individual #274 was scored as cooperative (i.e., yes) with allowing an exam with a mirror or tongue depressor, and allowing a polishing cup to be used on his teeth. However, the comments noted that he pulled away and demonstrated other resistance on both of these steps. Similarly, the task analysis for Individual #226 noted he allowed suction to be used, but the comments noted he displayed resistance and wanted to close his mouth on the suction machine. A second task analysis related to brushing with assistance from staff also was completed for the 10 men. Based on the information gained through these initial assessments, the Facility provided dental desensitization plans for nine individuals. These were presented as ISP addendum meeting notes with an attached Desensitization Program Data Sheet on which a goal was identified. Individual #417 and Individual #61 were to learn to independently brush their teeth, Individual #169 was to allow staff to brush his teeth, Individual #57 was to allow a suction brush in his mouth, Individual #200 was to participate in oral care, and the goal for Individual #226 noted that he should have only suction tooth brushing. A goal was not identified for Individual #248, Individual #292, and Individual #190. There were no accompanying Skill Acquisition Plans for the six	

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		individuals for whom even a rudimentary goal was identified. The Facility also provided a list of the 10 most recently developed and approved medical or dental desensitization plans. Four dental plans were outlined, all with goals related to brushing. Four of the five that were actually medical plans outlined weekly or monthly visits to the medical clinic for three individuals and increased comfort with assessment of vital signs for one individual. There was no plan for Individual #394. Similar to the nine individuals noted above, there were no attached Skill Acquisition Plans to indicate the strategies used to reach these goals. At the committee meeting held the week of the onsite review, a draft Skill Acquisition Plan for Individual #274 was presented. The goal was for him to learn to tolerate a spin brush turned off in his mouth for 15 seconds. However, the plan included his allowing the brush to be on as staff cleaned his teeth. Formal training was to occur twice weekly. The plan was unclear and provided few opportunities for the individual to develop greater tolerance for dental hygiene procedures. More detailed feedback regarding Skill Acquisition Plans is provided with regard to Section S. The Facility had provided a master list of individuals with medical and/or dental desensitization plans. This listed 279 individuals, seven of whom had medical plans, 141 of whom had dental plans, 45 of whom had both, and 86 of whom had no plans. It was unclear why only four of the 10 individuals from the pilot dental project (Residence 785) were identified as having plans, and why none of the five individuals with the most recent medical plans were identified. This database did not correspond with other information provided by the Facility. As noted in the last full report of the Monitoring Team from one year ago, it appeared that the Facility had made little progress in minimizing to the extent possible the use of sedation for medical and dental procedures. The Facility remained out of compliance with this provision.	
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	In accordance with the new policy directives, restraint checklists had been revised. As discussed above, staff training was continuing to be implemented regarding both the new policy and the use of the restraint checklists and other forms. Review of training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. Training had been specifically designed and implemented for restraint monitors. A list of nine trained restraint monitors was included in the documentation the Facility provided. In addition, the Facility provided a list of 105 nurses who had been trained to monitor and document the vital signs and mental status during and after a restraint	Noncompliance

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	and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	episode. There were only 26 debriefing forms provided as requested for Sample #C.1. Therefore, significant information for reviewing compliance with this provision was available for only 87% of the episodes reviewed. The failure to complete documentation was addressed by the Director of Behavioral Services through the retraining of restraint monitors. In addition, as noted below, available documentation indicated and/or lack of documentation resulted in a failure in some instances to comply with expectations for the monitoring of restraint. Based on a review of 30 restraint records, a face-to-face assessment was conducted: • In 21 out of 30 incidents of restraint (70%) by an adequately trained staff member. ▪ In 21 out of 30 instances (70%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. The time of notification and the time of the monitor's arrival were required elements on the checklist. In some instances, the monitor was present in the residence when the behavioral episode occurred. ▪ In 26 of the 30 episodes reviewed (87%), documentation showed that an assessment was completed of the application of the restraint. ▪ The circumstances leading to restraint were to be discussed at both the Unit morning meeting and the daily Incident Management meeting. In 22 out of 30 instances (73%), the documentation showed that an adequate assessment was completed of the circumstances of the restraint at the Unit level, and for 10 out of 30 (33%) at the Incident Management Review Team meeting. During the site visit, discussion of recent restraint episodes occurred in both meetings, as expected. However, as indicated above, documentation did not always confirm that those discussions occurred as expected. In order to ensure that nursing documentation could be adequately reviewed, a separate sample was selected. It was random, except it included only the first restraint if multiple restraints occurred over a short period of time (i.e., one right after the other). In such instances, the initiation of restraint would be counted from the time the first restraint began. Based on a review of this sample of 23 restraint records for 13 individuals for restraints that occurred at the Facility (i.e., Individual #397, Individual #210, Individual #358, Individual #406, Individual #421, Individual #30, Individual #303, Individual #380, Individual #74, Individual #344, Individual #56, Individual #98, and Individual #109), there was documentation that a licensed health care professional: ▪ Initiated monitoring at least every 15 minutes from the initiation of the restraint in four (17%) of the instances of restraint. Records that did not contain	

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		documentation of this included those for: Individual #397; Individual #210, on 10/22/12 and 10/25/12; Individual #406, on 10/5/12 and 10/27/12; Individual #421, on 8/2/12, 9/19/12, and 10/1/12; Individual #30, on 8/24/12 and 9/3/12; Individual #303; Individual #380; Individual #74, on 7/6/12 and 8/2/12; Individual #344, on 9/19/12 and 10/4/12; Individual #56; Individual #98, and Individual #109. ▪ Monitored and documented vital signs in seven (30%) episodes. Records that did not contain appropriate documentation of this included those for: Individual #397; Individual #210, on 10/22/12 and 10/25/12; Individual #358; Individual #421, on 8/2/12, 9/19/12, and 10/1/12; Individual #30, on 8/24/12 and 9/3/12; Individual #303; Individual #74, on 7/6/12; Individual #344, on 9/19/12 and 10/4/12; Individual #56, on 9/5/12 and 10/26/12; and Individual #109. Problematic issues noted that resulted in noncompliance included the vital signs not recorded or marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required. In addition, noncompliance with this indicator was found for individuals whose Restraint Checklists indicated that individuals had significantly high or low values for their vital signs, and did not include documentation that the vital signs were retaken to ensure the individuals were medically stable. ▪ Monitored and documented mental status in 10 (43%) episodes. Records that did not contain appropriate documentation of this included: Individual #210, on 10/22/12; Individual #358; Individual #421, on 8/2/12, 9/19/12, and 10/1/12; Individual #30, on 9/3/12; Individual #303; Individual #74, on 7/6/12 and 9/24/12; Individual #344, on 10/4/12; Individual #56, on 9/5/12 and 10/26/12; and Individual #109. Problematic issues noted that resulted in noncompliance included either the mental statuses were not recorded, recorded as "refused", or were generic, such as "alert, and oriented" without a specific description of the behavior included to support the generic documentation. At the time of the review, the QA Department had not assigned the monitoring of the nursing documentation to nursing staff. Thus, these areas were only being audited for completion rather than in alignment with nursing standards of practice regarding the quality of the documentation. Thus, data generated from audits only noting if the sections addressing nursing documentation had been filled out did not accurately reflect appropriate nursing practices. In addition, the Chief Nurse Executive reported that the Nursing Department had not yet established a system to review and analyze these data, or to address the problematic issues found in relation to the data above or the data related to Section C.6, which addressed the documentation of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects.	

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C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 30 restraint checklists for individuals in restraint was selected for review. The following compliance rates were identified for each of the required elements, including the elements in Appendix A as required by this provision of the Settlement Agreement: ▪ In 93%, continuous one-to-one supervision was provided. Two episodes of restraint for Individual #445 were described as "enhanced" staffing, but there was no further explanation as to what was meant; ▪ In 100%, the date and time restraint was begun was documented; ▪ In 100%, the location of the restraint was documented; ▪ In 29 out of 30, information was provided about what happened before, including prior to the change in the behavior that led to the use of restraint. However, the quality of this description was not consistent and, in only three of 29 episodes (10%), did the documentation adequately describe the environmental context, including the presence and actions of peers. The focus was primarily on describing the behavior of the individual, especially his behavior towards staff. Descriptions documented in one episode involving Individual #288 (on 5/8/12) and two episodes for Individual #406 (on 10/05/12 and 10/13/12) were consistent with the instruction to "describe the individual's environment, actions, and interactions with others in the time before you began taking steps to avoid the use of restraint." ▪ In 30 out of 30 episodes (100%), the actions taken by staff prior to the use of restraint, in order to permit adequate review, per Section C.8 of the Settlement Agreement, were included on the form. However, the checklist did not require the actions to be described in any detail. It simply required a check against a list of possible actions. It would be helpful to have further information in order to determine whether the PBSP, for example, actually was implemented as written and approved. ▪ In 100%, the specific reasons for the use of the restraint were stated; ▪ In 100%, the method and type (e.g., medical, dental, crisis intervention) of restraint was identified. ▪ In 100%, the names and signatures of staff involved in the restraint episode were listed. ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o In 100%, the documentation of observations every 15 minutes and at release; o In 100%, the specific behaviors of the individual that required continuing restraint; and o In 100%, the care provided by staff during the restraint was noted in the requisite column. Most often, the codes described the action taken regarding release from restraint. Opportunities to exercise restrained	Noncompliance

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		limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bedpan were seldom recorded. However, this likely was related to the brief duration of the restraints. o In 100%, the level of supervision provided during the restraint episode was described. The level of supervision in all but two instances for Individual #445 was one-to-one; and ▪ In 100%, the date and time the individual was released from restraint were documented. Based on a review of 23 restraint records for 13 individuals for restraints that occurred at the Facility (i.e., Individual #397, Individual #210, Individual #358, Individual #406, Individual #421, Individual #30, Individual #303, Individual #380, Individual #74, Individual #344, Individual #56, Individual #98, and Individual #109): In 13 (57%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented. Records that did not contain documentation of this included: Individual #210, on 10/22/12 and 10/25/12; Individual #358; Individual #421, on 8/2/12 and 9/19/12; Individual #30, on 9/3/12; Individual #303; Individual #344, on 10/4/12; Individual #56, on 10/26/12; and Individual #109. Problematic issues noted that resulted in noncompliance included either the injury section being left blank, and/or the lack of appropriate nursing documentation regarding the specific descriptions of injuries found in the Integrated Progress Notes (IPNs). Although progress had been made, the documentation of antecedents and actions taken by staff prior to use of restraint needed further work. In addition, nursing documentation of injuries required improvement. As a result, the Facility remained out of compliance with this provision.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to the restraint review the Facility provided, during the six-month period (May through October) prior to the onsite visit, a total of eight individuals were placed in restraint more than three times in any rolling 30-day period. A sample of four (50%) of these individuals was selected for review to determine whether the requirements of the Settlement Agreement were met. The four individuals reviewed were Individual #445, Individual #406, Individual #421, and Individual #74. For each of these individuals	Noncompliance

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		(100%), there was evidence that the team had met when restraint was applied more than three times in a rolling 30-day period. Documents reviewed included the following: Functional Skills Assessment, Preferences and Strengths Inventory (excluding Individual #406 and Individual #421), Individual Support Plan, Individual Support Plan Addenda, Monthly QDDP Review (excluding Individual #445), Psychological Evaluation, Positive Behavior Support Plan, Crisis Intervention Instructions, and ABC (antecedent/behavior/consequence) data sheets. It should be noted that with the exception of the Individual Support Plan Addenda, all documents for Individual #445 were dated after the period of time during which she was restrained more than three times in a rolling 30-day period. The timeframe for more than three restraints in any rolling 30-day period was the following: ▪ Individual #445: 5/2/12 through 5/22/12; ▪ Individual #406: 5/6/12 through 5/27/12, 8/6/12 through 8/19/12, and 10/5/12 through 10/27/12; ▪ Individual #421: 8/2/12 through 8/17/12; and ▪ Individual #74: 7/6/12 through 7/26/12. The specific restraint episodes as well as the documentation submitted for each are identified in the section above that lists documents reviewed. The results of the review are discussed below with regard to Section C.7.a through C.7.g of the Settlement Agreement. It should be noted that there was discrepancy between the ISP addenda provided for Individual #406 and the Restraint Log. Over four meetings held during July, the team reviewed restraints applied on 6/14/12, 6/22/12, 6/29/12, 7/14/12, 7/15/12, and 7/24/12. None of these restraints were included in the Restraint Log. It is concerning that the Facility's database did not accurately reflect the use of restraints. It is imperative that this error in reporting be corrected as soon as possible. For one of the individuals reviewed (25%), the team reviewed the individual's adaptive skills. The following are examples of individuals for whom this was done appropriately. ▪ The team reviewed the speech and language therapist's report for Individual #406. Staff were reminded to use his augmentative communication strategies (e.g., picture schedule, choice board, and communication board). It was noteworthy that a standardized assessment of adaptive behavior had been completed for Individual #445, Individual #421, and Individual #74. However, it did not appear that the information gleaned from these assessments was used to guide habilitation planning. The following are examples where teams failed to do this adequately. ▪ Individual #445: The team reviewed this individual's verbal communication	

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		skills, but did not recommend strategies to improve her use of language for functional communication. ▪ The team for Individual #445 noted that her visual impairment "…affects her ability to function independently." While visual impairment is certainly a factor to be considered when designing teaching interventions, it does not preclude an individual's ability to develop greater skills and improved independence. As the orientation and mobility consultant had conducted an initial assessment with this individual, further consultation should be sought to ensure that her habilitation needs are adequately met. Although not directly related to compliance with this section, the following information is provided, because it illustrates that the entire planning process for the individuals in this sample was flawed. This likely contributed to teams' inability to effectively address the use of restraint for these individuals. It should be noted that although the Functional Skills Assessment had been completed for all four individuals (100%), none of these assessments included a summary of the individual's strengths or needs, nor did they outline recommendations for specific skill development. Teams should have recognized this, and identified the need for revisions to these assessments at the ISP meetings and/or at the ISPA addenda meetings at which these restraints were discussed, but they did not. Similarly, further problems related to adaptive behavior were found in the ISPs for three individuals. ▪ Individual #445 had only two training objectives. ▪ There were no training objectives in the ISP for Individual #421. ▪ The only training objectives in the ISP for Individual #74 were related to her Individualized Educational Plan. As of 1/2/12, she no longer attended the local public school, but received her educational services on campus (i.e., homebound). She graduated on 5/31/12, yet her next ISP date was not until 1/13. Other concerns regarding adaptive skill development were raised after review of the Monthly Review completed by the individuals' QDDPs. ▪ Three monthly reviews were provided for Individual #406. These suggested that only three training objectives were addressed. Over a period of three months, each objective was addressed five, zero, or three times, respectively. ▪ Over three monthly reviews for Individual #421, it was noted that there was no or incomplete data on her training objectives. The only action was to report this to the home supervisor, although this clearly did not resolve the matter. At the ISPA meetings to address the more than three restraints in 30 days, for two of the individuals reviewed (50%), the team adequately reviewed the biological, medical, and psychosocial factors. The following are examples of where teams appropriately considered these factors:	

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		▪ In consideration of his seizure disorder, an EEG was recommended for Individual #406 to establish a "neurological baseline." ▪ Individual #406 had one occurrence of restraint when he was in his room for private time. His assigned staff member was present. When the second shift staff member entered the room to assume supervision, the individual became aggressive. The team agreed that supervision would be provided just outside the individual's bedroom door when he was alone in his room during the day or when he was asleep. ▪ Because enforcement of dietary restrictions often led to problems, the team identified alternative foods that could be provided to Individual #406 when he wanted more food. The dietician and speech therapist also were scheduled to monitor staff adherence to the individual's dietary plan. ▪ The team recommended an updated EEG to determine if Individual #421 was experiencing seizures. There was also a recommendation to track her menses to determine if this was a contributing factor to her problem behavior. ▪ The team noted that Individual #421 often became upset when other individuals were being disruptive. The recommendation was to encourage her to move to another, quieter location at these times.	
	(b) review possibly contributing environmental conditions;	For none of the individuals reviewed (0%), the team adequately reviewed the possibly contributing environmental conditions. However, for one individual, some components of the environment were appropriately addressed. Concerns are noted below, but the following provides examples of positive ways in which the team reviewed and addressed environmental factors: ▪ Individual #406 experienced several restraints as a result of poor implementation of his dietary restrictions. The speech therapist was scheduled to in-service staff on the individual's Condiment Menu. ▪ The speech therapist reminded staff of the availability of noise dampening head-phones for Individual #406. ▪ A picture of an X-box connect was to be added to the picture schedule for Individual #406 to increase the range of available activities. ▪ The psychologist was scheduled to work with staff to help encourage Individual #406 to attend work. ▪ Staff were in-serviced on appropriate documentation of relevant information in the shift communication log. This occurred following an incident with Individual #406 in which staff were not informed that he had already received his pay from workshop. The following are examples where teams failed to do this adequately. ▪ Staff were told to offer Individual #406 a variety of alternative activities when he did not want to go to the workshop. While opportunities to swim, attend the	Noncompliance

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		computer lab, play ball, or go for a walk might reduce occurrences of aggression, self-injury, and property destruction, this plan did not address his difficulties with the workshop. In fact, this plan might reinforce his work refusals. ▪ In a review of events leading to restraint, the team noted that Individual #445 became upset while waiting for her medication and when asked to complete a task. There were no recommendations made regarding possible alternative activities when a delay in medication administration was likely, or for offering a choice or changing the approach used when placing demands on the individual. ▪ For this same individual, her dislike of the workshop and day habilitation services were noted, but there were no recommendations for assessment of her work skills or preferences, or offering different environments to address her daytime activities.	
	(c) review or perform structural assessments of the behavior provoking restraints;	For one of the individuals reviewed (25%), the team reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately. ▪ In November of 2011, a functional behavior assessment was completed for Individual #406. This consisted of both indirect and descriptive assessments. The team reviewed this and indicated it was still valid. The following are examples where teams failed to do this adequately: ▪ The psychological evaluation for Individual #445 referenced indirect and descriptive assessment completed in 7/12. However, there was no description of what was observed and no identification of patterns of behavior. Without this information, it appeared that the assessment relied on the rating scales completed by staff. Further concerns related to the lack of summary information regarding environments in which problem behavior was most likely and least likely to occur was left blank. During the meeting regarding the more than three restraints in 30 days, the team did not review this information and/or make recommendations for further assessment. ▪ The psychological evaluation for Individual #421 suggested that an indirect assessment had been completed in 12/11, but there was no indication that staff had spent time observing the individual in an attempt to identify patterns of behavior (i.e., antecedent, behavior, consequence). Reliance on indirect assessment is not appropriate, particularly for an individual who presents with such challenging behavior. During the meeting regarding the more than three restraints in 30 days, the team did not review this information and/or make recommendations for further assessment. ▪ The psychological evaluation for Individual #74 referenced a completed assessment, however there were no dates and no review of the activities completed (either indirect or descriptive). During the meeting regarding the	Noncompliance

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		more than three restraints in 30 days, the team did not review this information or make recommendations for further assessment.	
	(d) review or perform functional assessments of the behavior provoking restraints;	Please 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 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;	For four of the individuals reviewed (100%), the individual had a Positive Behavior Support Plan (PBSP). For three individuals, these plans were in place at the time they experienced multiple restraints (i.e., more than three in a rolling 30-day period). The plan for Individual #445 is excluded from this review, because it was written after she had experienced multiple restraints. A review of these plans is summarized below. ▪ All (100%) were based on the individual's strengths; ▪ All of the plans (100%) specified the objectively defined behavior to be treated that led to the use of restraint; ▪ All of the plans (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of restraint; and ▪ Two of three plans (67%) specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. The following are examples of individuals for whom adequate PBSPs were in place: ▪ Individual #421 had a PBSP that advised staff to provide attention to this individual every five minutes. Staff were also instructed to provide her with choices, to suggest a change in environment when the noise level increased or when others were experiencing difficulties, and to observe for possible seizures or pain associate with her menses. ▪ The plan for Individual #74 included daily and weekend contracts, and outlined several appropriate prevention strategies. The following are examples of individuals who had PBSPs with concerning elements: ▪ The PBSP for Individual #406 instructed staff to not react or run away when he was yelling, grabbing one's hand, or stomping on one's foot. While this might be justified clinically, it will likely be very difficult for staff to follow these guidelines. As noted in the Facility's updated materials used to train staff in crisis management and restraint, on 6/15/12, the Safety Plan for Crisis Intervention had been discontinued. In its stead, the Facility was using Crisis Intervention Plans. A plan, entitled Crisis Intervention Restraint Instructions, had been developed for all four individuals (100%) in the sample. Two of these plans were identified as drafts. The plan for Individual #445 included a team approval date of 7/16/12 with a Behavior Therapy Committee (BTC)	Noncompliance

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		approval date of 9/17/12. The Human Rights Committee (HRC) had not yet approved the plan. The team on 8/6/12 had approved the plan for Individual #421. There were no approval dates by the BTC or HRC noted on her plan. Two consecutive monthly progress notes for Individual #74 noted that her crisis plan should be implemented, once approved. Any crisis plan should be identified as a priority for necessary approvals to ensure timely processing. Each of the crisis plans reviewed included information regarding the approved method of restraint and the maximum duration of 15 minutes in restraint. (As of 6/8/12, the policy was changed to note that release from any restraint must be attempted at 15 minutes.) Three plans (75%) included information regarding termination of restraint. Specifically, the mittens would be removed from Individual #445 when she was no longer biting her hands for two consecutive minutes; Individual #406 would be released from restraint when he was no longer a danger to himself or others (i.e., no struggling, yelling, growling, etc. for three consecutive minutes); and Individual #74 would be released from restraint as soon as she stopped trying to hurt others. The plan for Individual #421 did not include clear criteria for termination of the restraint other than a suspected seizure or her falling asleep. Only two of the plans (50%) included clear descriptions of situations that would lead to restraint (Individual #406 and Individual #74). Any crisis plan should clearly address each of the above elements.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	The Facility was just beginning its monitoring of implementation of behavior support plans. In no case for the four individuals reviewed (0%) was there a report of objective data that demonstrated a high level of treatment integrity with regard to PBSP implementation. For two individuals, the team did recommend further in-service training for staff on the individual's PBSP. ▪ A psychological assistant was scheduled to provide a refresher course to the staff working with Individual #445. The purpose was to help staff identify behaviors that occur prior to targeted problem behavior and to use more effective intervention strategies. ▪ The team for Individual #406 recommended monitoring of PBSP implementation and the psychologist was scheduled to provide further in-service training to the direct support professionals working with him.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	The minutes from the ISPA meetings for all four individuals did not include recommendations for changes to the individuals' PBSP.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the	According to the new policy, each restraint used for a person without a crisis intervention plan was to be reviewed within one business day by the IDT. With a crisis intervention plan, the schedule could be individually determined. However, according to	Noncompliance

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	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.	the Settlement Agreement, this review needed to be completed within three business days. As indicated in previous reports, through interview, record review and observation, it was illustrated that AUSSLC had mandated a number of ongoing practices to ensure that each episode of restraint was analyzed and evaluated in accordance with the requirements of the Settlement Agreement. According to policy, each incident of restraint was to be reviewed at the Unit Meeting and the Incident Management Review Team meeting. During the onsite monitoring visit, Incident Management Review Team meetings were observed and, during this time, discussion of restraint was evident on the day after the episode. Follow-up to restraint episodes was noted as being tracked more thoroughly and consistently. However, the restraint documentation reviewed did not support this change in practice. In fact, the restraint checklists examined for Sample #C.1 documented that: ▪ Review and discussion occurred at the Incident Management Review Team meetings within three business days in 10 out of 30 (33%) of the restraint episodes. Discussion was documented at the Unit level for 22 out of 30 episodes (73%). ▪ The Restraint Monitor completed debriefing forms, as required, in the 26 out of 30 restraint episodes (87%). ▪ In 26 out of 30 episodes (87%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. ▪ Based on the information provided, it could not be determined whether the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified, if the restraint was applied correctly and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. ▪ There was evidence that the Director of Behavioral Services or his designee had reviewed each incident of restraint and had analyzed conformance with the requirements of the Settlement Agreement. The Facility acknowledged in its Action Plans for Section C.8 that additional work was needed with this provision. The Facility remained out of compliance with this provision.	

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. The Facility should ensure that reference to programmed restraint is removed from all documentation. (Section C.4).
5. Staff should revise 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 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)
7. The Facility should ensure that a licensed health care professional timely and regularly monitors, and appropriately documents the vital signs, and the mental status of an individual in restraints at least every 15 minutes from the start of the restraint episode, except for a medical restraint pursuant to a physician's order. (Section C.5)
8. The Facility should develop and implement a system to ensure that nursing staff audits nursing documentation addressing restraints, the Nursing Department regularly reviews auditing data regarding restraints, and plans of correction are implemented addressing the problematic issues identified. (Section C.5)
9. The Facility should ensure that nursing staff assesses and appropriately documents 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 or when the individual experiences frequent restraint. (Section C.7.c and Section C.7.d)
14. Staff should ensure that necessary Crisis Intervention plans 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 Individual Support Plan when events leading to restraint are identified. This includes ensuring that habilitation programs are comprehensive and effective. (Section C.7.a and C.7.e)
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. 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 AUSSLC Policy: Client Injury, June 2012; o AUSSLC Policy: Protection from Harm - Abuse, Neglect, and Exploitation (A/N/E), dated August 2012; o AUSSLC Policy: Incident Management, undated draft; o Sample #D.1 included a sample of 21 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following Department of Family and Protective Services (DFPS) investigation numbers: 42000112, 42081492, 42115292, 42143452, 42212926, 42308132, 42318777, 42331753, 42344714, 42342366, 42351678, 42362352, 42399059, 42394012, 42465544, 42449306, 42444370, 42438837, 42443668, 42403641, and 42424115; o Sample #D.2 included a sample of nine investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample #D.2 included cases: 12-075, 12-101, 13-005, 12-052, 12-120, 12-108, 12-118, 12-048, and 12-056; o Incident Management Review Team (IMRT) meeting minutes for each Monday since the Monitoring Team's last review; o Individual Support Plans (ISPs) for Individual #73, Individual #74, Individual #246, Individual #263, Individual #376, Individual #406, Individual #421, and Individual #445; o Background check spreadsheets; o Rights Poster; o Training records/transcripts for seven Facility investigators; o Training records/transcripts for 13 DFPS investigators; o Statements acknowledging reporting obligations signed by 30 employees; o Training transcripts for 30 employees regarding training on the reporting of abuse, neglect, and exploitation; o Presentation Book for Section D; o Minutes of Quality Assurance/Quality Improvement Council meetings, dated from 7/11/12 to 10/3/12; and o Executive Leadership Team meeting minutes, dated from 4/30/12 to 10/15/12. ▪ **Interviews with**: o Charles Bratcher, Facility Director; o Andy Maher, Assistant Director of Programs; o Jennifer Russell, Director of Risk Management and Incident Management; o Carl Williams, Lead Investigator; o Derrick Bunton, Director of Residential Services; o Robert Wayman, Unit Director, Castner Estates; o Diana Kennedy, Unit Director, Sunrise;

	○ Charmaine Jones, Unit Director, Wood Hollow; ○ Jose Levy, Director of Behavioral Services; ○ Curtis Walters, Director of Quality Assurance; and ○ Informal interviews/conversations with staff and individuals. ▪ **Observations of**: ○ Site visits to living units and the workshop. 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; ○ Incident Management Review Team Meetings, on 11/5/12, 11/6/12, and 11/8/12; ○ Quality Assurance/Quality Improvement Council meeting, on 11/8/12; ○ Self-Advocacy Group meeting, on 11/7/12; and ○ Human Rights Committee meeting on 11/8/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D, dated 10/22/12. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section D, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section D – Protection from Harm – Abuse, Neglect and Incident Management." In conducting its self-assessment, the Facility selected a sample of investigations from the database of all cases from 5/12 to 9/12 and applied this tool. ○ These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provisions of the Settlement Agreement. ○ The monitoring tools included adequate methodologies. For example, the investigation case files, training documentation, and rights posters were reviewed. Interviews and observation were to be conducted as appropriate. However, "appropriate" was not clearly defined, and there was no detailed evidence provided of observation in living units or interviews with individuals or staff. The monitoring appeared to consist primarily of documentation review. ○ The Self-Assessment identified the sample(s) sizes, but not the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). ○ The monitoring/audit tools had instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, there was not consistency (inter-rater

	reliability) on all questions of the tool. The Facility should assess whether the current instructions are adequate, or if other issues (e.g., staff training on the tools) were contributing to the lack of reliability. o The following staff/positions were responsible for completing the audit tools: the Program Auditors from the Quality Assurance Department worked collaboratively with Risk Management and Incident Management Department staff to conduct the audits. Department staff positions were not identified in the documentation reviewed. o It could not be determined from the information provided whether the staff persons responsible for conducting the audits were competent in the use of the tools, and whether they were clinically/programmatically competent in the relevant area(s). o According to the information provided, inter-rater reliability was reviewed, but had not been consistently established between the various Facility staff responsible for the completion of the tools. This remained a priority issue for the Facility. ▪ The Facility used some relevant data sources. For example, it used data from the Training Department database on A/N/E training. In addition, the Facility reviewed and analyzed data from a tracking system for alleged perpetrators. However, the Facility did not present data on key indicators or outcome measures in its Self-Assessment. It was the Monitoring Team's understanding that State Office was working on developing such measures. ▪ The Facility consistently presented some data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented many of the findings as specific, measurable indicators. However, many indicators were missing. Just as one example, Section D.3.e includes a number of requirements related to investigation reports. However, the Facility only addressed the four related to timely reporting. o Consistently did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with the following subsections of Section D*:* Section D.2.b, Section D.2.d, Section D.2.f, Section D.2.g, Section D.3.a, Section D.3.b, Section D.3.c, Section D.3.d, Section D.3.f, Section D.3.g, Section D.3.h, Section D.3.i. Section D.3.j, Section D.4, and Section D.5. This was consistent with the Monitoring Team's findings with the exceptions of Section D.3.i. The Facility's Self-Assessment did not include all of the components included in that provision of the Settlement Agreement. ▪ The Facility data did not identify in sufficient detail the areas in need of improvement. There was scant analysis of the information, without identifying, for example, potential causes for the issues leading to the issues or connecting the findings to the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: The leadership of AUSSLC is to be commended for the significant improvements noted with regard to its adherence to the protection from harm requirements included in Section D. The investigation reports reviewed were much stronger in their organization and substantive content. Many of the problems noted in past reviews of investigations, such as the lack of timeliness and the lack of evidence of supervision had been largely corrected. The commitment to zero tolerance of abuse,

	neglect, and exploitation was evident in the disciplinary actions taken, including the actions taken against employees who failed to report. The failure to report incidents of such transgressions as improper lifting, which resulted in a fractured arm, or intimidating staff behavior was documented in the sample of investigations reviewed for this report. Employees found to have abused or neglected the individuals under their care were dismissed. Recommendations for improved staff performance and, occasionally, for active treatment were more frequently included in the investigation reports issued by both DFPS and AUSSLC. Recommendations were now tracked daily and there was an up-to-date tracking log provided to the Monitoring Team. The forums for discussing and assessing the Facility's performance, including the Quality Assurance/Quality Improvement Council and the daily Incident Management Review Team meetings, had been reconvened with a more streamlined format. The investigations indicated the continuing need to enforce the requirements for timely reporting. Although efforts had been made to develop tracking and trending reports, these initiatives required further refinement in order to provide the information that would be most useful. Since the Monitoring Team's last visit, the Director of Risk Management/Incident Management had begun to implement systematic methods for data collection and analysis. She was working closely with the Director of Quality Assurance and the Executive Leadership Team to reduce risk in the living environments. The addition of Skill Acquisition Specialists permitted a greater focus on individualized approaches to habilitation. The individuals and staff who lived/worked in the houses with fewer people commented positively on this change. Although the Facility was not in substantial compliance with all of the provisions of Section D, the Facility's progress and improvement were recognized.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Based on a recent agreement of the parties and the Monitors, Section D.1 has been interpreted to only address the development of a policy. Implementation of the policy is assessed in other Section D provisions. AUSSLC had a policy that: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result, the Facility was found to be in substantial compliance with this provision.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement		

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>incident management policies, procedures and practices. Such policies, procedures and practices shall require:</td><td></td><td></td></tr>
<tr><td></td><td>(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>According to the AUSSLC policy "Incident Management," staff were required to verbally report abuse, neglect, and exploitation immediately or within one hour. This was consistent with the requirements of the Settlement Agreement.

With regard to serious incidents, the Facility policy entitled "Incident Management" required staff to report serious incidents immediately or within one hour of the discovery or observance of the incident to the Director or her designee. This policy was consistent with the requirements of the Settlement Agreement.

Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note again that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and would need to review carefully whether incidents were preventable, and whether adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken.

Since the Monitoring Team's last visit, the Director of Risk Management/Incident Management had made considerable progress in analyzing and reporting data about serious incidents and allegations of abuse, neglect, or exploitation. The Facility's progress in analyzing data collected and in addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.

Document Request TX-AU-1211.16 provided the numbers for each serious incident category. Despite the specifics of the document request, the data were provided for 1/1/11 through 10/9/12. It was not broken down by date or year as requested. As a result, the following information summarized the data provided to the Monitoring Team for the entire period:

<table><tr><th></th><th>1/1/11 to 8/15/12 (19.5 months)</th></tr><tr><td>Deaths</td><td>13</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Serious Injuries	21
Sexual Incidents	9
Suicide Threat (credible)	1
Unauthorized Departure	17
Choking	1
Other (med error, police)	62

Documentation provided to the Monitoring Team for the period 1/1/11 through 10/9/12 indicated:

- There were 144 allegations of physical abuse, including 16 that were substantiated (11%), 53 that were unsubstantiated (37%), and 17 that were inconclusive (19%).
- There were 33 allegations of emotional/verbal abuse, including one that was substantiated (3%), 13 that were unsubstantiated (39%), and three that were inconclusive (9%).
- There were 158 allegations of neglect. Of these, 25 were confirmed (16%), 38 were unconfirmed (24%), and 11 allegations were inconclusive (7%).
- There were two allegations of exploitation. There was one unsubstantiated allegation (50%) and the other was inconclusive (50%).

Although not directly related to this provision, despite the capacity to do so, since the last review, there had been no root cause analyses conducted. However, there were specific actions being implemented for some individuals at higher risk. The individuals' interdisciplinary teams were responsible for developing these plans/supports, and they were documented in the Individual Support Plan Addenda. Efforts had been initiated to analyze the causes of falls and aggression among peers, and remedial actions were beginning to be implemented. Discussion at the Incident Management Review Team meetings was noted to be more thorough, more cognizant of the completion of recommended actions, and increasingly focused on Facility-wide issues that required attention. However, efforts to identify and address systemic causes were being initiated but were still at a rudimentary level. Although there was increased attention to the individual, programmatic and environmental factors did not seem to be explored as intensively. These efforts are discussed in more detail with regard to Sections D.3.i and D.4.

Based on interviews of 10 direct support professionals responsible for the provision of supports to individuals, nine (90%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Their identification badges outline the specific steps for reporting.

#	Provision	Assessment of Status	Compliance
		Based on interviews of 10 direct support staff responsible for the provision of supports to individuals, nine (90%) were able to describe the reporting procedures for other serious incidents. Two samples of investigations were selected for review. These included: ▪ Sample #D.1, which included a sample of 21 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were related. This sample included the following DFPS investigation numbers: 42000112, 42081492, 42115292, 42143452, 42212926, 42308132, 4231877, 42331753, 42344714, 42342366, 42351678, 42362352, 42399059, 42394012, 42465544, 42449306, 42444370, 42438837, 42443668, 42403641, and 42424115; ▪ Sample #D.2, which included a sample of nine investigation reports completed by the Facility only or by the Facility in conjunction with DFPS. Sample #D.2 included cases: 12-075, 12-101, 13-005, 12-052, 12-120, 12-108, 12-118, 12-048, and 12-056. Based on a review of the 30 investigation reports included in Sample #D.1 and #D.2: ▪ According to information included in the investigation files, individuals or at their request, a family member or a member of the general public filed two reports. These incidents of delayed reporting were not included in the percentage cited here, because there was no requirement that individuals or family members or the public report timely. In addition, there were two investigations in which the time of occurrence was unknown and timeliness, therefore, could not be determined. Therefore, of the applicable investigations reviewed, 14 out of 26 (54%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Investigation reports that documented delays in reporting included: 42394012, 42438837, 42344714, 42449306, 12-075, 42143452, 12-120, 42331753, 12-056, 42444370, 42115292, and 42403641. ▪ 23 out of 26 (88%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. Reporting was not done as expected in investigations 42308132, 42443668 and 42444370. The Facility used a standardized reporting format. As discussed in earlier reports, the format met generally accepted standards and included the criteria required by the Settlement Agreement, including information for adequate tracking and trending of incidents. Based on a review of 30 investigation reports included in Sample #D.1 and Sample #D.2,	

#	Provision	Assessment of Status	Compliance
		29 (97%) contained a copy of the report utilizing the required standardized format. Due to the delays in reporting identified in the review of investigation reports, the Facility remained out of compliance with this provision. This was consistent with the Facility's finding in its Self-Assessment.	
	(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.	According to AUSSLC's policies, the Facility must immediately remove alleged perpetrators, if known, and must take actions to ensure the safety of the individual. Based on a review of 30 investigation reports included in Sample #D.1 and Sample #D.2, all (100%) of the alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. It was the undisputed policy/practice of AUSSLC to assign alleged perpetrators away from the site of the allegation until the investigation was completed, and they were cleared. Review of 30 investigations documented that re-assignment was handled promptly in every incident. Alleged perpetrators usually were assigned foodservice tasks. The Facility had designed and implemented an Alleged Perpetrator Reassignment log to analyze the alleged perpetrator reassignment dates and return to work dates. In addition to promptly removing the alleged perpetrator, a review of the 30 investigations documented that the Facility took appropriate actions in all but four cases (87%) to ensure the health and safety of the Individual. In 42143452, 12-056, and 42465544, staff training was to be implemented, but there was no evidence in the record that it had occurred. In 42394012, the IDT did meet to assess the level of supervision required by the individual. However, the meeting was not held promptly. The incident occurred on 7/26/12, and the IDT met on 8/21/12. The Facility maintained its compliance with this provision. However, it is absolutely essential that attention be paid to ensuring the appropriate actions are taken in a timely manner to protect individuals involved in abuse and neglect allegations. Should the Facility not correct this issue, its substantial compliance rating will be in jeopardy.	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 AUSSLC policy, during new employee orientation and every 12 months thereafter, all staff were obligated to attend competency-based training on preventing abuse and neglect. All required training must be appropriately documented by certification and by date of completion. Supervisors were to periodically assess employee knowledge, and provide additional training as needed. This was consistent with the requirements of the Settlement Agreement. The Facility reported that there had been no substantive changes in the training curricula	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		since the Monitoring Team's last review. As reported in the last report, a review of the training curricula related to abuse and neglect was reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: ▪ In relation to the requirement that training be competency-based, the training did include quizzes to determine whether the employee had mastered the knowledge and performance criteria. ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. The Facility provided documentation for 30 staff selected randomly from the current list of employees. Review of records indicated that all of these 30 staff (100%) had completed competency-based training on abuse and neglect either prior to working directly with individuals and/or as part of their annual refresher training. During the informal visits to the living units, direct support and clinical professionals were queried about the process of reporting allegations of abuse, neglect, exploitation, or other serious incidents and their comfort level with these obligations. One employee had reported an allegation and confirmed that the process worked as expected. All but one (90%) of these staff could describe reporting procedures accurately. Posters reminding employees of this duty were posted throughout the Facility's buildings. Furthermore, during the review of investigations, it was noted that staff retraining was required in any case where reporting was not done according to the provisions of policy and the Settlement Agreement. As a result, the Facility was found in substantial compliance 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	As described in earlier reports, the Facility's policy and practice required that all employees sign a statement confirming the obligation to report abuse, neglect, and exploitation. The statement was first signed at new employee orientation and, then, annually thereafter. A sample of 30 employees was selected for review. Twenty-eight (93%) of the employees reviewed had evidence of the acknowledgement of the obligation to report located in their personnel records. The Facility was unable to locate the two missing forms. Each of the 10 employees queried informally about this obligation were able to describe their responsibility, although one employee cited the timeframe for reporting incorrectly. She was clear, however, that she had a duty to report.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	any mandatory reporter's failure to report abuse or neglect.	As described above, employees were disciplined for failing to report abuse and neglect. The Facility was found in substantial compliance with this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	As in earlier reports, a review was conducted of the materials and processes used to educate Legally Authorized Representatives (LARs), or others significantly involved in the individual's life. The Facility stated that it utilized the annual ISP meetings to educate individuals, primary correspondents, and LARs about the means to identify and report unusual incidents, including allegations of abuse, neglect, and exploitation. Since the Monitoring Team's last review, in preparation for the annual ISP meeting, information about an individual's incident, injury, and restraint data had been given to the QDDPs. Investigation reports were now provided to the QDDPs who were then responsible for sharing the information with the team. The obligation to report an incident was to be raised with the individual and the family/guardian at the ISP meeting. The review of investigation case files documented that one Individual (i.e., Investigation 42081492) reported an allegation of abuse. This allegation was investigated. ISPs were examined for Individual #73, Individual #74, Individual #246, Individual #263, Individual #376, Individual #406, Individual #421, and Individual #445. Information about the identification and reporting of incidents and allegations was found in the ISP or ISP Addenda for six of the eight individuals (75%) (i.e., Individual #421, Individual #774, Individual #376, Individual #263, Individual #246, and Individual #73). At this time, as evidenced by a 75% finding of compliance, the Facility had not developed sufficient and consistent methods to ensure that information about identification and reporting of unusual incidents was provided to individuals and their LARs. As a result, the Facility was not in substantial compliance with this provision.	Noncompliance
	(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.	As described in the last report, AUSSLC had taken actions to comply with its own policy requiring the posting of information on individual rights. As noted in the previous report, the Facility had printed a poster that used pictures/symbols to describe an individual's rights. The poster included information about how to exercise such rights, and how to report any violations. The Human Rights Officer's photograph and contact information were included on the poster. However, as pointed out by an individual present during the visit to the workshop, the information on the poster was incorrect. The Human Rights Officer explained that she had been waiting for the second Human Rights Officer to be hired before printing new posters.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition, posters were not located in all residential units and vocational/day program areas visited during the onsite review. Furthermore, several of the posters were not visible to the individuals, but were placed on the wall or bulletin boards in staff offices. When asked, employees working in the residences and the workshop were able to identify the location of the poster (if present) and to describe, in general terms, how they were used to teach individuals about their rights. However, employees stated that their usefulness was very limited. As recommended previously, the Facility might want to consider redesigning the poster or provide additional instruction to staff on its possible use. Further development of new educational materials regarding a "right of the month" also might encourage staff to discuss the exercise of rights with the individuals who reside at AUSSLC. Although not a requirement of the Settlement Agreement, the use of the posters would be supplemented and enhanced by participation in the Self-Advocacy Group. When queried about their knowledge of this Group, some individuals expressed interest, but also a lack of knowledge about membership. Expanded outreach might be useful. Continuity of opportunities to participate in self-advocacy would help increase membership. The Facility was determined to be in noncompliance with this provision due to the incorrect information included on the posters, as well as the absence of posters or their inappropriate placement in staff offices.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to AUSSLC policy, immediately or within one hour upon discovery or notification that an allegation might involve criminal activity, the Director or her designee were to notify DFPS who was then responsible for notifying law enforcement agencies. The Director, or her designee, was to report allegations involving "sexual exploitation" committed by a mental health services provider to the prosecuting attorney, and the appropriate state licensing board. According to the information received through interviews, there were no investigations currently under review by law enforcement agencies. A finding of unauthorized photography of a partially undressed individual in investigation #42351678 had led to the District Attorney's decision to bring charges against the employee, who was dismissed from AUSSLC. There also was evidence in four cases that the Office of the Inspector General (OIG) was notified appropriately. Quarterly meetings were expected to resume in order to maintain strong working relationships with the OIG.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility remained in substantial compliance with this provision.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	As indicated in the last report, according to AUSSLC's policy, retaliation against a person for reporting abuse, neglect, or exploitation was prohibited. Any person, who believed he or she was being subjected to retaliatory action upon reporting an allegation, or who believed an allegation had been ignored, was directed to immediately, within one hour, contact the Director or her designee. The Office of the Attorney General, the Office of the Inspector General, and DFPS also could be contacted. The Whistleblower Act, Texas Civil Statutes, Article 6252-16a, permitted prosecution of a supervisor who suspended, or terminated a public employee for reporting a violation of law to a law enforcement authority. Any employee or agent found to have engaged in retaliatory action was subject to disciplinary action. Based on interviews with the Director of Risk Management/Incident Management, the lead investigator and informal conversations with employees, no staff had reported a fear of retaliation or knew of such fear in another person. Based on a review of 30 investigation files (the 30 investigations in Samples D.1 and D.2), no concerns were noted in relation to potential retaliation. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to Facility policy, all injuries must be treated and documented. It also required the Director of Risk Management/Incident Management to "review and make use of audit reports that evaluate whether significant resident injuries are reported for investigation, at least semi-annually." The Facility had made limited progress in implementing the requirements for this provision. Injury reports were entered into the Avatar system and lists of injuries were provided as requested. Beginning in 10/12, the Quality Assurance Department was required to complete a 10% random sample quarterly, and was to report all instances where warranted. An "Under Reporting Record Review" form was created for this purpose. The Facility reported that the 10% sample was completed on 10/31/12. However, a summary of the findings was not provided to the Monitoring Team at the time of the site visit The Monitoring Team will review the Facility's progress in this regard during upcoming reviews. At the time of the site visit, there was insufficient evidence to confirm that the Facility had achieved compliance with this provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DADS Policy Number 002.2: Incident Management, dated 6/18/10, governed the investigation of abuse, neglect, exploitation, theft, serious injury, and other serious incidents involving individuals residing in State Supported Living Centers. DADS Policy Number 012: Protection from Harm - Abuse, Neglect and Exploitation, dated 6/18/10, established procedures for the identification, reporting, trending, analysis of incidents, and prevention of abuse, neglect, and exploitation at State Supported Living Centers. DADS Policy Number 002.2 specified the training required for investigators, and the expectation that they not be in the direct line of supervision of an alleged perpetrator. AUSSLC's policy described in a detailed manner how investigations would be conducted by the Facility, or referred to DFPS. The policy required that investigators be qualified through training, including completion of specific courses: Comprehensive Investigator Training, People with Mental Retardation, Conducting Serious Incident Investigations or Fundamentals of Investigation, and a class in root cause analysis. The policy also stated that the investigator must not be in the direct line of supervision of the alleged perpetrator. Based on the sample of records reviewed, none of the DFPS or Facility investigators were within the direct line of supervision of the alleged perpetrators. Training curricula and transcripts were reviewed for DFPS and Facility investigators. This review revealed the following: ▪ Training curricula was reviewed for the Department of Family and Protective Services and Facility investigators. This review was described in detail in previous monitoring reports. The curricula for the Facility and the DFPS investigators were generally determined to be adequate. The Adult Protective Services) APS Facility Instructor Led Skills Development (ILSD) curriculum contained excellent information regarding aspects of the investigation process as well as competency-based tests and quizzes.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		▪ DFPS provided transcripts regarding the training provided to its thirteen investigators. According to the information provided, all investigators (100%) had received training in fundamentals of investigations, and in working with people with an intellectual disability. ▪ The seven Facility Investigators (100%) had direct experience in working with individuals with mental retardation/developmental disabilities. All of their training transcripts (100%) indicated they had been trained in the courses the AUSSLC policy required. The Facility remained in substantial compliance with this provision.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Both State policy and policy governing AUSSLC required cooperation with outside entities conducting investigations of abuse and neglect. When requested, this included deferring and/or coordinating the interviewing of alleged perpetrators of abuse, neglect, or exploitation to the outside entities. Case files contained this instruction. Based on review of Sample #D.1 and Sample #D.2, which consisted of DFPS investigations and Facility investigations, respectively: ▪ All investigations (100%) showed Facility staff cooperated with DFPS investigators. In an effort to increase interagency collaboration, the Director of AUSSLC planned to reconvene quarterly meetings with DFPS, DADS Regulatory, and the OIG to review issues related to investigations and the requirements of the Settlement Agreement. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The 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." As discussed above with regard to Section D.3.b, there was evidence of cooperation between the Facility and law enforcement agencies, including the local police, and the OIG.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on a review of the investigations completed by DFPS and the Facility for this report, the following was found: ▪ Of the 21 investigation records from DFPS (Sample #D.1), there was no indication of direct involvement by the law enforcement agencies. However, notification was made to the OIG as appropriate. ▪ Of nine investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies because of the nature of the incidents (e.g., falls, medication error, injuries of determined cause without suspicion of abuse or neglect, sexual incident between peers, unfounded allegations, etc.). ▪ As indicated above, the District Attorney was prosecuting the perpetrator in investigation 42042812. ▪ Discussion with the lead investigator and the Director of Risk Management/Incident Management indicated a high level of cooperation between the Facility and law enforcement agencies for cases in which this was necessary. The Facility remained in substantial compliance with this provision.	
	(d) Provide for the safeguarding of evidence.	As reported previously, the AUSSLC policy on Incident Management provided instruction on the safeguarding of physical evidence. It required that the evidence be handled as little as possible to prevent destruction, labeled clearly, and secured in the Incident Management Offices. Documentary evidence (i.e., copies of individuals' records, photographs, etc.) was stored in locked cabinets in the Incident Management Offices. Only the Director of Risk Management/Incident Management and the Lead Investigator had keys to these cabinets. Based on a review of the investigations completed by DFPS (Sample #D.1) and by the Facility (Sample #D.2), no investigations required the safeguarding of physical evidence. AUSSLC had the capacity to videotape common areas in the residential units. Surveillance was 24 hours a day. The videotapes had been used successfully to identify and document abusive or neglectful practices. The tapes had provided important evidence that resulted in disciplinary action, including termination from employment. AUSSLC also used photographs to document injuries. AUSSLC policy contained instructions on the use of photographs to document injuries. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence	Both the DADS policy and the AUSSLC policies cited above required that investigations of serious incidents:	Noncompliance

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	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.	▪ 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. In order 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 21 DFPS investigations: ▪ Fifteen (71%) 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. Such evidence was not found in the documentation provided for investigations 42403641, 42115292, 42362352, 42399059, 42000112, and 42449306 (no complete DFPS report included). Based on the Monitoring Panel's discussions with DFPS in December 2010 and June 2011, DFPS developed a format to better document activities that occurred within the first 24 hours of the investigation. This information was evident in the documentation reviewed during this review. It consisted, for example, of the DFPS investigator contacting the Campus Administrator to begin the collection of documents. ▪ Fifteen of twenty-one investigations were completed within 10 calendar days of the incident, including sign-off by the supervisor. Extensions were requested for four of the remaining investigations. This resulted in either timely completion or an appropriate extension for 19 out of 21 (90%). The investigations that were not timely included: 42344714 (i.e., reported on 6/20/12 and signed on 7/6/12, resulting in a delay of six days was due to technical software problems, but an extension for issuing the report was not found in the file); and 42403641 (four days late). ▪ All investigations (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of	

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		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 (43%) reviewed, recommendations for corrective action were included. In these investigations, the recommendations were adequate to address the findings of the investigation. However, the recommendations were focused primarily on staff training. Unlike previous reports, many of the DFPS investigations offered thoughtful recommendations. Although it might not always be in DFPS' purview or area of expertise to offer recommendations, recommendations are key to ensuring issues noted in the investigations are addressed. At AUSSLC, the IDTs were responsible for designing and implementing corrective actions. Discussions of this nature took place in the residences, with the clinical disciplines, and, to a much greater extent, since the Monitoring Team's last review, in the daily Incident Management Review Team meeting. In just two of the investigation files, evidence was found that ISP Addenda were developed or that in-service training was provided to staff. Although these follow-up actions were important and, in certain cases, had very positive results, the Facility should continue to consider ways to prevent incidents from occurring in the first place through the development and implementation of proactive strategies at the individual and programmatic levels. DFPS and DADS should work together to determine the best process for ensuring appropriate recommendations are developed and implemented. <u>Facility Investigations</u> The following summarizes the results of the review of nine Facility investigations: ▪ Nine out of nine (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ Eight out of nine (89%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. ▪ All (100%) resulted in a written report that included a clear 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 six of the nine investigations reviewed, relevant recommendations for corrective action were included. Recommendations were not required in the other cases ▪ In all of the investigations (100%) in which recommendations were present, the	

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		recommendations were adequate to address the findings of the investigation. There was evidence of attention to staff training to prevent similar incidents. The Facility remained out of compliance with this provision due to the DFPS' lack of timely initiation of investigation, and the need for DFPS and/or the Facility to continue to improve the recommendations to address findings of the investigations.	

	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The State and AUSSLC policies regarding Abuse, Neglect, or Exploitation, and Incident Management referenced above required that:
		▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion;
		▪ The report utilize a standardized format that set 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.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		▪ In all of the investigations, or 100%, the contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately:
		o In 21 out of 21 (100%), each serious incident or allegations of wrongdoing;
		o In 21 out of 21 (100%), the name(s) of all witnesses;
		o In 21 out of 21 (100%), the name(s) of all alleged victims and
			Substantial Compliance

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		perpetrators; o In 21 out of 21 (100%), the names of all persons interviewed during the investigation; o In 21 out of 21 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 21 out of 21 (100%), all documents reviewed during the investigation; o In 21 out of 21 (100%), 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 In 21 out of 21 (100%), the investigator's findings; and o In 21 out of 21(100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations involving serious incidents: ▪ In nine out of nine 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 nine out of nine (100%), each serious incident or allegations of wrongdoing; o In nine out of nine (100%), the name(s) of all witnesses; o In nine out of nine (100%), the name(s) of all alleged victims and perpetrators; o In nine out of nine (100%), the names of all persons interviewed during the investigation; o In nine out of nine (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In nine out of nine (100%), all documents reviewed during the investigation; o In nine out of nine investigations (100%), 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 In nine out of nine (100%), the investigator's findings; and o In nine out of nine (100%), the investigator's reasons for his/her conclusions.	

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		A finding of substantial compliance was made.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Based on review of the DADS and AUSSLC policies referenced above, they included a clear expectation that investigations would be reviewed, and that recommendations would be acted upon in a timely manner. Ultimately, it was the Director's responsibility to ensure that the Facility investigation was complete, and that the report itself was accurate, complete, and coherent. The Director was responsible for addressing any deficiencies, and might interview witnesses and/or speak with the investigator. In order to implement these responsibilities, the Director had to rely on the Director of Risk Management/Incident Management and her staff, and on the members of the Incident Management Review Team, which was a team comprised of leadership staff that met daily, except on weekends or holidays. As observed during the review, the Director of Risk Management/Incident Management now played a critical role in this process of review. Over the course of the Monitoring Team's reviews, AUSSLC had implemented an increasingly comprehensive process for the review of investigations. Although there were areas needing improvement, for example, analyzing similarities between the incidents under review so as to obtain a more holistic view of AUSSLC, the Facility was clearer in its understanding of what was required for complete and adequate investigations and was working towards meeting these expectations. The Director of Risk Management/Incident Management was responsible for ensuring that investigations were completed according to policy. The deadlines for investigations were tracked in the minutes of the daily Incident Management Review Team meetings. Careful and consistent follow-up was noted during those meetings conducted during the Monitoring Team's onsite review. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 19 out of 21 investigation files reviewed, there was a notation that a supervisor had reviewed the report. However, there was nothing in the record to provide detail on the nature of the supervision, or how many errors were corrected due to that supervision. When the Monitors met with DFPS in April 2012, DFPS indicated it would submit a proposal to address this issue. In December 2012, DFPS provided additional information to the Monitors about their position on this issue. The Monitors agreed to discuss it further, and provide a response to DFPS. ▪ There was evidence of the Facility Director's review, and of his Review Team's attempts to clarify or correct certain conclusions. Each investigation file contained a review sheet bearing the signatures of the Director of Risk	Noncompliance

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		Management/Incident Management, the Director, and other leadership staff, indicating that the investigation file was reviewed and approved. In investigation 42449306, the Director requested that a full DFPS investigation be conducted instead of just a peer review, and he instructed that a nurse who did not work at the Facility evaluate the situation for him. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In nine out of nine investigation reports reviewed, evidence was found that the supervisor had conducted a timely review of the investigation report. It was positive that on a supervisor's review page, feedback in the form of notes and comments was included. In addition, the IMRT minutes stated that a review had occurred and, when appropriate, that next steps were being taken. A Recommendation Tracking Log was reviewed and found to be up-to-date and complete. As noted above, DFPS investigations did not provide evidence of the nature of the supervision provided. As has been discussed with the parties, a signature is not adequate evidence of supervisory review. The Monitoring Team appreciates that State's willingness to propose an alternative. However, a finding of noncompliance has been made due to this deficiency, as well as concerns with regard to the adequacy of the Facility's review process.	
	(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.	Substantial Compliance
	(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.	In its investigation report files, the Facility included copies of correspondence related to disciplinary action. The review of 30 files in Samples #D.1 and #D.2 indicated the termination of employees confirmed to have committed abuse or neglect. Three staff were terminated and two resigned from employment as the result of the findings from the investigations. Other disciplinary actions included suspension and performance counseling. As discussed earlier in this report, the Facility had begun to track the reassignment of alleged perpetrators and any ensuing disciplinary actions. The lack of a documented reliable tracking mechanism over a reasonable period of time, as identified by the Facility itself, has contributed to the finding of noncompliance. For 18 out of 30 of the applicable investigations reviewed (60%), prompt and thorough	Noncompliance

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		programmatic action had been taken and clearly documented. For example, the following programmatic actions had been taken: ▪ For one individual who had episodes of unauthorized departures, the team met promptly and reviewed his community placement planning (i.e., 12-101); ▪ Supervision was enhanced after the team met and discussed the aggression documented in 12-048; ▪ In 12-100, closer involvement of the IDT and psychology was implemented following the incident that led to an investigation. The following provide examples of investigations for which it did not appear prompt and thorough programmatic action had been taken: ▪ There were no recommendations, and as a result, inadequate tracking to ensure appropriate programmatic action was taken for improper lifting in the case where the individual's arm was fractured (i.e., 42308132). Although there continued to be environmental and programmatic issues of serious concern at the Facility, and although there continued to be instances where no or inadequate action was taken, the Facility had begun to implement consistent strategies to review investigation reports, and to develop programmatic interventions, as appropriate. The review of the minutes of Incident Management Meetings documented the intention to follow-up at the unit and Facility levels. Although additional work is required to reach compliance, it was evident that attempts to recognize and address areas of continuing concern were being made by the leadership staff. Because the Facility did not establish specific measureable objectives for corrective actions or the implementation of recommendations, it was sometimes difficult to determine if the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action. The following are examples of the recommendations' outcomes which were easier to track: ▪ Three employees were terminated as a result of findings from the investigations where abuse and/or neglect were confirmed. The following are examples of where it was difficult to determine if the outcomes had been achieved through the implementation of the programmatic and/or disciplinary action: ▪ Although in-service training was provided, it was difficult to determine if staff competencies actually were increased as a result. The Monitoring Team found the Facility in noncompliance with this provision, because it was not clear adequate tracking was occurring of the recommendations to address	

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		findings of abuse/neglect, and/or that the corrective action resulted in the desired changes in outcomes.	
	(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.	Earlier reports have provided details about the Facility's storage of investigation files. Based on observation and interview with the personnel of the Incident Management office, since the Monitoring Team's last review, the space had remained secure and accessible to the investigators as needed. The Facility remained in substantial compliance with this provision.	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.	As referenced above, AUSSLC had made progress in the analysis of data related to allegations of serious incidents, and allegations of abuse, neglect, and exploitation. In September 2011, a statewide Avatar database was implemented. This new system was proving to be very useful in the systematic collection and retrieval of important information despite some technical problems. There was evidence that a system for trending and tracking had been implemented. However, this system was in the initial phases of development. All of the areas identified in this provision of the Settlement Agreement were not being tracked and or trended/analyzed. All unusual incidents and investigations were reviewed daily at the Incident Management Review Team meeting. The limited trend reports produced were discussed at the Quality Assurance/Quality Improvement Council. The Director of Risk Management/Incident Management was assigned responsibility for tracking incidents, investigations, and injuries. The Director of Behavioral Services tracked restraint use. A review of peer aggression was a major priority at the time of the review. The Facility was in the beginning stages of developing and implementing specific action plans to address identified trends. In addition to ensuring that these plans are adequate to address trends and include measurable outcomes, next steps include tracking the status of the plans, and ensuring their completion and effectiveness at addressing the trends. It is essential that, when trends are identified, adequate actions are taken. Although important progress had been made, the Facility had not yet achieved compliance with this provision.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more	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	Substantial Compliance

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	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.	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. As discussed in earlier reports, the State Office and the Facility Director had worked together to implement a stringent process to track the investigation of the backgrounds of Facility employees and volunteers. Extensive documentation was provided to verify that each employee and volunteer was screened for any criminal history. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to random drug testing. New employees were required to undergo fingerprint checks. The Facility received a "rap back" providing any updated information regarding current employees who had been fingerprinted previously. In September, the Facility had conducted its annual employee registry check and criminal history submission. Also, the Facility submitted documentation indicating that background checks were conducted on volunteers. A random sample of 20 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. The Facility remained in compliance with this provision.	

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

1. The Facility should finalize and maintain its Allegation Tracking Log in order to organize by incident the name of the alleged perpetrator, where the alleged perpetrator was assigned, the outcome of the investigation, and the date on which the alleged perpetrator was released to return to duty or other personnel action was taken. (Sections D.2.b and D.3.i)
2. With regard to appropriate follow-up for investigations:
    a. The State, including DADS and DFPS, and the Facility should continue to 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 Director of Risk Management/incident Management and/or IDTs should review DFPS reports and ensure that all concerns raised are addressed through recommendations in the Incident Management Report that accompanies each investigation and/or an ISPA.
    c. If concerns are not identified or raised in a DFPS report, the Director of Risk Management/Incident Management should identify them and raise them.
    d. Expected outcomes for the corrective actions identified should be set forth.
    e. In addition to reviewing documents, as appropriate, the Facility should physically confirm that changes expected as a result of the

implementation of recommendations resulting from investigation reports have occurred. (Section D.3.e)

3. More in-depth analysis about previous incidents involving both the victim and the alleged perpetrator should be completed in the formulation of conclusions and the development of recommendations, and this analysis should be documented. (Section D.3.f)
4. The Facility should expand its efforts to conduct critical analysis 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)
5. The findings from the intensive review of incidents should continue to be followed-up with corrective actions that do not focus solely on the individual who was injured. It is critical that environmental and peer-related risks be examined, and that reliable remedial actions be instituted without delay. The Facility might find it useful to expand its root cause analyses to explore risks in the residences, and to propose remedial actions from both the individual and systemic level. (Section D.4)

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

1. The Facility might want to consider redesigning the poster regarding individuals' rights or providing additional instruction to staff on its possible use. Development of educational materials regarding a "right of the month" also might encourage staff to discuss the exercise of rights with the individuals who reside at AUSSLC. (Section D.2.f)
2. Training of staff should continue to include explanation that any retaliation related to the good faith reporting of abuse or neglect at AUSSLC or involvement in a related investigation, whether such alleged retaliation occurred onsite or offsite, will be investigated, and prosecuted, if appropriate. The Facility should continue to utilize creative approaches, such as the poster emphatically expressing the prohibition of retaliation, in its efforts to educate and reassure staff. (Section D.2.h)

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, including blank monitoring forms for each of the sections of the Settlement Agreement; o DADS Policy Number 003.1: "Quality Assurance," dated 1/26/12; o Quality Assurance/Quality Improvement Council meeting minutes, dated from 7/11/12 to 10/3/12; o Executive Leadership Team meeting minutes, dated from 4/30/12 to 10/15/12; o AUSSLC Quality Assurance Policy, I.A.5, dated 9/12; and o AUSSLC Quality Assurance Plan, dated 7/19/12. ▪ **Interviews with**: o Charles Bratcher, Facility Director; o Andy Maher, Assistant Director of Programs (ADOP); o Curtis Walters, Director of Quality Assurance (QA); o Cheryl Gard, Program Auditor; and o Stephanie McDonald, Settlement Agreement Coordinator. ▪ **Observations of**: o Incident Management Review Team meetings, on 11/5/12, 11/6/12, and 11/8/12; and o Quality Assurance/Quality Improvement Council meeting, on 11/8/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, updated on 10/22/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment: ▪ The Facility Had just initiated, in September, monitoring/auditing tools. Consequently, at this time, the Facility acknowledged that no significant progress in analysis or corrective actions was determinable. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a limited sample of completed monitoring/auditing tools, as well as interviews with staff: o The Facility had begun to conduct a review of some important components of the quality assurance system, including, for example, some key meetings and meeting minutes, such as the QA/QI Council Meeting, as well as ongoing Corrective Action Plans (CAPs) and documentation related to their implementation. o Although some indicators related to the adequacy of the Facility's QA system had been established, the current review process for Section E did not include adequate indicators to allow the Facility to determine compliance with this section of the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional areas that are relevant to making compliance determinations. o The Self-Assessment did not consistently identify the sample(s) sizes, including the

	number of meetings/records (e.g., CAPs) reviewed in comparison with the number of meetings/records in the overall population (i.e., n/N for percent sample size). o The following staff/positions were responsible for completing the audit tools: it was not clear who was responsible for auditing the Facility's performance in implementing an adequate quality assurance system. However, it appeared it was the Director of Quality Assurance. o There was insufficient information to determine whether the staff member responsible for conducting the audits/monitoring was programmatically competent in the relevant area(s). ▪ The Facility did use some relevant data sources and/or key indicators/outcome measures. The Facility, for example, used its tracking log for CAPs as part of its assessment of its compliance with Section E. ▪ Although more information was needed with regard to the Facility's compliance with Section E, the Facility had begun to present the limited data it did have in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Recognized the importance of presenting findings consistently based on specific, measurable indicators. However, this work had been initiated only recently (September 2012) and continued to be an area in which improvement and expansion were needed. Particularly, focus was needed to better define additional measurable indicators. o Although this is an area that will need continued work and more definition, for Section E, some efforts were beginning to be made to measure the quality as well as presence of items. For example, in looking at CAPs, the Facility assessed whether they were resulting in the desired outcome. The timeliness of completion was not yet evaluated. However, a comprehensive CAP review was scheduled for completion at the end of October 2012. (The results of this review were not available at the time of the Monitoring Team's onsite visit.) In other areas, however, timeliness was afforded greater focus than substance. For example, the quality of the discussions and activities of the QA/QI Council were not fully evaluated, but rather just that the meetings had occurred at a certain frequency. ▪ The Facility rated itself as being in noncompliance with each of the subsections of Section E. This was consistent with the Monitoring Team's findings. ▪ The Facility data did identify limited areas in need of improvement. However, there was no reference to action plans that specifically addressed the deficits identified, or analysis of the underlying issues.
	Summary of Monitor's Assessment: Although compliance with the provisions of Section E had not been reached, there was clear evidence of energy, initiative, and resolve to reach that goal. In partnership with the Facility's executive leadership team, the Director of Quality Assurance and his staff had formulated a clear framework for the quality assurance process at AUSSLC and were in the early stages of its implementation. There was a commendable focus on ensuring habilitation and person-centered supports for the individuals residing at the Facility. For example, the 5 x 5 Key Elements Audit was designed to ensure that attention was directed to the most visible individuals at AUSSLC in order to reduce the use of restraint and the occurrence of undesired behaviors, injuries, etc. At the same time, there was a realistic

	assessment of the potential barriers to achieving compliance with the Facility's goals and the concurrent goals of the Settlement Agreement. As a result, there were significant efforts underway to establish collaboration with the clinical departments in order to strengthen monitoring processes and the evaluation of the outcomes. The results of this collaboration should be evident during the next visit. One of the primary concerns noted during the onsite visit continued to be the lack of established key indicators and/or outcome measures. According to information obtained during the review, the State Office assumed responsibility for the determination of the final set of key indicators and/or outcome measures. However, this work had not been finalized, but the Facility had made a conscientious effort to move forward to the degree possible. It is essential that the State Office resolve this issue as soon as possible so the structure of the monitoring process and the requirements for the review of critical outcome data can be finalized. The failure to determine a set of key indicators will most certainly affect the Facility's ability to move forward with its establishment and implementation of a comprehensive quality management system. For example, as reported previously, it was the Monitoring Team's assessment that the Facility had identified data that was being or could be collected. However, in the absence of key indicators and/or outcome measures, the collected data was not sufficiently linked to the Facility's programmatic goals, such as health, safety, and meaningful lives for the individuals who reside at AUSSLC. The absence of key indicators and outcome measures undermined the Facility's expressed desire to establish adequate and substantive goals and benchmarks. As noted in earlier reports, the Facility's resources, staff expertise, the design of the campus, and community resources would affect the established goals and benchmarks. These variables should be organized and directed to assist with the attainment of the short and long-range goals and outcomes. Moreover, as the Monitoring Team previously noted, a comprehensive Quality Assurance system should include measures and strategies for qualitative evaluation of the progress made by individuals who reside at the Facility. Such progress might be evidenced by growth in independence, social skills, and the ability to exercise meaningful choice. These can all be incorporated into an outcome management system. As the State Office works to finalize these outcome measures, the Monitoring Team continues to recommend an incremental approach to implementation, so that any necessary adjustments can be made effectively and in a timely manner. In July 2012, the Facility reconvened the Quality Assurance/Quality Improvement Council. It was scheduled to meet twice a month. Review of its monthly minutes and attendance at one of its meetings continued to demonstrate the importance and effectiveness of this organizational structure. The agendas consistently focused on achievement of compliance with the provisions of the Settlement Agreement. Corrective Action Plans (CAPs) were beginning to be identified, refined, and tracked. The Facility had instituted a CAP Tracking System to review the CAPs submitted to the Quality Assurance Department. For the quarter following the Monitoring Team's visit, the Facility had noted its intent to prioritize the monitoring and reporting of the CAPs and the comprehensive CAP review. The Monitoring Team agreed this should be implemented in a timely manner. The results of the comprehensive review of the CAP process and its implementation should provide important information for the Council's

	consideration. Without such reporting and analysis, it would be difficult to determine whether the CAPs were addressing the cited concerns in a reliable and sustainable manner. In summary, commendable progress was evident in the establishment of a strong Quality Assurance Department at AUSSLC. The enthusiasm and commitment of the Department's staff was apparent. The Facility's efforts to establish qualitative measures, as evidenced in the 5 x 5 Key Elements Audit and the Engagement Observation and Monitoring Tool, were noteworthy in their focus on the individuals residing at AUSSLC. It will be important to continue to analyze and disseminate the findings from such qualitative approaches.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	DADS Policy Number 003.1 was issued on 1/26/12. In 9/12, the Facility revised its own Quality Assurance policy. The policy addressed all requirements of the Settlement Agreement and the State policy. The minutes from the 10/1/12 meeting of the Executive Leadership Team confirmed the policy was approved and training would be provided at the 10/17/12 meeting of the Quality Assurance/Quality Improvement Council. However, those minutes were not provided. The Facility had designated a Quality Assurance Director. The Director of Quality Assurance and his staff had worked in collaboration with Department and discipline leadership to become knowledgeable about the specific requirements of each section of the Settlement Agreement in order to develop and implement applicable monitoring tools and protocols. The Facility had not yet completed a QA data list/inventory of data collected at Facility. On 7/19/12, the Quality Assurance Plan was revised. The Plan indicated that it: "describes the quality assurance system in terms of the organizational structure, functional responsibilities of management and staff, lines of authority, and required interfaces for those planning, implementing, assessing, monitoring, and improving all activities conducted." Although the structure of the Quality Assurance Plan was referenced, the actual detail of the Plan and its implementation were still in the formative stages. At the time of the site visit, AUSSLC was in the process of developing and implementing monitoring tools related to the provisions of the Settlement Agreement. Due dates for monitoring were being established, effective 9/12. The Settlement Agreement Coordinator had been, and continued to be, an integral part of these discussions and activities. There was a notable effort to integrate the goals and provisions of the	Noncompliance

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		Settlement Agreement into the overall work and responsibility of the Facility. Based on discussion and the review of documentation submitted by AUSSLC, the Facility was beginning to implement its recently updated Quality Assurance Plan as written. The degree to which monitoring was to be delegated to the Departments and disciplines was still under discussion at the time of the onsite visit. It was clear that collaboration and cooperation existed among the various staff involved in these assignments. The Facility provided the copies of monitoring tools currently in use. The Quality Assurance Director had worked closely with the members of the Quality Assurance/Quality Improvement Council to review the monitoring tools, their instructions and the schedule for implementation. As noted throughout this report, including in narrative sections of the report as well as the Facility Self-Assessment sections, the Monitoring Team continued to note many concerns with regard to the monitoring tools and their implementation. It was positive that AUSSLC staff were looking critically at the tools and making changes, as appropriate. The Monitoring Team continues to emphasize the need to develop adequate instructions to ensure valid results and to ensure that personnel completing the tools are trained and clinically/ programmatically competent. According to the Director of Quality Assurance, beginning in December 2012, inter-rater reliability was to be tested. There was no other information provided about this essential requirement. In coordination with the respective Departments/disciplines, Quality Assurance staff was in the initial stages of collecting monitoring/auditing data. However, at the time of the site visit, these data were not fully compiled and analyzed. In addition, as discussed in previous reports, in order for the Facility to be in compliance with this component of the Settlement Agreement, a tracking system needs to be in place to allow identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. DADS Policy Number 003.1 required the development of a set of key indicators. However, the policy did not define those indicators or provide specific direction for their definition. At the time of the Monitoring Team's onsite visit, there had been no final determination by the State Office about this requirement and its implementation. Although AUSSLC staff had attempted to define and measure some reasonable measures of performance, there was a significant gap, waiting for a decision by the State Office.	

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		Although the Facility acknowledged, and the Monitoring Team agreed, that substantial work remained, progress in the requirements of this provision was noted.	
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.	AUSSLC had begun to move forward with the actions required to achieve compliance with this provision. Although considerable more work was needed, the Facility had made a concerted effort to analyze some data from its monitoring efforts and to develop trend reports. For example, there was a trend report regarding the use of restraint and a trend report regarding allegations of abuse, neglect, and exploitation. The latter report had led to the development of a tracking log for recommendations resulting from the investigations of abuse, neglect, and exploitation. At the time of the Monitoring Team's onsite visit, the ongoing work with the Departments was referenced, but specific details were not provided. As the process for implementing quality assurance strategies moves forward, it will be critical that the QA Department regularly meets with departments, discuss data and outcomes, review conduct of the self-monitoring tools, create corrective action plans, and review previous corrective action plans. In addition, it will be important for the QA Department to produce reports that facilitate department/discipline analysis of data, including graphs. Such analysis should identify individual problematic issues, systemic problematic issues, and areas for improvement. Based on the review of minutes and attendance at one meeting, it was apparent that the regularly scheduled and fully represented Quality Assurance/Quality Improvement Council had become a relied-upon partner in the efforts to reach compliance with the requirements articulated in Section E. For example, data regarding injuries, incidents, and restraint use were discussed routinely at the Council meetings. In addition, each of the Settlement Agreement sections was discussed on a rotating basis during Council meetings. However, there was insufficient evidence that these reviews were data-driven. The Quality Assurance/Quality Improvement Council and the Executive Leadership Team meetings were the forums identified for discussion of the CAPs. The structure for the Corrective Action Plans was under review in order to include measureable outcomes to address the identified issues and to allow for an accurate review of the efficacy of the Corrective Action Plan. By 10/31/12, the review was to be completed. At the time of the site visit, information about the findings was not yet available. The existing eleven CAPs were in varying stages of implementation. At the time of the site visit, none of the CAPs had been completed. The format for a tracking log had been	Noncompliance

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		completed and was in use. It lacked some specific details, such as the date of implementation. In addition, the adequacy and timeliness of the CAP activities had not been analyzed. The Corrective Action Plan Tracking Log did not include the date of the Corrective Action Plan's inception. It did note the person(s) ultimately responsible for ensuring the completion of each assigned task. However, as noted previously, potential barriers to the implementation of a Corrective Action Plan should be more clearly defined. The exploration of barriers might assist with the establishment of realistic timeframes. While the Facility was not in substantial compliance with this provision, incremental progress continued to be made.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	For the limited number of Corrective Action Plans the Facility had developed, it appeared they were disseminated to entities/personnel responsible for implementation. For example, there were two CAPs assigned to the Psychology Department regarding the documentation of restraint. However, the Corrective Action Plan Tracking Log provided to the Monitoring Team did not include the date of the Corrective Action Plan's inception in addition to the person ultimately responsible for ensuring the completion of each assigned task. As documented by the meeting minutes and by observation at a Quality Assurance/Quality Improvement Council session held during the Monitoring Team's onsite visit, content and responsibilities for the completion of the Corrective Action Plans, as assigned, was discussed routinely at these meetings. It was evident that the Director of Quality Assurance and his staff monitored the completion of these assignments. However, the utilization of the CAPs was still in its initial phases at the Facility and there was insufficient evidence to conclude compliance with this provision. Based on the limited documentation provided, the scope of and assigned responsibility for the CAPs could not be fully determined.	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.	The Corrective Action Plan Tracking Log documented the issue requiring remedial action, the responsible staff person, and the discrete actions to be performed by certain established timeframes. The protocol for monitoring the Corrective Action Plan was consistent with the intent of this provision, but was not fully implemented at the time of the Monitoring Team's onsite visit. Although the Director of Quality Assurance stated that there would be a full review of the CAPs, insufficient information was available regarding their current status, any barriers to implementation, or the outcomes that had been achieved. Therefore, the implementation of the CAPs was determined to be	Noncompliance

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		incomplete. As discussed in the last report, corrective action plans need to be written to allow determinations to be made regarding their effectiveness, and if not revise them. Without this determination, the Facility's leadership and the Quality Assurance/Quality Improvement Council cannot be assured that serious issues have been resolved. The Facility stated its intent to review of the effectiveness and timeliness of a discrete Corrective Action Plan by October 31, 2012. This initiative was reported to be underway at the time of the Monitoring Team's site visit. The Monitoring Team will continue to review progress towards compliance. It will be critical to determine whether the Corrective Action Plans have been implemented in a timely and complete manner, and if they do not result in demonstrable positive change for the individuals residing at AUSSLC, that they are revised.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The Facility had not completed any CAPs at the time of the Monitoring Team's visit, although there was evidence of progress in implementation. The Monitoring Team was informed that the Quality Assurance/Quality Improvement Council intended to review Corrective Action Plans on an ongoing basis. A comprehensive review of the CAPs was to be completed by October 31, 2012. The results of this review were not available at the time of the site visit. The Facility should continue to focus on ensuring that clear measures are defined, including outcome measures, to allow the Quality Assurance/Quality Improvement Council to determine when a Corrective Action Plan has been successful, and when one needs to be modified.	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 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.)

4. 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.)
5. 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)
6. 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)
7. In its discussions, the Quality Assurance/Quality Improvement Council should continue to 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)
8. 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)
9. As the Facility moves forward in developing its self-assessment processes, in addition to important narrative information, 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 Draft DADS Policy Number 004: Individual Support Plan Process (Integrated Protections, Services, Treatments and Supports), dated 2/8/12; o DADS Draft Policy Number 017: Habilitation, Training, Education, and Skill Acquisition Programs, effective 2/2/12; o List of Qualified Developmental Disabilities Professionals (QDDPs) with their assignments, dated 10/4/12; 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, undated; o Over the last one year period: a) the total number of ISP annual meetings held; the total number of ISP annual meetings that occurred more than 365 days after the previous meeting; and 3) the total number of ISPs that were filed more than 30 days after the annual ISP meeting was held, undated; o Presentation Book for Section F; o Assessment Tracking for ISP dates 5/1/12 to 10/5/12; o Attendance Tracking for ISP dates 5/1/12 to 10/5/12; o Supporting Visions: Person-Centered Planning presentation, dated 9/12; o Supporting Visions: Person-Centered Planning Workgroup, dated 9/12; o Supporting Visions Lesson Plan and Content, dated 9/12; o ISP Monitoring Checklist, revised 3/26/12; o List of QDDPs Deemed Competent Using Q Construction Tool, undated; o In response to the request for the last 10 monitoring tools completed by the QDDP Coordinator and the Quality Assurance Department, the response: "These represent the last 10 tools completed by the QDDP leadership. Several are incomplete; we are still working out the process and vetting the validity of the tool;" o In response to the request for: "Based on monitoring/audit data, or other reviews or data that the Facility has collected in relation to integrated protections, services, treatments, and supports, reports showing analysis of such data, as well as descriptions of actions taken or corrective action plans developed," the response: "Due to piloting of a new Section F tool, there is not enough data to generate report, analysis, or corrective action plan;" o AUSSLC Smart Objectives tool, revised 2/8/11; o ISPs for Individual #21, Individual #26, Individual #333, Individual #282, Individual #298, Individual #34, Individual #454, Individual #63, Individual #216, and Individual #32; o AUSSLC Individual Support Planning from New Employee Orientation Handbook, undated; and

	○ Draft ISP for Individual #62. ▪ **Interviews with**: ○ Holly Lindsey, Director of QDDP Services; ○ Sarah Knowles, Director of Education and Training; ○ Keith Robinson, QDDP Educator; and ○ Derrick Bunton, Director of Residential Services. ▪ **Observations of**: ○ ISP meetings for Individual #302, on 11/5/12, and Individual #62, on 11/6/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 10/22/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section F, in conducting its self-assessment: ▪ The Facility had begun to use a new monitoring/auditing tool. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, as well as interviews with staff: ○ The monitoring/audit tools the Facility had begun to use to conduct its self-assessment included the ISP Monitoring Checklist. It consisted of three parts, including the annual ISP preparation checklist, ISP meeting facilitation and meeting management, and post-meeting documentation. At the time of the review, the Facility had just begun to use the tool, and data was not available for inclusion in the Self-Assessment. ○ The current monitoring/audit tool appeared to include some valuable indicators to allow the Facility to determine compliance with the Settlement Agreement, but it was not always clear what the connection was between the monitoring tools and the Self-Assessment. For example, often the Self-Assessment referenced the tool, but did not indicate which of the many indicators would be used to assess each of the various sections of the Settlement Agreement. The following was a typical statement found in the current Self-Assessment: "Analyze data from completion of Section F monitoring tool, compliance being indicated by 85% integration." However, it was unclear which data from the tool would be used. In a number of sections, adequate indicators were not included. For example, Section F.2.a.1 of the Settlement Agreement includes a number of requirements. The Facility's Self-Assessment only addressed some (e.g., identification and use of preferences, strengths, and needs) and not others (e.g., prioritization of needs, explanation of needs and barriers not addressed, etc. Similarly, for Section F.2.a.2, the Self-Assessment did not address the quality of ISPs in addressing the needs of individuals, which is a major component of compliance with this provision of the Settlement Agreement. As new/revised monitoring tools are considered, the State/Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ As noted above, the monitoring tool(s) was in the beginning stages of implementation, and

	no instructions for its use were provided. However, based on interview with QDDP Department staff, the methodologies would include observations, and record reviews. o The Self-Assessment did not identify the sample(s) sizes. In future Self-Assessments, this should include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). As noted with regard to Section F.2.g, the Facility staff reported that their intention was to audit 20% of the ISP meetings held each month, and the resulting documents. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: a Program Compliance Monitor from the QA Department, the Director of QDDP Services, the QDDP Educator, and the Lead QDDPs. o The staff responsible for conducting the audits/monitoring had not been formally deemed competent in the use of the tools. Although the staff responsible had experience with developing and implementing ISPs, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o As the Facility recognized, adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures. For example, the Facility maintained a database to track the timeliness of assessments, as well as attendance at ISP meetings. Some of this information was included in the Self-Assessment. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not consistently present findings based on specific, measurable indicators. o Did not include indicators that consistently measured the quality as well as presence of items. It was not consistently clear whether or not the quality of the ISPs was being assessed. For example, for Section F.2.e, an indicator addressed training data. It was unclear if the quality of the training, including the requirement for competency-based training had been addressed as part of the auditing process. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section F. This was consistent with the Monitoring Team's findings. ▪ In very limited incidences, the Facility data's identified areas in need of improvement. Although no specific details were yet included, the Facility's Self-Assessment for Section F specifically referenced CAPs in its methodology sections (i.e., "activities engaged in to conduct self-assessment, including review of existing CAPs that had been designed to address issues identified through the review of its data. This was a positive development, and should assist in "closing the loop" to show that data that identifies problems is acted upon.
	Summary of Monitor's Assessment: In May 2012, DADS State Office had revised Policy #004.1: Individual Support Plan (ISP) Process, and had provided the Monitoring Teams with a draft copy. A number of changes had been made to the ISP format/template and process. A revised ISP Meeting Guide

	(Preparation/Facilitation/Documentation Tool) was developed to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. At the time of the review, AUSSLC staff had not undergone the full training on the new ISP process, including the new Integrated Risk Rating Form (IRRF) and the Integrated Health Care Plan (IHCP) process. Although teams had begun to use some of the new forms and processes, they were awaiting further training from State Office. At the time of the Monitoring Team's last compliance review in November 2011, a number of factors were identified that 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. Since then, although not all of these problems had been remedied, some important work had been done to address these issues, and progress was being made. In addition to some assessments beginning to show some improvements, based on the Monitoring Team's observations during the week of the review, team members were more meaningfully participating in team meetings, and information was sought and provided by team members, including direct support professionals. These were extremely important shifts, and were illustrative of the greater teamwork that was seen across campus during this review. Although issues with the timeliness and quality of assessments prepared for ISP meetings continued to require improvement, as noted in other sections of this report, some improvements were being seen. For example, psychiatric, OT/PT, and speech assessments all showed some improvements. In addition, based on observation of a newer format ISP meeting while the Monitoring Team was on site, as well as a video Facility staff shared of an individual with a visual impairment whose team had worked together to revise the supports provided to her, teams had begun to use assessment findings and recommendations in a more integrated fashion. For example, the video presented an example of good use of the recommendations from a specialized assessment from an orientation and mobility specialist in combination with the knowledge and information others at the Facility had of the individual to significantly improve the individual's day-to-day life. Similarly, during an ISP meeting, one individual's team demonstrated use of information from a variety of assessments to creatively develop some plans to address health risks as well as to assist the individual to become more independent. It is the Monitoring Team's hope that teams throughout the Facility will replicate similar practices. Although more work was needed, it was clear that teams were trying to expand action plans to include more of the protections, supports, and services individuals required. In addition, based on limited documentation review, it appeared that efforts were being made to make goals and objectives more measurable and functional. In addition, efforts were being made to better define the role of the direct support professionals in ISPs. The Facility recognized that monthly review reports were an area requiring improvement, and Facility staff were working with a group State Office was leading to address this issue. However, as noted in a number of

	portions of this report, teams were not consistently identifying and addressing individuals' changes in status. Some improvements were seen with the timeliness of ISP meetings. However continuing concerns were noted with the timely completion of the final documents to allow implementation to occur. AUSSLC had begun to offer QDDPs two days after an ISP meeting during which someone else covered their other duties to provide time to finalize the draft ISP. This had been welcomed as a potential solution to the long delays. 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 conducted limited monitoring, and the QA Department also had just begun to conduct monitoring. The Facility recognized that it was not yet collecting adequate data, aggregating and analyzing it, 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:	In May 2012, DADS State Office had revised Policy #004.1: Individual Support Plan Process, and had provided the Monitoring Teams with a draft copy. It was anticipated that a final policy would be issued soon. Should the Monitoring Teams have comments on the policy, they will submit them jointly. DADS State Office recognized the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups including State Office and Facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. At the time of the review, AUSSLC staff had not undergone the full training on the new ISP process, including the new Integrated Risk Rating Form (IRRF) and the Integrated Health Care Plan (IHCP) process. Although teams had begun to use some of the new forms and processes, they were awaiting further training from State Office. In consultation with the parties, it was agreed that beginning in August 2012, the Monitoring Teams would only review and comment on the ISP documents that utilized the newest process and format. The intention of limiting the Monitoring Teams' review to newer plans is to provide the State and Facilities with more specific information about the revised process. Compliance will then be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement requirements. As noted above, AUSSLC had not completed the full training on the new processes. During the week of the review, two teams held meetings using the new forms and processes, but recognized that this was somewhat hampered by the lack of training.	

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		Although members of the Monitoring Team observed the ISP meetings held during the week of the review, final ISP documents were not available for review. The Monitoring Team also recognized without full training on the new processes, teams were not fully to implement the revised methodologies. As a result, limited review of the new processes could be conducted. Other relevant information was reviewed, and a fuller review of the newer ISP documents will occur during the next review.	
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.	At the time of the Monitoring Team's last compliance review in November 2011, a number of factors were identified that 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. Since then, although not all of these problems had been remedied, some important work had been done to address these issues, and progress was being made. In addition to some assessments beginning to show some improvements, based on the Monitoring Team's observations during the week of the review, team members were more meaningfully participating in team meetings, and information was sought and provided by team members, including direct support professionals. These were extremely important shifts, and were illustrative of the greater teamwork that was seen across campus during this review. Progress had been made and/or sustained with regard to 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 Draft Policy #004.1 in both the definition section and in Section II.F.1.b indicated that the QDDP would assist the individual and Legally Authorized Representative (LAR), as appropriate, in leading the team in an interdisciplinary discussion. ▪ The Director of QDDP Services confirmed that QDDPs facilitated the teams, including team meetings. Observations of team meetings also illustrated that the QDDP was the team leader and responsible for ensuring team participation. In observing the ISP meeting for Individual #62, the individual's guardian participated in the meeting. It was clear the QDDP had spent time before the meeting speaking with the guardian. The QDDPs assisted in ensuring that the guardians' concerns, positive comments, and questions were raised and addressed during the meetings. The QDDP also brought the individual, who had limited communication skills into the discussion appropriately.	Noncompliance

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		▪ With regard to staffing, the Facility had a Director of QDDP Services and QDDP Educator. In addition, the Facility had three Lead QDDPs, a PNMT QDDP, 21 QDDPs, and a QDDP Clerk. The QDDP Department had and was continuing to experience turnover. At the time of the review, although the Department had been fully staffed for a short time before the review, nine positions were vacant, many due to internal promotions. As a result of the turnover, many QDDPs had limited experience in these roles. ▪ Although AUSSLC teams had not been fully trained on the revised processes, beginning in November 2011, teams had begun to use the new ISP Meeting Guide (Preparation/Facilitation/Documentation Tool). It was developed to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. The Director of QDDP Services indicated that since July 2012, some of these pre-panning activities had begun to occur. ▪ The Facility had identified some supports for QDDPs to assist with the facilitation of meetings, as well as the generation of the final ISP document. More specifically, in addition to having another QDDP Department staff person at each meeting to add information to the ISP draft on the computer and document the team's discussion, QDDPs were given two "Ghost Days," following each ISP meeting. These were days during which the QDDP's other responsibilities were transferred to someone else in the Department so that they could concentrate on finalizing the draft ISP. These were positive supports that should assist in the development of improved ISP documents. ▪ During the week of the review, the Monitoring Team observed the entire meeting for Individual #62, and part of the annual ISP meeting for Individual #302. Progress had continued to occur with regard to the facilitation of meetings. Based on these limited observations, some of the areas in which progress had begun included: o Although improvements were still needed, teams made better use of data related to risk ratings. o For Individual #62, interdisciplinary collaboration was noted throughout the meeting. Team members shared their expertise related to their disciplines, but also contributed ideas and knowledge about the individual to many of the discussions the team had. This resulted in a more well-rounded plan that sought to improve the health, comfort, and independence of the individual. At times, it was difficult to discern the titles or specific clinical expertise of the various team members, because the discussion on various topics included many team members. This was refreshing to see and showed increasing integration between the various disciplines.	

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		o The Residential Services Department had identified direct support professionals who knew each individual best and assigned them and backups to attend all team meetings. At the meeting for Individual #62, the benefit of this was seen in both the information the direct support professional brought to the table, but also in what she expressed she learned that would assist in better provision of services. o At annual ISP 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, as well as the comfort of the individual throughout the meeting. o The teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. This included review of plans, such as the PNMP, with team discussion and modifications made, as necessary. o The team for Individual #62 also made good efforts to include some of the individual's preferences and strengths into plans designed to address some of her need areas. o During Individual #62's meeting, assessments such as the Functional Skills Assessment were referenced, and the information used to develop plans. Based on the Monitoring Team's observations, facilitation of team meetings was improving. However, areas in which improvements should be made in order to achieve compliance, included: ▪ At the time of the review, AUSSLC staff had not undergone the full training on the new ISP process, including the new Integrated Risk Rating Form (IRRF) and the Integrated Health Care Plan (IHCP) process. As discussed in further detail with regard to Section F.2.e, the discipline heads had undergone some training on these topics with their colleagues from other Facilities, but full training had not occurred for the teams on campus. At the time of the review, the training had been scheduled, but cancelled twice. ▪ Previously, the Facility had been using the "Q Construction: Facilitating for Success" tool to assess QDDPs' competence with regard to facilitation. Using this tool, ten QDDPs had been deemed competent, including two Lead QDDPs; one additional Lead QDDP, who had taken another job within the Facility; and a QDDP, who also had taken another job. At the time of the most recent review, the Facility was no longer using this tool, and had begun to use the Section F monitoring tool to assess QDDPs' competence with facilitation. One QDDP had	

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		been deemed competent using this process. Based on documentation provided, this resulted in nine of the 21 current QDDPs and three Lead QDDPs (38%) having been deemed competent. ▪ Based on limited observations of meetings held the week of the onsite review, areas in which QDDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: o Continuing to expand the depth of the preferences identified for individuals. QDDPs should continue to challenge teams to define what it is the individual prefers about items such as foods or activities to allow teams to offer the individual new experiences, and to expand the discussion to include preferences related to work, relationships, past experiences, future opportunities, etc. These then should be incorporated into action plans. o Continuing 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. o Although some improvements were seen, seeking data from various team members to assist in decision-making, and justify the teams' conclusions. For example, data should be used consistently, including when reviewing PBSPs and skill acquisition programs, as well as outcomes related to individuals' risks. In addition, as appropriate, historical information or causation should be investigated fully (e.g., causes for falls or fractures, history of issues related to previous failed community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services. o Increasing teams' discussion of action plans. For example, although health care plans for Individual #62 were referenced, unlike the PNMP mentioned above, drafts were not presented, reviewed and modified by the team, and/or approved. o Setting forth clearly the methodologies or how outcomes will be accomplished. o Focusing teams on defining measurable, functional objectives during team meetings. o Assisting teams to articulate meaningful outcomes for individuals. ▪ The ISP meeting the Monitor observed was quite lengthy. In addition, the majority of the time was spent on the risk rating process. Although this was an essential activity in which teams needed to engage, it resulted in little time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics. Focus should be placed on the preparation before the meetings, so that meeting time is available for both the clinical discussions that	

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		need to occur, but also adequate time is devoted to developing supports to assist individuals to expand their independence, involvement in the community, and in leading meaningful lives. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. If action plans were presented in draft format, including Integrated Health Care Plans, team members could review them prior to the meeting, and discuss necessary changes and additions at the meeting. Progress had been made. However, continued work was needed to ensure the ISP process resulted 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 Draft Policy #004.1 described the interdisciplinary team as including the individual, the Legally Authorized Representative, if any, the QDDP, direct support professionals, and persons identified as providing services and supports to the individual, as appropriate, including professionals dictated by the individual's preferences, strengths, and needs, and who are professionally qualified and/or certified or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. This policy statement was consistent with the requirements of the Settlement Agreement. As noted above, in November 2012, the Facility had just begun to use the new ISP Meeting Guide (Preparation/Facilitation/Documentation Tool), and AUSSLC teams had not been fully trained on the process, including the IRRF and IHCP processes. As a result, as agreed with State Office, the Monitoring Team did not conduct a review of ISPs developed using previous templates and formats, and none of the new ISPs had been finalized. However, as part of the process for ISPs, at the ISP Preparation Meeting 90 days prior to the ISP, the team was to make a determination regarding whether a team member's attendance was required or not. Reportedly, in July 2012, the Facility had begun conducting ISP Preparation Meetings, and so the meetings being conducted in November presumably would benefit from this process. Moving forward, this information would be included in the database. The ISP signature sheet included a column to indicate if a team member's participation was required. The Monitoring Team looks forward to further reviewing the results during upcoming reviews. The Facility had three action plans related to this section of the Settlement Agreement. In addition to training and then tracking to ensure that team members whose presence	Noncompliance

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		was required at meetings attended, the Facility also recognized the importance of ensuring that team members actively participated in a meaningful way in in ISP meetings. An action plan was in place to address this issue. An important step the Facility had taken was to identify direct support professionals that knew each individual best, and assign a primary staff and a back-up staff to attend the meetings. As evidenced during Individual #62's meeting, this added extremely valuable information to the meeting. The Facility is commended for taking this step to identify a viable method for including direct support professionals in the ISP process. In terms of tracking attendance, in May 2012, the ISP Tracking database became operational, and beginning in July, data was presented to the QA/QI Council. In response to the Monitoring Team's document requests, the Facility presented data from the database that generally showed over 100% attendance for each of the disciplines/team members. This was due to the database including "non-required" team members in the numbers. In other words, if a team member attended, but was not a required attendee, the percentage was increased. In talking with Facility staff, they reported a number of issues with the databases, including difficulty in running reports that would be helpful in identifying areas in need of attention. At the time of the review, work was being done to remedy these issues. Moving forward, the criteria for determining when a team member's attendance at an ISP meeting is required were now defined in draft resources from the State Office. Given that the Settlement Agreement requires: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs," in completing ISP Preparation Meetings, teams should ensure that if needs are identified for an individual for which the presence of a team member is warranted, if the team decides the team member's presence is not necessary, clear justification should be provided. In summary, the Facility was populating its ISP Tracking database, and working to make improvements to the database. It was in the initial stages of formally identifying team members that needed to be present at ISP meetings through the 90-day ISP Preparation Meetings, and was beginning to identify issues with attendance and attend to them during the QA/QI Council meetings. The Facility remained out of compliance with this provision.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the	Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included: ▪ DADS Draft Policy #004 defined "assessment" as: "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence,	Noncompliance

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	individual's strengths, preferences and needs.	and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the 'Action Plans' section of the ISP." In Sections II.B and III.C, the policy stated: o "Ninety days prior to the annual ISP meeting… The IDT identifies what assessments need to be completed based on the resident's preferences, strengths, needs, and risks, in addition to ICF/ID required assessments. The IDT should use the guidelines outlined in Exhibit A: Assessment/Report Schedule when determining which assessments should be completed or updated. All assessments should incorporate and reflect the individual's preferences, strengths, and needs… o IDT members complete the recommended and required assessments and place them in the facility computer share drive for the IDT to review no later than 10 working days before the annual ISP meeting. Copies of the assessments will be shared with the resident's LAR, family, actively involved person, or designated representative prior to the ISP meeting…" ▪ The State Office also had developed a Draft Assessment/Report Schedule – Minimum Requirements, dated 7/20/12. Although it will be important to ensure that this document addresses the Settlement Agreement as well as regulatory requirements, it appeared to provide a good framework from which teams could work to determine the standard assessments that should be completed, and the timeframes for their completion. ▪ As noted above, in July 2012, the Facility had begun conducting ISP Preparation Meetings, and so the meetings being conducted in November presumably would benefit from the process of having teams identify the assessments needed ahead of time, as well as focusing the assessments on individuals preferences, strengths, needs, and desired goals or outcomes. ▪ Moving forward, the assessments that teams decided were necessary for each individual's annual ISP meeting would be included in the assessment database. In 5/12, the Facility's ISP Tracking database became operational. It included a component for tracking the timeliness of assessments. Based on the data this database generated for ISPs meetings held between 5/1/12 and 10/5/12, significant issues were noted with regard to the timeliness of assessments. Timeliness rates were calculated at between 25% and 41%. However, Facility staff indicated discrepancies had been identified between this data and data various departments maintained. Efforts were underway to ensure the validity of the data. Based on discussions with the Director of QDDP Services and the QDDP Educator, although the 10-day timeframe was not always met, they reported an	

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		improvement in having assessments available prior to the ISP meetings. In addition, they reported increased involvement of discipline heads in tracking and following up if assessments were late, as well as trying to improve the quality of assessments. ▪ Active Treatment Coordinators had completed shoulder-to-shoulder training on the completion of the Functional Skills Assessment and its uses in the ISP process. The results of this training are discussed further with regard to Section S of the Settlement Agreement. The Facility as well as State Office recognized that the quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. This is discussed in further detail throughout this report with regard to the sections of the Settlement Agreement that address, psychology (Section K), nursing services (Section M), physical and nutritional supports (Sections O), and vocational, habilitation and skill acquisition (Section S). Some assessments in which improvements were seen included psychiatry, OT/PT, and speech and language assessments. Reportedly, the State Office was developing a list of quality indicators for each of the discipline-specific assessments. In order for adequate protections, supports and services to be included in individuals' ISPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. As noted above, due to the Facility's status with regard to the new ISP process and as per the agreement with the State Office, the Monitoring Team did not complete reviews of older ISP documents. During upcoming reviews, the Monitoring Team will conduct reviews of the newer ISPs and related documentation, including assessments. Although some improvements were seen with the quality of some assessments, and some infrastructure and guidance had been developed regarding the frequency and/or indications for completion of assessments, concerted efforts of all team members will be necessary to bring the Facility into substantial compliance with this provision.	
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.	It is important to note that during the ISP meeting for Individual #62, it was encouraging to hear references to assessments, including for example, the Functional Skill Assessment, as the team deliberated about potential skill acquisition goals and other action plans. Various team members referenced their assessments, and helpfully, pulled out relevant findings and recommendations for the team's consideration. Importantly, this was done in an integrated fashion, so that as opposed to each assessor reading his/her assessment and the team viewing each discipline's assessments as separate entities, the information was used throughout discussions about the individual's risks	Noncompliance

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		and plans to address them, as well as plans to assist the person to become more independent and to maximize her comfort and health. Similarly, during the opening session, the Facility shared a video and the story of an individual with a visual impairment whose team had worked together to revise the supports provided to her. This presented an example of good use of the recommendations from a specialized assessment from an orientation and mobility specialist in combination with the knowledge and information others at the Facility had of the individual to significantly improve the individual's day-to-day life. This was a positive example of how assessment information and the resulting recommendations could be used to assist individual to become more independent and improve outcomes. These two individuals represented a small number of individuals the Facility served. However, it is the Monitoring Team's hope that other teams will replicate these positive practices for other individuals. As noted above, due to the Facility's status with regard to the new ISP process and as per the agreement with the State Office, the Monitoring Team did not complete reviews of older ISP documents. During upcoming reviews, the Monitoring Team will conduct reviews of the newer ISPs and related documentation, including assessments. Moving forward, as noted in previous reports, teams should incorporate thoroughly the results of assessments in the ISPs. Recommendations resulting from assessments should be addressed in the ISPs either by incorporation, or evidence that the team considered the recommendation and justified not incorporating it. When teams agree to implement recommendations, corresponding action plans should be developed. The Facility should continue to address the 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. These included the need to: 1) increase consistent interdisciplinary discussion and coordination in the development of ISPs; 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, and assessments of individuals' physical and nutritional management support needs. The Facility should 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. Many individuals require	

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		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 ISPs, while focusing on the individual and his/her preferences, strengths, etc. As noted above, based on a few examples seen during the week of the review, the Facility was making progress in effectively using assessment information. These efforts as well as efforts to improve the recommendations included in assessments should continue. However, given that these efforts were in the beginning stages, the Facility remained out of compliance with this provision.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. To highlight some of the issues of concern: ▪ Based on a review of 10 ISPs (including those for Individual #21, Individual #26, Individual #333, Individual #282, Individual #298, Individual #34, Individual #454, Individual #63, Individual #216, and Individual #32), in nine of the 10 ISPs reviewed (i.e., Individual #32, Individual #216, Individual #63, Individual #34, Individual #282, Individual #292, Individual #333, Individual #26, and Individual #21), the team had documented a determination of the professionals regarding whether or not transition to the community was recommended. However, for only five of these individuals (56%) was adequate justification provided. The following provide examples of inadequate justification for teams' conclusions: o Although Individual #32's team made a recommendation that the individual was not appropriate for transition to the community, it was not independent of the guardian. The team used the guardian's desire for the individual to remain at AUSSLC as its justification for not recommending the individual transition to the community. Given that the assessments (except for nursing and vocational, which did not include the required statements) all indicated the individual could be supported in a less restrictive environment, it was unclear why the team did not recommend transition to the individual and guardian. o Individual #34's team concluded he: "would not benefit from moving to a less restrictive environment at this time," but no justification was provided. The team stated that they agreed he would enjoy living closer to his family, and his sister was looking to move him to Brenham SSLC. The lack of justification was concerning given that the teams' assessments all said he could be supported in a less restrictive setting (only the nursing assessment did not include a recommendation)].	Noncompliance

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		o Although the professionals on the team concluded that Individual #298 "would not benefit from moving to a less restrictive environment at this time," inadequate justification was provided. The team stated this was based on the individual's personal preference, which they earlier said they could not determine, and the Primary Correspondent's preference. This was not an opinion independent of the individual and family. It also was inconsistent with the statements in the assessments, which all stated she could be served in a less restrictive setting. No reconciliation of the professional team's final recommendation with these statements was provided. o For individual #282, the ISP stated: "facility discipline members (independent of the resident and LAR/family) determined that [individual] would not benefit from moving to a less restrictive environment on this time." As its justification, the team quoted assessments that indicated she could be served in a less restrictive setting. The team's justification for its conclusion was unclear. ▪ Within the overall sample of 10, one individual's team had referred them for transition to the community (i.e., Individual #26). ▪ For four individuals (i.e., Individual #216, Individual #333, Individual #21, and Individual #63), 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. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. In summary, the State had developed a list of standard obstacles to referral that teams had begun to utilize as part of the ISP process. However, IDTs had made little progress in accurately and completely identifying obstacles to referral, and/or developing plans to overcome them. AUSSLC had not yet begun to systematically collect data on obstacles to transition. The Facility was at the very initial stages of complying with this component of the Settlement Agreement. The Facility remained out of compliance with this provision.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for		

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	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;	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. DADS Draft Policy #004.1 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The revised policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…" As noted above, due to the Facility's status with regard to the new ISP process and as per the agreement with the State Office, the Monitoring Team did not complete reviews of older ISP documents to evaluate these requirements. During upcoming reviews, the Monitoring Team will conduct reviews of the newer ISPs and related documentation. The following provides some limited observations from the meeting the Monitor observed, as well as documents provided in the Presentation Book for Section F. <u>Identification and Use of Individuals' Preferences and Strengths</u> As part of the new ISP process, the Facility had begun to utilize the Preferences and Strengths Inventory (PSI). Based on the meeting for Individual #62 and review of documentation included in the Presentation Book for Individual #73, these individuals' teams had identified and tried to incorporate preferences and strengths into the ISP. Moving forward, the Facility should continue to concentrate on the following: ▪ Teams should use 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. ▪ When preferences identified for individuals relate to items, food, or activities, in	Noncompliance

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		addition to incorporating these into plans, 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. ▪ Further emphasis is needed on individuals' specific strengths, as well as the use of strengths to address other need areas. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> In addition to listing priority needs, justification or explanation of how these priority needs were determined should be provided. In addition, careful delineation of barriers to addressing needs should be provided. <u>Identification of Supports Needed to Encourage Community Integration</u> Individual #62's team identified off-campus trips once a month as an objective. Although this represented a limited schedule, the team had some brief discussion about potentially creative options for incorporating skills she would be learning elsewhere. Individual #73's ISP included rather limited opportunities as well (i.e., two times per month), and included some objectives that could be implemented in a variety of settings, one of which was the community (e.g., shaking hands). In addition, for Individual #72, many of the objectives that indicated implementation in the community would be ones that would be implemented anywhere (e.g., implementation of the BSP). Moving forward, community participation objectives should be individualized and specific enough to ensure that such participation is meaningful to the individual. Whenever possible, they should encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. As discussed with regard to Section S.1, only four of the 42 ISPs reviewed in relation to skill acquisition (10%) included a goal that was specifically designed for training to occur in the community. In a number of cases, the community was listed as one of many venues in which the objective could be implemented. Although it appeared that these were areas on which the Facility was working, the Facility remained out of compliance with this provision.	
	2. Specifies individualized, observable and/or measurable goals/objectives,	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	Noncompliance

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	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;	identified barriers to living in the most integrated setting appropriate to the individual's needs. Facility staff indicated that action plans, particularly those related to risk, were an area requiring ongoing attention. Based on the Monitoring Team's observations onsite, as well as the review of documents for Section I and the sample presented in the Presentation Book, although some progress was seen, the Monitoring Team agrees with this assessment. As noted above, due to the Facility's status with regard to the new ISP process and as per the agreement with the State Office, the Monitoring Team did not complete reviews of older ISP documents to evaluate these requirements. During upcoming reviews, the Monitoring Team will conduct reviews of the newer ISPs and related documentation. However, areas on which the Facility should focus include: ▪ Teams should ensure ISPs include goals and objectives adequate to address the full scope of individuals' preferences, strengths, and needs. Examples have been provided in previous reports (e.g., plans to address rights restrictions, psychiatric care plans, therapy plans, use of adaptive equipment, as well as integration of alternative or augmentative communication (AAC) devices, integrated health care plans, etc.). ▪ Monitoring of supports should be defined clearly and consistently. ▪ ISPs should include measurable, observable objectives to determine the efficacy of the various 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. Although it was clear the teams observed were trying to improve in this area, further work was needed to assist teams in identifying adequate, measurable clinical indicators (e.g., goal for blood pressure or parameters for notification of PCP) or outcome measures (e.g., objective for improvement in weight gain or loss). In addition, teams should identify parameters for when direct support professionals or nurses need to contact the nurse or the PCP, respectively, and/or the team needs to meet to ensure changes in status are adequately addressed. ▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, significant work was needed to individualize action plans to overcome obstacles to community transition, and ensure they are measurable. The Facility remained out of compliance with this provision.	
	3. Integrates all protections, services and supports,	Since the last review, some action had been taken to improve the comprehensiveness of ISPs. Specifically, after Staff Office had issued a new ISP Meeting Guide	Noncompliance

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	treatment plans, clinical care plans, and other interventions provided for the individual;	(Preparation/Facilitation/Documentation Tool), along with a new process for completing the IRRF and developing integrated health care plans. As noted above, although AUSSLC staff had not been fully trained on this process, it was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed individuals' array of needs for protections, supports, and services, while approaching this in a person-centered manner and incorporating individuals' preferences and strengths. On a positive note, based on observations of an ISP meeting onsite and review of the sample ISP for Individual #73, it appeared that teams were discussing a fuller array of the individuals' support needs, and developing a more comprehensive set of action plans to address these needs. In addition, efforts were being made to integrate and incorporate other plans into the ISPs to avoid having multiple stand-alone plans. Examples of this included the team's discussion, modification, and approval of the PNMP during Individual #62's ISP meeting, as well as other team members' recognition that components of the PNMP needed to be incorporated into other plans. Similarly, the sample ISP for Individual #73 incorporated behavioral objectives from his PBSP, as well as components of his PNMP into action plans in the ISP. The revised meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and integrated health care plans. Although the Facility was in the beginning stages of implementing this new process, it showed promise for the development of more comprehensive ISPs. As the Monitoring Team's observations of ISP meeting on site indicated, the majority of the time was spent on the risk rating process and discussion about current supports or the need to modify supports. Although these were essential activities in which teams needed to engage, it resulted in limited time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics, such as the individual's plans to increase skills leading to greater independence, ways in which greater integration into the community could occur, etc., although some of this discussion did occur. Additional preparation by the QDDPs as well as other team members before the meetings was an area for improvement. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. Another consideration would be the development of draft action plans prior to the ISP meeting. This would seem to be a reasonable and necessary process to allow the meeting time to be shortened and adequate time to be spent on other important topics. However, the major caution relates to the concern that this would result in less collaboration	

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		between disciplines and the "silo" effect of team members coming to the table with predetermined plans. If action plans were to be drafted ahead of time, QDDPs would need to make clear that they were drafts, and the expectation would need to be set that changes to the drafts would be the norm as opposed to the exception. Again to reduce meeting time, an expectation might also be set that team members review them ahead of time, and come to meetings with mark-ups and/or questions. As noted above, due to the Facility's status with regard to the new ISP process and as per the agreement with the State Office, the Monitoring Team did not complete reviews of older ISP documents to evaluate these requirements. During upcoming reviews, the Monitoring Team will conduct reviews of the newer ISPs and related documentation. However, areas on which the Facility should focus include: ▪ All plans that currently are considered stand-alone plans (e.g., medical, psychiatric, counseling, and nursing care plans) should be integrated in a measurable way into the ISPs, through, for example, measurable objectives, and should show an integration of various disciplines and team members. ▪ Action plans should recognize the multiple staff and disciplines that need 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. Action plans should detail the steps and the staff who need to work in an integrated fashion to achieve the stated outcome. Examples have been provided in previous reports. Although the Facility remained out of compliance with this provision, some progress had been made.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	As noted above, due to the Facility's status with regard to the new ISP process and as per the agreement with the State Office, the Monitoring Team did not complete reviews of older ISP documents to evaluate these requirements. During upcoming reviews, the Monitoring Team will conduct reviews of the newer ISPs and related documentation. However, based on extremely limited review of Individual #73's ISP, many of the objectives were measurable, and included implementation and completion dates, as well as staff responsible. However, there continued to be objectives that were not measurable (e.g., "Adequate fluids will be provided via g-tube," or "bathed by staff on elevated bath trolley"). In addition, the timeframes often were confusing, because the ISP did not distinguish between timeframes for implementation of action steps, and monitoring or oversight of implementation. It was positive that this plan identified the direct support professionals' roles within many of the action plans. Areas on which the Facility should focus include: ▪ Whenever possible, specific timeframes should be delineated, or some form of	Noncompliance

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		measuring staff's level of involvement should be included. ▪ Timeframes for "Reviewing for Progress and Effectiveness" should be delineated, as well as any other specific steps for developing or implementing the objectives. ▪ Teams should focus on defining the methods for implementation. In other words, the "how" should be provided. ▪ In addition, as is discussed with regard to Section I, action plans for individuals identified as being at risk should include adequate methodologies to reduce the at-risk factors to the extent possible. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. ▪ Teams should continue to identify direct support professionals, when they are responsible for an action plan or some component of an action plan. Their specific role should be described. Based on very limited review, it appeared the Facility was making some progress in this area. However, the Facility remained out of compliance with this provision.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Although as noted above, it appeared teams were expanding the scope of protections, supports, and services in the ISPs, this remained an area on which the Facility needed to focus. As other sections of this report discuss, a number of plans continued to not be included or addressed in ISPs (e.g., psychiatric treatment plans, nursing care plans, communication plans, etc.). Although the new format was promising in terms of the prompts it provided to teams, teams will need to ensure they are effectively addressing the individuals' needs for services and supports. Based on the limited observation of an ISP meeting and review of the sample included in the Presentation Book, it appeared that teams were attempting to identify functional objectives that would lead to more independence for the individual. For example, some objectives were developed to attempt to give individuals more control over their environments or develop useful skills. This will be an area in which further review will need to be conducted when the Monitoring Team conducts a full review of the newer plans. However, as noted in previous reports, due to some of the characteristics of the Facility, 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. 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	Noncompliance

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		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. In summary, although improvement were beginning to be seen with regard to the comprehensiveness of individuals' plans, as well as the functionality of some of the objectives, the Facility remained out of compliance with this provision.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	As noted above, due to the Facility's status with regard to the new ISP process and as per the agreement with the State Office, the Monitoring Team did not complete reviews of older ISP documents to evaluate these requirements. During upcoming reviews, the Monitoring Team will conduct reviews of the newer ISPs and related documentation. However, based on extremely limited review of Individual #73's ISP, generally it specified data to be collected and/or documentation to be maintained, and sometimes specified a frequency for data collection. As compared with previous reviews, it was clearer who was responsible for reviewing the data. However, the frequency of such review was not identified, and/or timeframes (e.g., specific shifts, days of the week, etc.) were not identified for monitoring activities. In addition, as discussed in other sections of this report, measurable objectives often had not been developed (e.g., in risk plans developed in relation to Section I, for therapy plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Although some improvement was seen with regard to data being used to inform some of the at-risk discussions, this was an area on which the Facility continued to need to focus. At ISP meetings, data should be included related to the implementation of other plans (e.g., PNMPs, PBSPs, nursing care plans, psychiatric care plans, etc.), as well as 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,	Noncompliance

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		problems continued to persist with regard to the reliability of the data. The Facility remained out of compliance with this provision.	
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.	Although this was an area that continued to require further review, during this review, some initial signs of improvement were noted. As discussed above, the team the Monitor observed made efforts to better coordinate services. Due to the fact that the ISP document was still in the process of being finalized, the Monitoring Team was not able to assess whether or not the discussions at the meeting resulted in a coordinated plan. As noted in the Monitoring Team's previous reports, the Facility should focus on ensuring that coordination occurs between, for example, the following: 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.	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 Draft Policy #004.1 at I.C.22 required the ISP to be accessible and comprehensible to staff who must implement it. Copies of the ISPs were being maintained in the Active Records in the residences to which staff working with the individuals had access. Due to the limited review of ISP meetings the State agreed to, the Monitoring Team cannot comment on manner in which plans were written, and whether or not they facilitated direct support professionals' understanding. In previous reports, an issue related to comprehensibility of ISPs was the lack of delineation of responsibility for the implementation of the plans. For a direct support professional, the ISPs were not written to allow easy determination of what his/her responsibilities were for the individual during the course of the 24-hour day. Given the way most of the action items or objectives were written, any team member would have had difficulty determining specifically what their responsibilities were. As noted above, often, the methodology, or the "how" was missing. During this most recent review, observations of ISP meetings and review of one ISP for Individual #73 showed that teams were trying to correct some of these issues. More discussion than in the past occurred about specifically what the responsibilities were of direct support professionals, as well as other team members. Although it was very early in the new ISP process, this was encouraging to see, and, hopefully will result in plans that are more understandable to those that need to implement them. As noted above, continuing work also was needed on defining the methodologies.	Noncompliance

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		In addition, implementation of the new ISP process had begun to pull together the previously many separate plans and integrate them 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. In doing this, staff should be able to reference 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. This document also should point team members to the more detailed plans that the team has approved. Although some progress appeared to have been made, the Facility remained out of compliance with this provision.	
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 Draft Policy #004 at III.A addressed personal support plan monitoring. This included the requirements of the Settlement Agreement for monthly reviews and action, as appropriate. The Director of QDDP Services candidly shared with the Monitoring Team that the completion of monthly reviews of ISPs was an areas requiring improvement. She explained that this was recognized not only at AUSSLC, but also across the SSLC system. She was working with a workgroup the State Office was leading to address the need for a comprehensive and workable monthly report format. In the Presentation Book for Section F, the Facility provided sample monthly reports. As the Director of QDDP Services predicted, these reports mainly addressed data for skill acquisition goals. This data was set out in an easy to read format, but was not graphed. However, given the ISPs included many additional programs and supports, the limited additional information provided in the monthly report was not adequate to meet the requirements of this provision. 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. Although some progress had been made in integrating skill acquisition data into the QDDPs' monthly reviews, the Facility did not yet have an adequate monthly review process in place. The Facility remained out of compliance with this provision.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility	The following provides an update on the training related to the ISP process that had been provided to staff as of the time of the review:	Noncompliance

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	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 part of AUSSLC's Directed Plan of Correction that was implemented in response to survey and certification reviews and findings, QDDPs had been provided a wide variety of training, including considerable training on the planning process. ▪ In addition, a number of Active Treatment staff had completed training entitled: "Performing Functional Skills Assessments and Developing Skill Acquisition Plans." In the spring and summer of 2012, consultants performed this training. ▪ As reported in previous reports, training on ISPs had been standardized across the SSLCs. However, since the Monitoring Team's last review, this training had been modified. Based on documentation provided, beginning on 10/16/12, the new Supporting Visions: Person-Centered Planning, dated 9/12, was being used during new staff orientation. Based on review of the PowerPoint presentation and related Workbook, the training appeared to provide an overview of the planning process, and the roles of the various team members. It also set forth DADS Leadership's expectations with regard to person-centered planning. A role-playing exercise required participants to take on the role of a particular team member. Participants were assessed on their role-play, and also took a written test. ▪ As noted with regard to Section F.1.a, in September 2012, some of the management staff and discipline coordinators had attended a two-day ISP and Risk Training with the State Office. Amongst other topics, it covered the PSI and the ISP Preparation meeting. The Facility was using the new ISP Meeting Guide (Preparation/Facilitation/ Documentation Tool), but full training had not been provided on the revised ISP format, including the new Integrated Risk Rating form and Integrated Health Care Plans. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As noted above, although discipline heads had attended training with their peers from other Facilities, QDDPs and other team members had not yet undergone additional training on the revised Integrated Risk Rating form and Integrated Health Care Plans. At the time of the review, the training had been cancelled twice, and it was unclear when it would be rescheduled. ▪ 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. Previously, the Facility had been using the "Q Construction: Facilitating for Success" tool to assess QDDPs' competence with regard to facilitation. Using this tool, ten QDDPs had been deemed competent, including two Lead QDDPs; one additional Lead QDDP, who had taken another job within the Facility; and a QDDP, who also had taken another job. At the time	

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		of the most recent review, the Facility was no longer using this tool, and had begun to use the Section F monitoring tool to assess QDDPs' competence with facilitation. One QDDP had been deemed competent using this process. Based on documentation provided, this resulted in nine of the 21 QDDPs and three Lead QDDPs (38%) having been deemed competent. ▪ 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. ▪ As recommended in previous reports, there should be additional training on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's 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 an 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 Facility staff indicated continued to be a need. ▪ 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, QDDPs' competence with meeting facilitation should be assessed, competency measures should be developed and implemented for the development of the ISP documents, and the Facility should ensure that staff responsible for the implementation of the plans successfully complete competency-based training.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP	Since the last review, no individuals had been admitted to AUSSLC. Based on data the Facility provided, over the last one-year period, annual ISP meetings were held for 326 individuals. Of these 293 (90%) occurred within the 365-day timeline. The Facility tracked the dates ISPs were filed in the records. Over the last one-year	Noncompliance

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	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.	period, 108 of the 326 plans (33%) were filed within 30 days of the ISP meeting. The Facility had begun to provide two "Ghost" days to QDDPs following an ISP meeting to allow the QDDP that facilitated the meeting to write-up the ISP. Based on interviews with staff, with very limited interruptions, this appeared to be having a positive effect on QDDPs' ability to turn-around the ISP documents quickly and accurately, so that implementation could begin. The Facility remained out of compliance with this provision. However, AUSSLC had pursued and begun to implement some potential solutions to completing the ISP documents within 30 days of the ISP meetings.	
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.	Due to staffing changes and priorities related to complying with regulatory requirements, staff from the QDDP and Quality Assurance Departments candidly reported that monitoring of ISPs had not occurred with any great frequency. QDDP Department staff also reported that it was difficult to monitor plans while new expectations for the plans were being implemented. Those within the Department also were responsible for providing technical assistance to teams. The Monitoring Team agrees that pure monitoring cannot be completed when the auditors intervene in the process to provide technical assistance. As discussed while on site, the Facility will have to give some thought to priorities for monitoring, while ensuring that the necessary training, technical assistance, and supervision are provided to the QDDPs, many of whom were new to their positions. Positive developments included: ▪ DADS Draft Policy #004.1 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ After working with the State Office to make some modifications, the Facility had begun to utilize a new audit tool. It was entitled: "ISP Monitoring Checklist." It consisted of three parts, including the annual ISP preparation checklist, ISP meeting facilitation and meeting management, and post-meeting documentation. It was positive that the ISP process was viewed in this holistic way. By looking at the process from beginning to end, some valuable information should be collected about any portions of the process that are not working correctly. ▪ Based on interview with staff, the Facility had developed a plan to identify a sample of 40% of the ISP meetings scheduled for the month, with a goal of monitoring 20%. The larger sample was being identified to ensure that if meetings were cancelled or other factors prevented the auditors' attendance, a large enough sample was available from which to choose. Given the staffing changes and other priorities for both the Quality Assurance and QDDP Departments, extremely limited information was provided in relation to any monitoring	Noncompliance

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		the Facility was completing with regard to Section F. The following concerns were noted: ▪ In response to the Monitoring Team's request for the last 10 monitoring tools completed by the: a) QDDP Coordinator; and b) Quality Assurance staff, the Facility provided the following response: "These represent the last 10 tools completed by the QDDP leadership. Several are incomplete; we are still working out the process and vetting the validity of the tool." Although it was difficult to tell, it appeared that a member of the QA Department had completed some of these audits. ▪ As noted above, the Facility had begun to use a new monitoring tool. However, instructions were not submitted with the tool. In addition, inter-rater reliability had not been established between the various auditors. ▪ In addition, in response to the request for: "Based on monitoring/audit data, or other reviews or data that the Facility has collected in relation to integrated protections, services, treatments, and supports, reports showing analysis of such data, as well as descriptions of actions taken or corrective action plans developed," the response: "Due to piloting of a new Section F tool, there is not enough data to generate report, analysis, or corrective action plan." 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, minimal progress had been made. The Facility remained out of compliance with this provision.	

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 Individual Support Plan process. (Section F.1)
2. Based on the ongoing competency checks for all QDDPs, as necessary and appropriate, the QDDP Coordinator should provide QDDPs with additional technical assistance or training on group facilitation, particularly as it relates to the interdisciplinary team process. (Section F.1.a)
3. The draft criteria for determining when a team member's attendance at an ISP meeting is required should be finalized. As previously recommended, 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." In addition, in completing ISP Preparation Meetings, teams should ensure that if needs are identified for an individual for which the presence of a team member is warranted, if the team decides the team member's presence is not necessary, clear justification is provided. (Section F.1.b)
4. 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)
5. The Facility/State should finalize 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. The ISP Preparation Meeting documentation should include a justification, particularly when they are not requiring completion of an assessment for which the individual has specific needs. 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.1.c)

6. Assessments should include a full set of recommendations that are designed to assist the teams in developing action plans that describe the array of protections, supports and services that the individual requires. As appropriate, assessments should recommend specific areas of focus for skill acquisition programs, as well as detail data that needs to be collected for various purposes (e.g., addressing individuals' risk factors, measuring efficacy of various plans, etc.), and roles and responsibilities of various staff. (Section F.1.c)
7. Now that the ISP process includes an annual review of incidents, and abuse, neglect, and exploitation allegations, teams should adequately address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. (Section F.1.c)
8. 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)
9. 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)
10. 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)
11. 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)
12. 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)
13. The IDT should review and approve all related plans, and the specific plan that has been approved should be referenced in the ISP, including the title and date of the plan. The team should approve any modifications of the approved plans through an ISPA. IDTs also should include a set of objectives in the ISP related to each of the plans, including, but not limited to the expected outcomes for the plans, any related skill acquisition plans, as well as defining what supports need to be implemented, who is responsible, how success will be measured, who is responsible for data collection, as well as who is responsible for monitoring and/or data review. (Sections F.1.d, F.2.a.2, and F.2.a.3)
14. As teams continue to receive training on the new ISP 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)
15. Whenever possible, specific timeframes should be delineated in action plans. For action plans that involve service objectives, some form of measuring staff's level of involvement should be included. (Section F.2.a.4)
16. 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)
17. ISPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
18. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that ISPs 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)

19. 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 ISPs. (Section F.2.d)
20. 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)
21. As the facilitation skills performance tool evolves, guidelines should be provided as necessary to support reviewers' understanding of the indicators. (Section F.2.e)
22. 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)
23. 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)
24. The Facility should ensure ISPs are completed in a timely manner and prepared to allow implementation to begin within 30 days. (Section F.2.f)
25. 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)
26. As the Facility expands its self-assessment activities, the Facility Self-Assessment should include the results of data analysis to substantiate the Facility's findings of noncompliance or substantial compliance. The Facility Self-Assessment also should indicate how the Facility has used this data to identify problematic trends, and develop corresponding corrective actions. (Section F.2.g and 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 Presentation Book for Section G; o For medical morning meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for following dates: 10/1/12 to 10/5/12, 10/8/12 to 10/12/12, and 10/15/12 to 10/19/12; o For hospitalizations in the previous six months, copies of follow-up ISPAs for the following individuals: Individual #175 9/17/12, Individual #324 9/4/12, Individual #321 5/28/12, Individual #321 6/7/12, Individual #72 8/13/12, Individual #72 8/21/12, Individual #204 6/27/12, Individual #204 8/6/12, Individual #204 8/14/12, Individual #204 8/30/12, Individual #214 5/19/12, Individual #214 5/27/12, Individual #214 8/10/12, Individual #375 7/26/12, Individual #375 9/11/12, Individual #426 7/11/12, Individual #426 7/13/12, Individual #426 7/20/12, Individual #426 7/26/12, Individual #426 7/30/12, Individual #301 8/13/12, Individual #65 7/23/12, Individual #65 7/24/12, Individual #65 8/13/12, Individual #65 9/12/12, Individual #381 7/6/12, Individual #381 9/12/12, Individual #381 9/17/12, Individual #96 7/30/12, Individual #398 5/29/12, Individual #336 5/25/12, Individual #336 8/14/12, Individual #81 7/9/12, Individual #247 8/13/12, Individual #247 8/17/12, Individual #171 6/1/12, Individual #16 8/1/12, Individual #16 8/9/12, Individual #182 7/11/12, Individual #182 9/7/12, Individual #296 9/5/12, Individual #312 8/8/12, Individual #239 5/18/12, Individual #90 6/18/12, Individual #402 5/16/12, Individual #402 5/30/12, Individual #402 6/25/12, Individual #402 8/20/12, Individual #402 7/30/12, Individual #402 8/13/12, Individual #389 5/18/12, Individual #389 5/26/12, Individual #389 5/31/12, Individual #423 6/11/12, Individual #423 6/14/12, Individual #423 8/7/12, Individual #423 8/17/12, Individual #161 7/2/12, Individual #416 9/12/12, Individual #363 5/23/12, Individual #363 7/2/12, and Individual #73 6/4/12, Individual #73 7/27/12, Individual #73 9/4/12, and Individual #73 9/5/12; o For one individual from each residential home, copies of all consultant reports (i.e., medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes (IPNs) commenting on consultant reports (i.e., medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing) and any ISP addendum related to the consultant report for: Individual #290, for eye clinic 3/9/12, ophthalmology 6/8/12, podiatry 6/20/12, and ophthalmology 9/14/12; Individual #214, for podiatry 6/20/12, and hematology 7/11/12; Individual #168, for podiatry 5/23/12, and ENT 7/5/12; Individual #430, for rheumatology 6/13/12, and neurology 7/9/12; Individual #426, for orthopedics 8/13/12, orthopedics 9/10/12, orthopedics 7/27/12, ENT 5/10/12, ENT 8/16/12, and ENT 6/8/12; Individual #82, for ENT 6/11/12, infectious disease 5/29/12, gastroenterology 8/3/12, ENT 5/24/12, ENT 5/15/12, ENT 5/10/12, gastroenterology 8/30/12, and infectious disease 5/10/12; Individual #315, for

	gastroenterology 8/3/12, gynecology 5/25/12, and gynecology 4/27/12; Individual #22, for sleep study 6/25/12, sleep study 8/2/12, and surgery 6/11/12; Individual #208, for ENT 6/7/12, and surgery 4/9/12; Individual #141, for eye clinic 8/10/12; Individual #80, for neurology 7/16/12; Individual #99, for gynecology 4/27/12, gastroenterology 8/3/12, ENT 6/25/12, neurology 6/25/12, and neurology 5/12/12; Individual #264, for neurology 7/9/12, and neurology 8/20/12; Individual #13, for orthopedics 7/2/12, cardiology 6/29/12, urology 7/9/12; Individual #281 nephrology 9/13/12, neurology 9/17/12, dermatology 4/24/12, and neurology 6/18/12; Individual #344, for endocrinology 4/25/12; Individual #189, for ENT 6/21/12, and ENT 4/20/12; and Individual #172, for neurology 7/16/12; o AUSSLC Quality Assurance Monitoring for Section G, undated; o For the self-assessment process for Section G, list of monitoring/audit tools used, for each tool the number of the eligible population to be sampled, the number included in the sample (the percentage of the eligible population sampled), the method used to determine how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor/survey/review, and any inter-rater reliability data analyzed for the audit/monitoring review; and o For the self-assessment process for Section G, the databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, documentation of the frequency of the data collection.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility did not use monitoring/auditing tools. There was a "Medical Consultation Auditing Tool" that had been developed, but it had not been implemented. Further, there needed to be some clear instructions in completing the audit, because three staff had been assigned to complete the audit. With regard to the monitoring tool: o This draft monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with all aspects of this section of the Settlement Agreement. One of the indicators concerned referring the consult to the IDT for review, but this needed further guidance. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. Additional indicators and/or tools were needed to review the ISPA process in response to a change in health status, the time required to complete the document, and the quality of the content in addressing the concern. o The monitoring tool in draft from appeared to include adequate methodologies, such as consult report reviews and record reviews focusing on PCP IPN entries. o The draft audit tool identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). This sample size was adequate to consider them representative samples. However, the audit tool had not been piloted to determine the length of time to complete an audit.

	○ The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tool: Clinic Nurse, Medical Director, and QA Compliance Nurse. ○ The staff responsible for conducting the audits were clinically competent in the relevant area(s). ○ Inter-rater reliability had not yet been determined. ▪ The Facility did not use other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. The Facility was in the preliminary stages of exploring audit tools and creating databases. ○ Some examples of databases/data sources that were not considered included attendance tracking (although it was listed in the self-assessment report, no data was provided), tracking rates of closure items from the morning report as well as rates of outstanding concerns at the end of each month, timeliness of ISPA development to address clinical concerns, and PNMT recommendation tracking. ○ As the Facility was in the early stages of database development and monitoring, measurable indicators were being explored. Some clinical indicators the Facility had created are discussed with regard to Section L. However, for Section G, the consult report review had measurable indicators. However, it had not been piloted to determine if changes needed to be made. ▪ When data was available, the Facility consistently presented it in a meaningful/useful way. The comprehensive list of onsite and offsite consultations, as well as the data concerning hospitalizations, repeat hospitalizations, and ER visits was useful. However, what appeared to be lacking was an analysis of information from databases. For instance, it was not clear how the data concerning the onsite and offsite clinics was analyzed, and how it led to further improvements in clinical care, or an action step. The data from the hospitalizations and ER visits did not lead to any conclusion, next step, or additional information that might need to be tracked to clarify or confirm an issue. ▪ All data in the Self-Assessment was from the Medical Department. There was no data available from the QA Department. ▪ The Facility rated itself as being in noncompliance with Section G. This was consistent with the Monitoring Team's findings. ▪ One of the ongoing challenges for the Facility was analysis of the data. There were no reports analyzed available data to identify areas of in need of improvement. Methodologies to manage data should be developed that meet the needs of the Medical Department, as well as other clinical departments, but the Facility was in the early stages of database management.
	Summary of Monitor's Assessment: The Medical Department had made much progress in implementing a quality system. However, many areas still needed to be reviewed to determine if revisions or improvements were needed. The medical morning meeting minutes were thorough and reflected interdisciplinary discussions,

	providing some evidence of integrated clinical services. However, the minutes were a resource that was underutilized. An analysis of the minutes over time would provide documentation of the activities of the group, the number of closure items identified, the number closed each month, the number outstanding at the end of the month and at 30 days, etc. Although the self-assessment indicated that departmental attendance was tracked, evidence of this was not submitted. This would be an additional valuable area for providing evidence of integrated clinical care. Criteria needed to be established to determine the quality of the ISPAs developed to address hospitalizations, with a focus on preventive aspects of care, and not only addressing the individual's immediate transition needs back to the Infirmary or residence. Timelines should be established for related activities, including timelines from the time the morning meeting group makes a referral to an individual's team, the team conducts the ISPA meeting and returns documentation to the morning meeting group, and the medical morning group reviews the ISPA. The Settlement Agreement's requirement of five days for changes health status should be followed. Tracking of PNMT recommendations also needed to occur. The Medical Department had identified this need, but not further pursued it. The consultant tracking monitoring tool template had been developed, but the Medical Department had not implemented this monitoring tool. There was a tracking tool utilized for on and offsite appointments, which also included missed and refused appointments, but it did not appear to generate referrals to the IDT to address missed appointments. This information also should be processed back to the morning meeting. In the previous six months, the Medical Department had begun the process of creating a systems approach for compliance with integrated clinical services. The momentum had provided evidence of considerable steps forward. However, much remained to be accomplished, such as the completion of databases, analysis of data, and periodic summaries, and implementation of monitoring tools. The Facility remained noncompliant with Section G.

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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	Several Medical Department processes and Facility systems were reviewed to determine quality integrated clinical services. A sample of provider morning meeting minutes was submitted. The dates of these meeting minutes were from 10/1/12 to 10/19/12. The following information summarizes the contents of these meetings. The number of meetings totaled 15. ▪ Fifteen of 15 meeting minutes (100%) recorded attendance. ▪ Fifteen of 15 (100%) included discussion of the Campus Coordinator Log. ▪ Twelve of 15 (80%) included discussion of the on-call provider report. ▪ Fifteen of 15 (100%) included a report by the Hospital Liaison Nurse.	Noncompliance

#	Provision	Assessment of Status	Compliance
	receive the clinical services they need.	▪ None of 15 (0%) discussed measures to prevent another hospitalization for seven hospitalized individuals. ▪ Two of the seven were hospitalized with pulmonary concerns (i.e., aspiration pneumonia, pneumonia). ▪ None of 15 (0%) appointed a member of the morning meeting to review the open record for seven or more days prior to the hospitalization/ER visit. ▪ None of 15 (0%) included discussion of results of an open record review. ▪ The Infirmary census during this time period ranged from two to nine. ▪ One of 15 (7%) included additional information. The information at the one meeting concerned a medical ethics education opportunity provided through a Medical Director announcement. ▪ One of 15 (7%) included discussion and resolution of closure items. ▪ Twelve concerns/closure items were identified at nine medical morning meetings. Six medical morning meetings did not have any additional closure items identified. ▪ None of 15 (0%) reviewed ISPAs as part of the closure process at the medical morning meeting. A total of zero ISPAs were reviewed, and the medical morning group reviewed and commented on none of the ISPAs in terms of their ability to address any prior concern directed to the IDT. ▪ None of 15 (0%) ISPAs were returned to the IDT for further review to address the concern. ▪ None of 15 (0%) meetings reviewed consult reports, and/or whether scheduled consults were or were not completed. ▪ Seven of 15 (47%) provided Dental Department updates. ▪ None of 15 (0%) provided infection control updates. ▪ Three of 15 (20%) recorded a PNMT report. An additional three of 15 (20%) were recorded as part of a Physical Therapy (PT) report. ▪ Two of 15 (13%) recorded a skin integrity report, as part of a PT report (not a PNMT report). ▪ None of 15 (0%) recorded a report of any individuals with significant weight gain or loss. ▪ None of 15 (0%) included a discussion/in-service of systemic medical concerns, policies or procedures, quarterly analyses of data, etc. The medical morning meeting group developed a spreadsheet/chart to track concerns identified as needing closure. At the time of the Monitoring Team's onsite review, this was currently in place. The document included the following column headings that were to be completed as applicable for each concern identified: the name of the topic needing closure, the date initially presented, the description of the issue needing to be addressed, responsible person, action plans, follow up/closure date, and other comments. The closure tracking spreadsheet was submitted for October 2012, indicating this form was	

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		being completed. As one month ended and another began. However, for closure items that remained unresolved from the prior months, it was not clear who the delegated person was to track these or the frequency of the review. It is recommended that the Medical Department create a policy or procedure for follow-up on the monthly closure spreadsheet, specifically providing guidance to the assigned personnel responsible for review of these monthly spreadsheets, and the interval of review until closure. Information summarizing the numbers of closed items and number outstanding also should be reported on a monthly basis at the medical morning meeting, recorded in the minutes, and also be part of a quarterly medical report. The medical morning meeting was used as a forum to discuss data from the Medical Department. Reports were submitted for the first three quarters of 2012 concerning hospitalizations and ER admissions. The Facility provided no information concerning the date(s) on which the group reviewed these, and whether there was any discussion or action plans based on this information. However, the interdisciplinary forum was an opportunity to share the information among disciplines and develop action plans based on an interdisciplinary approach. It is recommended that the discussions be recorded in the minutes of the medical morning meetings, with action steps identified, along with delegation of responsibility. It is recommended that a copy of the minutes from the discussion, and descriptions of the processes identified and action steps taken also be attached to the quarterly report. An additional area needing further analysis was the percentage of medical morning meetings attended per month by each department. Although this was mentioned in the Facility's Self-Assessment, there was no information provided to indicate that it had occurred. Tracking attendance by department would provide important evidence of integrated clinical care through the discussions at the medical morning meeting. The Facility submitted ISPAs for hospitalizations that occurred during the six months prior to the Monitoring Team's visit. Hospitalizations involved 30 individuals. These were reviewed to determine the reason for hospitalization, evidence of a record review for events prior to the hospitalization, evidence of identification of new triggers as early signs and symptoms of illness, evidence of recommendations to increase monitoring of specific parameters, and additional steps implemented to reduce the risk of recurrence of illness and hospitalization. Of the 30 individuals, one individual was hospitalized for concerns that did not apply to these measures and was excluded (i.e., planned surgery, etc.), leaving 29 individuals. There were 65 ISPAs reviewed, of which three did not apply directly to hospitalizations. In summary, there were 62 ISPAs involving acute care concerns for 29 individuals. Several individuals had more than one hospitalization, and measurements did not	

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		separate out the various admissions per individual, but all documentation related to the hospitalizations was used to monitor the quality of the team approach to resolving health care issues to address the cause of the hospitalization or repeat hospitalization. Based on the clinical needs of the individual, not all individuals needed additional action steps/processes as part of the IDT review. However, the IDTs did demonstrate one or more processes in a number of cases. The findings included the following: ▪ Reference to an open record review was documented in none of 29 (0%) individuals. ▪ The IDT identified new triggers or early signs/symptoms for five of 29 individuals (17%). ▪ The IDT identified the need for increased monitoring in one or more aspects of care for nine of 29 individuals (31%). ▪ The IDT identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization in 20 of 29 individuals (69%). As evidence of collaboration and interdisciplinary discussion, the Facility was asked to submit the 10 most recent PNMT recommendations for which physician orders were generated. The Facility was able to provide two individuals with PNMT recommendations for which a follow-up physician order was written based in part on the PNMT assessment and recommendations. There is a need for improved tracking of the PNMT process once assessments are completed and recommendations are made to ensure there is follow through to completion, including physician orders where indicated. The PNMT process should document and monitor the recommendations through to completion, and have this data available in a usable format. According to a document submitted entitled: "Quality Assurance Monitoring," the QA Department had an important role in reviewing results of data that provided evidence for integrated clinical services. As the database was in the initial phase of development and/or implementation, there was no data available during the Monitoring Team's visit. According to the QA monthly monitoring grid, for Section G, members of the Medical Department would audit consults. The clinic nurse was to complete a 10% sample each month concerning consult tracking, the Medical Director was to complete a 5% sample, and the Program Compliance Staff (currently a vacant position) was to complete a 10% sample. Although AUSSLC had made progress in this area, the Facility remained out of compliance with this provision. The challenge in demonstrating integrated clinical care was several-fold. Maintaining the efficiency and increasing the breadth of the provider morning meeting will be important. From the Monitoring Team's review, the IDTs needed continued guidance and accountability, and an expansion of open record reviews	

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		to determine early signs and symptoms helpful in treating illness at an early stage. Documentation of interaction between the PCP and the PNMT needed improved tracking, including the PCPs' follow-up once the PNMT conducted assessments and made recommendations. For the ISPAs that were the written response to a concern assigned to the IDT, there was need to determine if the provider morning meeting participants agreed or not with the ISPA (i.e., did it satisfactorily answer the concern). As discussed in previous reports, each clinical department should provide evidence of their participation in and impact on integrated care. This should include development of measurable indicators for each department that reflect the integration of care across the campus.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Facility submitted consultant reports for one individual from each residence, as well as any IPNs or primary care practitioner (PCP) recommendation forms commenting on the consultant reports. Consultations for 22 individuals were submitted, with a range of none (it was unclear why the Facility selected these individuals for submission) to eight consultations per individual. A total of 53 consultant reports were submitted. Individuals for whom there were consult reports are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 53 reviewed, 39 (74%) included the PCP initials, indicating review by the PCP. ▪ Of the 53 reviewed, 38 (72%) included the date on which the PCP conducted the review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and ISPAs were requested. When submitted, these were reviewed. o Of the 53 reviewed, 39 (74%) consults included documentation of agreement or not with the consultant recommendations. o Of these, 35 included PCP IPN entries (66%). o Of these, no ISPAs were submitted that documented the discussion of the contents of the consultant reports, and the PCP's recommendation. Two IPNs documented results of the ISPA discussions. o The PCPs completed 20 Medical Department forms which indicated their agreement or not with the recommendations. A few observations are noted: ▪ The Medical Department forms provided a tracking system to ensure the PCPs reviewed the consultant reports and provided documentation of agreement or not with the recommendations. However, these forms did not include the consultant name or type of specialty, nor did they include the date of the consultation, which made it confusing when there was more than one consultant assisting with care of the individual or a consultation with frequent visits.	Noncompliance

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		▪ Several of the consult reports did not include the date of the consultation. There was a request date (presumably the date the consultation was ordered), but this was not synonymous with the consultation date, which made tracking difficult. ▪ Several consultation reports were missing, and evidence was provided through the IPNs and Medical Department recommendation forms. This made consultations difficult to track. It also called into question whether a copy of the consult report was available in the record for IDT members to review, or whether it was filed separately or not filed. Four individuals selected had no submitted documents to indicate a consultation in the prior six months. It was not clear the reason these individuals were chosen for the document request. In attempting to track consult recommendations for one individual per residence, there were significant gaps of information. The Medical Department provided a template of a "Medical Consultation Auditing Tool," which was developed in September 2012. However, it had not been implemented. Contents included general information concerning the consult as well as indicators to be measured. The type of consult was to be indicated, which will be helpful to anyone outside AUSSLC who might not know the names of the consultants. This also will provide information as to the specialties used and the frequency of use. Dates will be tracked to determine the timeline of the completion of the entire process (i.e., request date of consult, date seen by consultant, date consult placed in PCP's in-box, and date signed to show the consult was reviewed). The second part of the consult audit involved the PCP response, whether the PCP wrote a summary in the IPN section, whether there was agreement with the recommendation, and whether an action step based on agreement was written. When the PCP disagreed with the recommendation, the PCP was to provide reasoning and an alternate plan. The IDT was to be informed of consult results as needed. A copy of the "Medical Consult Audit Instructions" was also submitted. Based on a review of this audit tool, it should cover the essential aspects of Section G.2. There might need to be an additional line for the date the Facility received the consultation report, if it is different than the date it is placed in the PCP's inbox. It might be important to track the length of time between the Facility receiving the report and the time it gets to the PCP to ensure there are no delays. Additionally, the indicator concerning the IDT being informed of consult results as needed is too vague for an auditor to answer unless there is further guidance. The Medical Department or Facility might need to provide precise categories of those consults that should go to the IDT. As the IDT is responsible for the total health and safety of the individual, it would appear one option would be that all consultation reports go to the IDT. However, more delineation might be necessary regarding the specific need	

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		for the IDT to review a consultation report. In addition, further guidance from the Medical Department and /or Facility likely is needed concerning which consult reports the IDTs should address through the development of an ISPA. One process that might efficiently answer this on a systems level would be to bring the consultation reports to the medical morning meeting, and at that time have the meeting attendees determine whether or not the IDT needs to address one or more aspects of the consult report in an ISPA. The ISPA would then be brought back to the medical morning meeting for review and agreement or not. If such systems are put in place, these steps should be included in the audit tool to provide closure to the consult report. Further, when there is an audit process and more than one auditor completes the monitoring tool, inter-rater reliability should be established through analysis of the agreement between or among reviewers. According to the Action Plan for Section G.2, staff were identified that were responsible for auditing. Auditors were to be trained by 11/30/12. The Facility remained out of compliance with this provision. Concerns continued to exist with regard to the PCPs' consistent review and documentation of the review of consultant reports. In addition to ensuring that IPNs include evidence of follow-up to recommendations, the team process for reviewing and documenting review to show integration with existing supports and services also required improvement.	

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

1. The Medical Department should create a policy or procedure for follow-up on the monthly closure spreadsheet, specifically providing guidance to the assigned personnel responsible for review of these monthly spreadsheets, and the interval of review until closure. Information summarizing the numbers of closed items and number outstanding also should be reported on a monthly basis at the medical morning meeting, recorded in the minutes, and also be part of a quarterly medical report. (Section G.1)
2. With regard to quarterly data, the discussions that occur at the medical morning meetings should be recorded in the minutes, with action steps identified, along with delegation of responsibility. A copy of the minutes from the discussion, and descriptions of the processes identified and action steps taken also should be attached to the quarterly report. (Section G.1)
3. Improved tracking should occur of the PNMT process. Once assessments are completed and recommendations are made, tracking should occur to ensure there is follow through to completion, including the completion of physician orders where indicated. The PNMT process should document and monitor the recommendations through to completion, and have this data available in a usable format to allow analysis. (Section G.1)
4. Further analysis should occur of the percentage of medical morning meetings attended per month by each department. Tracking attendance by department would provide important evidence of integrated clinical care through the discussions at the medical morning meeting. (Section G.1)
5. With regard to the audit tool entitled "Medical Consultation Auditing Tool," consideration should be given to:
    a. Adding a line for the date the Facility received the consultation report, if it is different than the date it is placed in the PCP's inbox. It

might be important to track the length of time between the Facility receiving the report and the time it gets to the PCP to ensure there are no delays.

b. Additionally, the indicator concerning the IDT being informed of consult results as needed is too vague for an auditor to answer unless there is further guidance. The Medical Department or Facility should provide more precise categories of those consults that should go to the IDT. As the IDT is responsible for the total health and safety of the individual, it would appear one option would be that all consultation reports go to the IDT. However, more delineation might be necessary regarding the specific need for the IDT to review a consultation report.

c. In addition, further guidance from the Medical Department and /or Facility should be provided concerning which consult reports the IDTs should address through the development of an ISPA. One process that might efficiently answer this on a systems level would be to bring the consultation reports to the medical morning meeting, and at that time have the meeting attendees determine whether or not the IDT needs to address one or more aspects of the consult report in an ISPA. The ISPA would then be brought back to the medical morning meeting for review and agreement or not. If such systems are put in place, these steps should be included in the audit tool to provide closure to the consult report. (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; o For four individuals from each PCP's caseload, four diagnoses identified from the active problem list of the most recent annual medical assessments, with criteria for justification from the active record, including copies of supporting documentation, for the following individuals: Individual #366, Individual #214, Individual #78, Individual #357, Individual #23, Individual #302, Individual #101, Individual #149, Individual #378, Individual #31, Individual #13, Individual #107, Individual #230, Individual #119, Individual #310, Individual #423, Individual #331, Individual #439, Individual #172, and Individual #73; o AUSSLC Quality Assurance Monitoring for Section H, undated; o For the self-assessment process for Section H, list of monitoring/audit tools used, for each tool the number of the eligible population to be sampled, the number included in the sample (the percentage of the eligible population sampled), the method used to determine how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor/survey/review, and any inter-rater reliability data analyzed for the audit/monitoring review; and o For the self-assessment process for Section H, the databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, documentation of the frequency of the data collection.
	Facility Self-Assessment: For Section H, in conducting its self-assessment: ▪ The Facility did not use monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment had not been implemented. o These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. There are many aspects of Section H to be monitored and which need quality data for verification of the process. However, the Facility was in the early stages of database creation and monitoring tool development. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The draft monitoring tools for clinical areas (i.e., seizures, hypertension, consult processing) included adequate methodologies, such as record reviews, and auditing of consult reports. o The AUSSLC Quality Assurance Monitoring chart and the Self-Assessment process information submitted identified the sample(s) sizes, including the number of

	individuals/records to be reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). The monitoring tool for these clinical areas remained in draft form and had not been implemented. However, the defined sample size(s) were adequate to consider them representative samples. o The monitoring/audit tools for the clinical areas did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. These had not been submitted. o The following staff/positions were responsible for completing the audit tools: clinic nurses, Medical Director, and QA Compliance Nurse. o The staff responsible for conducting the audits/monitoring were clinically/ programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been addressed for the draft monitoring tool provided. ▪ The Facility did not use other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. Except for the data concerning hospitalizations and emergency room visits, the Facility did not have data to present that was meaningful. The data maintained in the other databases was in the initial phase of database entry. Generally, the Facility had not developed databases to the point where data could be presented consistently based on specific, measurable indicators. ▪ The only data/information available was through the Medical Department. The QA Department did not contribute monitoring data. ▪ The Facility rated itself as being in noncompliance with Section H. This was consistent with the Monitoring Team's findings. ▪ The Facility did not have sufficient data to analyze for this section. However, there did not appear to be a system in place to methodically analyze data that was available at intervals, and create an action plan based on departmental or inter-departmental discussion, including a methodology to assess the outcome to determine if it accomplished the intended purpose.
	Summary of Monitor's Assessment: The Medical Department had continued to make strides in implementing systems to ensure minimum common elements of clinical care were provided efficiently, and were of adequate quality. One of the limiting factors was development of data management systems and lack of ability to track information and progress steps, as well as lack of a summary document to allow effective review of the information. For areas for which there was information, challenges still remained. The timeliness of medical annual assessments and QDRRs required improvement. Dental annual assessments were timely. This section also should reflect timely assessment and monitoring of assessment of all clinical disciplines and related departments, such as PT, OT, speech, audiology, dietary, nursing, psychology, and psychiatry. More specific to the Medical Department, the diagnoses on the active problem list needed further review. The criteria/evidence provided was not always sufficient to determine the accuracy of the diagnoses. In the past, for one of the residences, a clinic log had been developed that recorded a number of parameters

	useful to track timeliness of assessment and quality of treatment. If updated and continued, this could be used to provide valuable information concerning the residences' identification of and PCPs' timely response to health status change, as well as provide a source of information to review the quality of care. Clinical indicators separate from the audit measurement tools used in the external medical and medical management audits had been developed, but had not reached implementation phase. The Medical Department had created a number of initiatives to improve systems of quality care and monitoring. However, it remained in the initial planning phase, with some implementation occurring. However, these efforts were challenged by the lack of data management system finalization, as well as lack of implementation of created audit tools. The Facility remained noncompliant with Section H.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Based on documentation provided, on 2/13/12, a clinical data tracking system for all clinical assessments was discussed with the data analyst. The database was developed in collaboration with the State Office. This database was to be completed and operational by 10/31/12. Initially, it would have the capacity to track annual medical assessments, annual physical exams, and medical quarterly reviews. Once implemented, and background information populated into the database, this had the potential to provide efficient and complete monitoring for the forms required in the clinical care of the individuals. However, at the time of the Monitoring Team's onsite review, it was not yet fully operational. Based on documents submitted for several clinical departments, several routine and periodic assessments were reviewed for timeliness. These included: ▪ A total of 179 of 313 (57%) medical annual assessments were completed in a timely manner. ▪ A total of 138 of 142 (97%) dental annual evaluations were completed in a timely manner. ▪ A total of 475 of 735 (65%) QDRRs were completed in a timely manner. The Medical Department created a template/guide for a care plan summary reflecting health status change for those returning from a hospitalization. This included a comprehensive list of areas of clinical and non-clinical care. The form indicated it was to be included in the medical morning report as well as the IPN. Several examples were provided of extensive IPN entries. It was not clear how this information was to be incorporated into the medical morning report. However, when completed, the IPN provided a systematic approach to include all areas that were needed in response to the health status change of the individual. The examples indicated the PCPs were to implement this process. The earliest example was from 7/30/12. It was not clear if all	Noncompliance

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		the PCPs had been in-serviced on this format for documentation of clinical care when a health status change occurred, because not all PCPs were represented in the sample provided. According to the Facility Self-Assessment, the Medical Department did not have a database developed to the point of providing reports for such basic areas of routine care as annual medical assessments, physical examinations, and quarterly medical reviews. As is illustrated above, some assessments were regularly being completed in a timely manner, while others were not. As is illustrated in other sections of this report, the timeliness and quality of assessments continued to be a concern for a number of clinical disciplines. The Facility remained out of compliance with this provision.	
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.	On 10/2/12, five PCPs completed an in-service entitled "ICD-9-CM Official Guidelines for Coding and Reporting," effective 10/1/11. A second attendance sheet was dated 10/31/12, and the reason for the second roster with a different date was not determined. A copy of the guideline was submitted, including a 107-page reference covering such topics as: conventions for the ICD-9-CM, general coding guideline, documentation of complications of care, selection of principal diagnosis, reporting additional diagnoses, and diagnostic coding and reporting guidelines for outpatient services. A sample of diagnoses listed in individuals' active problem lists was submitted. The sample was derived from four active records from each PCP's caseload, for individuals for whom annual medical assessments were most recently completed. The PCPs were asked to provide the criteria or evidence used to determine whether the diagnoses clinically fit the information in the corresponding assessments or evaluations. Evidence was provided through various sources (e.g., consultant reports, test reports, etc.). A total of 20 individuals' records were submitted for which the active problem list was provided. The Medical Department chose one of the diagnoses from this active problem list for further identification of criteria in 17 of 20 (85%). For three, no diagnosis was provided. It was unclear to the Monitoring Team why requested information was not submitted for these three individuals. Based on the review of the remaining 17: ▪ For 12 of 17 (71%) diagnoses submitted with supportive documentation, the criteria listed were consistent with the diagnosis listed. Submitted data did not provide verification of accuracy of diagnosis for five of 17 diagnoses. The psychiatric diagnoses utilized at AUSSLC were consistent with the nomenclature in the DSM-IV-TR. As discussed in further detail with regard to Section J.13, the review of the records of a sample of 21 individuals indicated that a description of the specific symptoms that would adequately support the psychiatric diagnosis of record could be	Noncompliance

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		identified for 18 individuals (86%). Due to the missing data to support diagnoses, the Facility remained out of compliance with this provision.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The Medical Department submitted a document entitled "Log of individuals seen in the Sunrise Clinic." The dates of the log were from 12/20/11 through 4/23/12. The document included the name of the individual, the symptoms, whether seen in the clinic and the time seen, the diagnosis, and the recommended follow-up. This form was outdated, but provided information that would demonstrate some of the necessary elements for this section. Currently, clinics were in place in some residential units and were to be implemented in additional units. The expectation was that a nurse would be available to assist the PCP. The clinic log would be a valuable document in determining the clinic's response to the individuals' needs. Additionally, the date and time of the first symptoms, as well as date and time the clinic was first informed about the concern would be important to determine timely response to clinical concerns. There were several gaps noted in the log generated for 12/20/11 to 4/23/12, and the Medical Department will need to consider a monitoring process to ensure completion of the document. A column adding intervention/treatment would allow comparison to various standards of care, such as the clinical guidelines or national professional association recommendations. As discussed with regard to Section G.2, the Medical Department provided a template of a "Medical Consultation Auditing Tool," which was developed in September 2012. However, it had not been implemented. This consult tracking system also should provide evidence of timely and appropriate clinical care through measuring the timing of the PCP response and whether orders reflecting the specialty consult recommendations were written. Implementation of these orders would also need to be monitored (i.e., were labs drawn as ordered in a timely manner, length of time before scheduling diagnostic tests, etc.). In addition, the Facility should use a clinical guideline or other set of recommendations focused on a diagnosis, determine the clinical departments required to ensure adequate care, and then review the active record to determine the degree of compliance with the recommendations. For instance, for osteoporosis, minimum common elements of clinical care would include the diagnostic work-up and treatment provided, along with periodic retesting to ensure adequacy of treatment (e.g., DEXA scans, vitamin D levels, etc.), a Dietary Department calculation of the amount of calcium and vitamin D supplement needed, Physical Therapy to develop and implement an exercise program as appropriate, Habilitation Services to provide guidance on protective apparatus and training of staff in appropriate transfer using a Hoyer lift, etc., and the interface of treatment with quality of life, such as time spent in sunshine without getting sunburned, etc.	Noncompliance

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		In summary, in addition to the other initiatives in which the Facility was engaged, the Facility should use the current clinical guidelines to create a set of clinical indicators to measure the timeliness and adequacy of clinical care. As discussed with regard to Section H.4, the Facility had begun work on this, which was positive. The State Office also should create clinical guidelines for other diagnoses common to the ID/DD population. Such guidelines would be helpful in the provision of care and treatment. They also would further identify clinical indicators to measure quality treatment.	
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.	A number of clinical indicators had been developed, but implementation of the audits had only started on 9/10/12, and results were not anticipated to be available for three months. Three topics were chosen, including hypertension, seizures, and consults. Results and analysis were expected to be available beginning December 2012. Quality indicators had been developed for hypertension, seizures, ER visits/hospital visits, osteoporosis, constipation, and diabetes. Each of the diagnoses included up to five measurable parameters. The parameters were based on recommendations from the Agency for Healthcare Research and Quality (AHRQ) and/or the Consortium for Performance Improvement (American Medical Association). These audits will require written instructions, and if more than one auditor completes these forms, inter-rater reliability should be established. As the Medical Department initiates this aspect of quality of clinical care, it is recommended that one diagnostic audit of quality indicators be utilized per month, with three different diagnoses for the first three months. This would allow reassessment to determine if changes/improvements and/or further training are needed. This is important to ensure the results are capturing the quality of care intended, prior to proceeding to the next quarter.	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.	The Medical Department began to complete medical quarterly reviews. However, the quality appeared to be variable, and different PCPs appeared to use different templates. Some areas of the template were not addressed in many reviews. This area needed further monitoring. Annual exams appeared to be thorough. Areas of concern are addressed with regard to SectionL.1. In addition, the at-risk process had not yet developed to the phase of being able to identify and/or monitor the clinical indicators necessary to show whether or not individuals' action plans were successful or to effectively monitor the health status of individuals. The completion of the Integrated Risk Rating Form (IRRF) at the time of the ISP and subsequent changes to IRRF based on ISPAs, as well as requests for review by the medical morning meeting would provide opportunities to capture information that demonstrated the health status of individuals was being monitored. Acute health status changes were identified in the medical morning meeting. The follow-	Noncompliance

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		up to closure, as well as the ISPAs requested and open record reviews also would provide further response to changes in health status to meet the needs of the individual. On a long-term basis for stable conditions, the timely quality reviews as part of monthly, quarterly, or annual reviews/assessments by the various clinical departments would provide evidence for monitoring of the ongoing health of individuals. However, these periodic documents needed to be working documents with accurate and complete data using quality indicators that have measurable components to guide the IDTs in determining whether health is stable or there is need for further intervention, testing, etc. Assessments and integrated health care plans did not yet include these components. This is discussed in further detail with regard to Section I, as well as Sections M and O. As this section was multi-disciplinary, every clinical department should have provided evidence of its participation in ensuring common elements of clinical care were provided to each individual when indicated. One of the areas needing further focus was tracking minimum common elements of clinical care required on an ongoing basis for preventive care and wellness, as well as routine care of diagnoses common to the IDD population. The Facility remained out of compliance with this provision.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The spreadsheet submitted entitled: "AUSSLC Quality Assurance Monitoring" indicated that the QA Department had an important role in reviewing results of data collected as evidence for minimum common elements of clinical care. The database development had not progressed to the point where data could be provided for this clinical area. However, a plan had been developed for implementation of the audit process for the medical management audits focusing on hypertension and seizures. Monthly, the clinic nurse was to review a 10% sample of individuals with hypertension, the Medical Director was to review a 5% sample, and the program compliance staff (vacant at the time of the Monitoring Team's visit) was to review a 10% sample. The same delegation of responsibility was to occur for review of seizure management. At the time of the review, no information was submitted that tracked changes in treatments and interventions based on signs and symptoms used as clinical indicators. The Facility remained out of compliance with this provision.	Noncompliance
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	As part of integrated clinical services and to ensure adherence to minimum common elements of clinical care, the Medical Department approved a policy entitled: "Medical Care, Policy Number III.A.15," effective October 2012. Additionally, the Medical Department reviewed the "HealthCare Guidelines, May 2009". A competency based training roster was submitted dated 10/17/12, signed by the five PCPs.	Noncompliance

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	services policies, procedures, and guidelines to implement the provisions of Section H.	However, the Medical Department will need to include the many systems currently being implemented in policy and procedures, such as the process for the medical morning meeting, the tracking of concerns needing closure, and the need for timely referral to the IDT, timely response through the creation of an ISPA, as well as the medical morning meeting group's review of such documents. A flow diagram might assist in determining which aspects of integrated clinical care and minimum common elements of clinical care are currently being monitored, and which areas need further review for measurable indicators.	

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

1. The QA Department should work with each clinical department to ensure measures are developed regarding the timely and adequate completion of required monthly, quarterly, or annual assessments and forms. (Section H.1)
2. For a given diagnosis, evidence should be available that the needed disciplines provided assessments, that the team discussed these evaluations, and that all essential elements for treatment of that diagnosis have been included in an integrated action plan. (Sections H.1 and H.3)
3. The State Office should continue to create clinical guidelines for other diagnoses common to the IDD population. (Section H.3)
4. The Facility should continue to develop a set of clinical indicators/outcome measures to assist in determining if treatments and interventions are implemented and effective. (Sections H.3 and H.4)
5. As the Medical Department initiates the implementation of audit tools to assess the quality of clinical care, it is recommended that one diagnostic audit of quality indicators be utilized per month, with three different diagnoses for the first three months. This would allow reassessment to determine if changes/improvements and/or further training are needed. This is important to ensure the results are capturing the quality of care intended, prior to proceeding to the next quarter. (Section H.4)
6. Monitoring should occur of the quality of the medical quarterly review, and actions taken, as appropriate. (Section H.5)
7. The Medical Department should include the many systems currently being implemented in policy and procedures, such as the process for the medical morning meeting, the tracking of concerns needing closure, and the need for timely referral to the IDT, timely response through the creation of an ISPA, as well as the medical morning meeting group's review of such documents. A flow diagram might assist in determining which aspects of integrated clinical care and minimum common elements of clinical care are currently being monitored, and which areas need further review for measurable indicators. (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 revised "Risk Guidelines" laminated record; o Section I Monitoring Tools and At Risk Guidelines; o AUSSLC Presentation Book for Section I; o AUSSLC's Self-Assessment and Action Plans; o AUSSLC At-Risk Individuals list; o For the following individuals' active records, selected documents, including: DG-1; most current annual medical assessment and physical exam; preventive care flow sheet; most current nursing assessment; past one year of IPNs; past one year of lab results, x-rays, scans, MRIs, and ultrasound reports; hospital discharge summaries for past one year; ER reports for past one year; consults and procedure reports for past one year; DNR forms, if applicable; physician orders for past one year; most recent ISP and subsequent addendums; most recent BSP; past three medical quarterly reviews; integrated risk rating form(s) for past one year; and risk action plan(s) for past one year, for the following: Individual #92, Individual #366, Individual #426, Individual #180, Individual #381, Individual #398, Individual #234, Individual #302, Individual #22, Individual #378, Individual #31, Individual #239, Individual #90, Individual #402, and Individual #62; and o The following documents: Integrated Risk Rating Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following: Individual #251, Individual #128, Individual #296, Individual #375, Individual #253, Individual #16, Individual #72, Individual #353, Individual #122, Individual #34, Individual #147, Individual #456, Individual #337, Individual #79, Individual #338, Individual #369, Individual #429, Individual #179, Individual #403, and Individual #405. ▪ **Interviews with**: o Andy Maher, Assistant Director of Programs (ADOP); o Michelle Head-Blalack, RN, Chief Nurse Executive; o Amy Van Vleet, RN, Program Compliance Nurse; o Valerie Kipfer, RN, MSN, State Office Nursing Services Coordinator; o Kim Ingram, MEd, CCC/SLP, Habilitation Therapies Director; and o Karen Hardwick, State Coordinator for Specialized Services. ▪ **Observations of**: o ISP meetings for Individual #302, on 11/5/12, and Individual #62, on 11/6/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment:

	▪ The Facility used monitoring/auditing tools. At the time of the review, the Facility was in the initial stages of reviewing and modifying its monitoring tool for Section I, recognizing that the current monitoring tool did not include all the provisions of the Settlement Agreement for the different subsections of Section I. From discussions with the Assistant Director of Programs, he candidly reported that basically no progress had been made addressing this area due to significant problematic issues related to the loss of gas and water at the Facility as well as a number of staffing issues and a number of changes in key leadership positions. In addition, at the time of the review, the Facility staff had not received the training regarding the revised At-Risk/ISP process. This training was to be scheduled and conducted sometime after the Monitoring Team's onsite review week. Consequently, no monitoring data was available for review, nor was any presented in the Facility's Self-Assessment. However, based on a review of the Facility's Self-Assessment: o As the Facility recognized, the current monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. As the Facility revises its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. In addition, the Facility should include adequate instructions addressing methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. Without adequate instructions, it is likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews resulting in inaccurate data. In addition, further definition is needed with regard to the criteria auditors should use to rate the various indicators. Thus, there is a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools are an accurate reflection of the area being audited. o Regarding identifying the sample and sample sizes, a description of the process for determining how the total population from which the samples were pulled (e.g., everyone with a completed risk rating tool, individuals identified with high-risk ratings, etc.) will be necessary to determine the relevance of the data. After clearly identifying the total population (N) used to define the sample selected, (n), an adequate sample size would be needed to consider the data representative of the actual practices being monitored. o Regarding the monitoring for Section I, in order for the Facility to generate accurate data reflecting the clinical quality of the documentation, auditors for this area should be deemed competent in the use of the tools and deemed programmatically/clinically competent in the relevant area(s). As noted during several past reviews and in the Monitoring Team's previous reports, the quality and adequacy of the assessments conducted by a number of disciplines regarding the at-risk individuals were consistently found to be significantly inadequate. In order to ensure the accuracy of the data, the Facility should evaluate who would best audit this highly clinical area. o Adequate inter-rater reliability should be established for the final Section I monitoring tool. ▪ Due to the lack of an adequate written procedure addressing the process of developing and implementing monitoring tools, lack of established inter-rater reliability, and overall data presentation, at the time of the review, the Facility did not yet have a consistent system for

	presenting data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present any findings based on specific, measurable indicators. For example, the Facility needs to be clear regarding what specific criteria had been used to determine compliance. In addition, items contained on the monitoring tool should not include more than one item, such as "objectives within the action plans were measurable and designated a person responsible for data review," making it impossible to determine which of these requirements were found to be in compliance and which had not. o Did not measure the quality of the documentation versus merely the completion of the documentation. ▪ The Facility rated itself as being in substantial compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings. However, the Monitoring Team's findings were based on the quality aspect of the documentation reviewed. In reviewing the Monitoring Team's report, the Facility should determine how quality will be assessed, and also identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data. ▪ Although the Facility was clearly able to articulate a number of valid barriers affecting many of the areas in need of improvement, the Facility Self-Assessment did not provide an analysis of this crucial information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that would be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition (APEN) was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. At the time of the review, the Facility had not yet received the necessary training regarding the revised At-Risk and ISP process. However, the Monitoring Team found a significant number of problematic issues in the existing At-Risk system, which if not addressed, could be transferred to the revised system. The Facility indicated that the massive technical issues related to restoring the gas and water at the Facility along with numerous staffing challenges, necessary responses related to regulatory reviews, and changes in key leadership positions had essentially prevented progress from being made in several areas, including Section I. Thus, at the time of the onsite review, most of the activities and monitoring outlined in the Self-Assessment to determine compliance scores had not been implemented. While the Monitoring Team agreed that changes to the At-Risk system needed to occur in order for the Facility to achieve substantial compliance, the overall lack of clear documentation included in the ISPs, Integrated Risk Rating Forms, the Risk Action Plans, and the

	associated disciplines' assessments regarding what actions were taken in response to pertinent events or changes in health status, and the lack of specific supporting documentation addressing actions and completion of action plans made it difficult for the Monitoring Team to determine a clear sequence of events in response to risk issues. The lack of progress in the existing At-Risk system was troubling at this juncture of the compliance process.

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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.	Interviews with the Facility staff, and review of AUSSLC's Self-Assessment indicated that since the last review, the following steps had been implemented regarding the At Risk process: ▪ Since the Monitoring Team's last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review) and the Department Heads only had begun to receive the initial training regarding the revised At Risk/ISP process. Additional training campus-wide was to be scheduled after the review week. However, some of the changes in the At Risk process included regrouping the Risk Guidelines so the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines that included seven groupings of risk categories. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including: data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers (trigger sheet indicated/not indicated), and criteria for IDT review. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that would be completed annually; different forms for the IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms to alert the staff to possible changes in status. Trigger data sheets were to be completed and implemented according to the high-risk category. When there was a change of status (according to the definition provided in the instructions), a change of status integrated risk rating form was to be completed. Each of the risk categories for that individual was to include a log of the monthly review by discipline. There was a separate form, entitled "Direct Support Professionals Instructions" to be completed for an identified high-risk category. It was to be completed by the home manager/charge and signed off by each direct support professional caring for the individual.	Noncompliance

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		▪ Although the Facility's Self-Assessment indicated that a review of the ISP calendar and roster of individuals the Facility supported found that 100% of the individuals received a risk rating assessment within the last calendar year, the findings of the Monitoring Team indicated that the quality of the risk rating assessments reviewed were inadequate as noted in detail in the following sections. ▪ The Facility indicated no data was available regarding activities including the review of individuals identified with high and medium risk across categories to ensure action plans had been developed to address risk; the review of data from 2010 to current to compare the number of individuals with high risk by risk category per 100 individuals served to assess if the Facility high risk ratings had declined; and the review of general trending data in clinical indicators (cause of death, hospitalization diagnoses, etc.) to assess general Facility effectiveness of risk management. However, given the accuracy of the risk ratings had been and continued to be questionable and had been based on inconsistent criteria throughout the compliance review process, it was unclear to the Monitoring Team what the value would be of reviewing data from 2010 to current to compare the number of individuals with high risk to assess if the Facility high-risk ratings had declined. <u>Self-Rating</u>: The Facility's Self-Assessment indicated: "based on the results of the self–assessment, this provision is not in substantial compliance." Although the Monitoring Team's findings supported the Facility's self-rating that it was not in substantial compliance with the Settlement Agreement requirements for Section I, the Monitoring Team's findings were based on a comprehensive review of the clinical quality and adequacy of the current documentation for individuals whose teams identified them as being at risk. In spite of the fact that the Facility had not received the necessary training regarding the revised At Risk and ISP process, as noted below, the Monitoring Team found a significant number of problematic issues in the existing At-Risk system, which if not addressed, could be transferred to the revised system. Overall, the recent statewide revisions made to the At-Risk system appeared to be positive. Candid discussions with the Assistant Director of Programs indicated that the massive technical issues related to restoring the gas and water at the Facility, necessary responses related to regulatory reviews, along with numerous staffing challenges and changes in key leadership positions had prevented progress from being made in several areas, including Section I. While the Monitoring Team agreed that changes to the At-Risk system needed to occur in order for the Facility to achieve substantial compliance, the overall lack of clear documentation included in the ISPs, Integrated Risk Rating Forms,	

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		the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or changes in health status, and the lack of specific supporting documentation addressing actions and completion of action plans made it difficult for the Monitoring Team to determine a clear sequence of events in response to risk issues. The lack of progress in the existing At-Risk system was troubling at this juncture of the compliance process. Although the Monitoring Team acknowledges that the significant structural issues and staff changes were necessary and of high priority, it is the hope of the Monitoring Team that considerable focus will be given to addressing the needs of individuals the Facility has determined to be at high risk regarding health and/or mental health issues. Since at the time of the review, the Facility had not received the training addressing the revised At-Risk/ISP process, the two ISPs observed by the Monitoring Team (i.e., Individual #302 and Individual #62) were not assessed for compliance with the following indictors. However, the indicators listed below will be used in future reviews in determining compliance with this provision of the Settlement Agreement: ▪ In _____ of _____ (__%) ISPs, all appropriate disciplines were present. ▪ The staff present at the ISP meetings appeared to be the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for _____ meetings (__%). ▪ _____ of _____ individuals (__%) were present for their ISP meetings, and/or left the meetings at times based on their choice. ▪ _____ of _____ IDTs (__%) consistently used the Risk Level Guidelines when determining risk levels at the ISP meetings. ▪ _____ of _____ IDTs (__%) consistently used supporting clinical data when determining risks levels for the ISPs observed. ▪ There were adequate clinical discussions among the team members in order to appropriately and accurately make decisions regarding risk levels for ____of ____ (___%) of the ISP meetings observed. ▪ Team disagreements regarding risk levels were adequately resolved 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 in ___ out of ____ (___%) for which this was necessary. ▪ Based on ____ of ____ ISPs observed (__%), the ISP facilitators made good attempts to keep the teams focused during the risk assessment and planning process. From limited observations, the Monitoring Team noted initial areas in which more work was needed to obtain full team participation and facilitate meaningful discussion included, but was not limited to: ▪ The Monitoring Team recognized that the ISPs observed represented the Facility's attempt to use the new process on which staff had not been fully	

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		trained, and thus were extremely lengthy. As the process continues, strategies to facilitate the process should be considered such as having draft IHCPs made available to the team before the meetings, and during the meetings, and providing more of a summary of data included on the IRRFs to make the meetings more time efficient and manageable. ▪ There was extremely limited mention of nursing protocols during the ISPs, but they were not individualized or used when developing the IHCPs for risk indicators. Consequently, most of the nursing interventions discussed at the ISPs were not adequate in addressing the health risk indicators and did not address the needed clinical assessments to ensure the health indicators were actually being monitored. ▪ Regarding the Integrated Health Care Plans, meeting time could have been used more efficiently if team members had been provided a more thorough and adequate draft ahead of time, and had come prepared to discuss necessary changes. Of course, based on discussion during the meeting, more changes might be needed. ▪ The IRRFs need to consistently include individual-specific information in order for the team to determine accurate risk ratings. Although this was an area in which improvements were noted for the ISP meetings held during the week of the review, it should continue to be a focus moving forward, and particularly should include clear analysis of the information from year to year, quarter to quarter, etc. ▪ In developing action plans, teams should consistently identify measurable objectives, and/or objectives to assist the team to determine if individuals are doing better or worse, or remaining the same. Although the teams identified some measurable objectives, as noted above, they did not adequately reflect the nursing protocols, and they often were related to the absence of bad outcomes (e.g., "no hospitalizations," "no episodes of injuries," or "zero instances of constipation requiring intervention") as opposed to reducing precursors to such bad outcomes, or increasing positive indicators that the individual was doing well. At other times, the objectives were not measurable (e.g., "will be free of complication related to overweight condition in the next 12 months"). The overall revisions to the At-Risk/ISP process were very promising steps forward regarding the structure and format of the ISP meetings and the associated documentation addressing the At-Risk system. However, at the time of the review, the Facility had not received the training regarding the revisions. Consequently, the Monitoring Team was not able to review any of the revised processes. However, from the documentation reviewed by the Monitoring Team, considerable efforts are needed to ensure that the appropriate risks levels are assigned based on individual-specific clinical data, that the risk plans/IHCPs reflect the needed clinical intensity in alignment with the	

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		appropriate designated risk levels, that objectives are functional and/or measurable, that adequate preventative measures are discussed and are included in the risk plans/IHCPs, and the entire process is clearly documented. In addition, the Facility should implement a system to address the reassessment of risk factors for individuals experiencing significant changes in status, including acute changes in status for at-risk individuals. Such a system should not only be activated in response to hospital admissions. AUSSLC should continue to provide training and mentoring for the IDTs regarding the At-Risk process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Based on a review of records for 20 individuals determined to be at risk (i.e., Individual #251, Individual #128, and Individual #296 for dental issues; Individual #375, Individual #253, and Individual #16 for urinary tract infections; Individual #72, Individual #353, and Individual #122 for weight issues; Individual #34, Individual #147, and Individual #456 for skin issues; Individual #337 for constipation; Individual #79, and Individual #338 for circulation issues; and Individual #369, Individual #429, Individual #179, Individual #403, and Individual #405 for falls.), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals. Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms did not consistently include specific clinical data to support the risk ratings for the health indicators, such as including the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls and fracture risks. Thus, the Monitoring Team was unable to determine if further assessment was needed; ▪ Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the Monitoring Team was unable to determine what additional assessments were needed and/or conducted in response to the change of status; and ▪ When recommendations for assessments were found on the Risk Action Plans, the date of completion frequently was left blank. Thus, it was not possible to determine what precipitated the recommended assessment, and if it was timely completed. <u>Nursing Assessments</u> Based on a review of 20 individuals' records for which assessments were to be completed to address the individuals' at-risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #251, Individual #128, and Individual #296 for dental issues; Individual #375, Individual #253, and Individual #16 for urinary tract infections; Individual #72, Individual #353, and	Noncompliance

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		Individual #122 for weight issues; Individual #34, Individual #147, and Individual #456 for skin issues; Individual #337 for constipation; Individual #79, and Individual #338 for circulation issues; and Individual #369, Individual #429, Individual #179, Individual #403, and Individual #405 for falls. The Comprehensive Nursing Assessments the Monitoring Team reviewed essentially did not reflect any clinical information regarding the health risk indicators, and merely listed the entries from the IPNs or the generic interventions from the Health Management Plans. As noted from the previous reviews, nursing continued to have no specific procedure in place regarding the nursing assessment process and the analysis of the identified risk indicators. Consistent with past reviews, the nursing assessments for the at-risk individuals were not adequate to address their health risks. Regarding the Integrated Risk Rating forms, although some contained overall more specific clinical information, for most of the areas that nursing was responsible for assessing and/or providing information, such as constipation, cardiac, osteoporosis, and dates of injuries/fractures, there was a consistent lack of individual-specific information. In addition, when reviewing some the Integrated Risk Rating forms for individuals who had experienced a change in status or hospitalization, there were no revisions found on the IRRFs addressing these additional health issues. At the time of the review, the Facility had not yet received all the required training regarding the revisions to the At-Risk Individuals Policy and had just begun to use the new ISP format during the review week. However, the significant existing deficits in the current At-Risk system, especially the nursing components of the system regarding the Comprehensive Nursing Assessments, the individual-specific information contained in the IRRFs from nursing, and the quality of the all the interventions contained in the Risk Action Plans and HMPs still needed to be addressed. As previously recommended, the Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area. <u>Medical Assessments</u> The 15 active records were reviewed to determine compliance with this section, including those for: Individual #92, Individual #366, Individual #426, Individual #180, Individual #381, Individual #398, Individual #234, Individual #302, Individual #22, Individual #378, Individual #31, Individual #239, Individual #90, Individual #402, and Individual #62. All 15 individuals were considered at high risk in one or more health domains. Based on a review of 15 records for individuals determined to be at risk, there was	

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		documentation that the IDT started the assessment process by developing an ISPA which addressed the health status change, with consideration of preventive steps if applicable, as soon as possible, but within five working days of the individual being identified as at risk for none of the individuals (0%). The Facility did not appear to have a process to track the timeliness of the IDT response to changes in health status. For the ISPAs reviewed during and after hospitalizations in relation to Section G, the Monitoring Team had difficulty determining the timeframe between the admission date to the hospital and the date of the ISPA. There often was no date identified. It is recommended that when an ISPA is created to respond to an acute care concern or health status change, the date of the onset of the concern be documented as a reference point in the ISPA. Further, the focus on the initial ISPA, often at the start or during the hospitalization, was to provide adaptive equipment to the individual. There was no mention of preventing a repeat hospitalization, and no review of triggers, open record review assignment, etc. This might have been due to the IDTs preferring to wait until a diagnosis was established. However, the specific diagnosis might not be necessary for an open record review and discussion of potential early signs and symptoms of severe disease. A subsequent ISPA at times addressed prevention, but valuable time had passed in reviewing preventive steps. Based on a review of 15 individual records for whom assessments had been completed to address the individuals' at risk conditions, one of 15 (7%) included an adequate medical assessment to assist the team in developing an appropriate plan. Lapses occurred in routine documentation, such as preventive care flow sheets, but also in further evaluation of recurrent health problems, such as GERD. The following provides an example of an assessment that was not comprehensive: ▪ Individual #31 had a history of esophagitis in 1995. The individual was currently on a proton pump inhibitor, and had anti-reflux procedures, such as head of bed elevation, and a positioning plan requiring the individual be kept upright for one hour after feedings. The individual also had a gastrostomy tube (G-tube) placement. The individual had Duoneb treatments ordered for wheezing. This individual had a history of periodic wheezing, which might have been a sign/symptom of severe reflux and aspiration. There was no further evaluation to identify the severity of GERD in order to determine the need to modify treatment to prevent chronic reflux with aspiration, to ensure optimal positioning, and/or to rule out a Barrett's esophagus. Such information could potentially assist in determining the need for additional medical or surgical options, or physical management. It was not clear at what point further GERD evaluation was to occur. At the time of the Monitoring Team's review, monitoring processes were currently being	

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		developed and implemented. It was anticipate these would assist in ensuring quality medical assessments and treatment, including preventive care. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within 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 20 records for individuals determined to be at risk (i.e., Individual #251, Individual #128, and Individual #296 for dental issues; Individual #375, Individual #253, and Individual #16 for urinary tract infections; Individual #72, Individual #353, and Individual #122 for weight issues; Individual #34, Individual #147, and Individual #456 for skin issues; Individual #337 for constipation; Individual #79, and Individual #338 for circulation issues; and Individual #369, Individual #429, Individual #179, Individual #403, and Individual #405 for falls), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage fluids or increase activity, which would have led to a preventative intervention, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 17 of the cases (85%). Individuals who had not had their Risk Action Plans integrated into their ISPs included: Individual #122, Individual #179, and Individual #369. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored.	Noncompliance

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		▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. The significant problematic issues resulting in noncompliance with the above compliance indicators included: ▪ The Facility indicated there were no Risk Action Plans for some individuals who had high and/or medium health risk indicators; ▪ The lack of revisions made on Integrated Risk Rating Forms when changes in status had occurred made it impossible to determine if there had been appropriate and timely associated assessments or changes made to the Risk Action Plans, and rendered many of the risk ratings inaccurate; ▪ The Risk Action Plans reviewed were found to be generic, and non-specific in addressing the health risks of the individual; ▪ Specific and measurable preventative interventions were not included in the Risk Action Plans; ▪ Interventions listed on the Risk Action Plans did not include specific clinical indicators to be monitored or the specific frequency was not included; ▪ Often the interventions listed on the Risk Action Plans were not in alignment with the designated risk rating of high or medium risks; and ▪ There was no supporting documentation indicating that interventions contained in the Risk Action Plans were actually implemented. In addition, general observations from the Monitoring Team regarding Section I that should assist in guiding the IDTs and in interpretation of the documents by all reviewers include the following: ▪ There needed to be a system to document timeliness of steps outlined in the Settlement Agreement (i.e., beginning the assessment process within five days, proof of implementation within 14 days, etc.). ▪ For several individuals, there should have been revisions of the IRRF and risk action plans in the past year in response to changes in status. It is important to differentiate new information (with date that paragraph or statement was updated) from prior information. ▪ Teams needed to clearly define the assessments being requested to create a final risk action plan. For most IRRF documents, it was difficult to determine if additional assessments were being requested, and when the request was made. This is especially important to identify the five-day time period in which the assessment process should begin. ▪ It would be helpful to have a chart at the end of the document listing the	

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		assessments with columns to indicate when it was requested, when it was completed, when it was received by the IDT, and the date of the ISPA at which it was discussed and acted upon. ▪ The IRRF and risk action plan did not include monthly/quarterly updates. There should be consistency across the campus about whether to include these in the reports or not. ▪ The ISPs did not appear to reflect the process for health status change, or the questions raised at the morning provider meeting that resulted in an IDT meeting followed by an ISPA. Documentation of the health status change and the effectiveness of any steps taken as a result of implementation of the ISPA would be expected to be part of a future ISP for that particular risk. For each hospitalization/ER visit, the goal would be to have a discussion about preventing a recurrence, with action steps that can be measured. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this provision. This was consistent with the findings of the Monitoring Team. Although the Facility was in the initial stages of receiving training regarding the revised At-Risk process, it was concerning to the Monitoring Team to note the consistent inadequate documentation regarding the At-Risk individuals risk ratings and Risk Action Plans. These problematic issues made determining the chronological clinical sequence of events, and the Facility's response to these events confusing and complicated. Clear documentation, especially while the Facility is in the process of revising the At-Risk system is essential. Regardless of the system changes, AUSSLC should focus its efforts on appropriately rating health risks using individual-specific clinical information and developing specific and clinically appropriate care plans for each individual. These action plans/care plans should meet the individuals' needs, contain functional and measurable objectives, include clinical indicators to be monitored and the specific frequency of that monitoring, include preventative interventions, and be fully integrated into the ISPs.	

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

1. PCPs should be encouraged to attend the risk rating meetings. They should be sufficiently prepared to discuss the work-ups or completed aspects of the work-up, interpret lab and test results for the IDT, provide details regarding the history as well as current health status of the individual, and recommend next steps. They should play an instrumental role in assisting the team to finalize measurable objectives and determine clinical indicators for each of the high and medium risks for the individual. (Sections I.1, and I.2)
2. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the IDTs. 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)

3. Additional training and/or technical assistance on the at-risk process should be provided to the IDTs. 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)
4. 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)
5. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. Additionally, for those members of the team unable to attend an IDT risk rating and/or action plan meeting, background information should be prepared and discussed with the QDDP ahead of the scheduled meeting, and the QDDP or designee should ensure all areas needing clarification are discussed and clarified, because the QDDP or designee will be the team member presenting that information. (Section I.1)
6. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
7. When there is a change in health status, the IDT should reconvene to rate the related categories of risk, and incorporate any changes in health into the risk categories and into a risk action plan. Particularly, when an individual is hospitalized and subsequently discharged home, the IDT should meet promptly to address any changes in health and functional status. (Sections I.1, I.2, and I.3)
8. 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)
9. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
10. Given that IDTs, at times, do not realize when more assessment is indicated, department heads should review IDTs' findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
11. 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)
12. The Facility should monitor the ISPs to ensure the risk ratings and action plans are integrated into individuals' ISPs. (Sections I.1, I.2, and I.3)
13. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Facility Self-Assessment 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)
14. Regarding the Facility's monitoring system addressing Section I, the Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. (Facility Self-Assessment)
15. Consideration should be given to standardizing the presentation of data across the Facility for consistency in interpretation, using, for example, tables to report monitoring findings rather than a narrative format that would be better for the presentation of the analysis of the data. (Facility Self-Assessment)

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 The following sections of the records for 21 individuals: the annual medical history; Physical Exam; Active Problem List; the Psychiatry section; the BSP/behavior services section; 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 21 individuals (16%) who were receiving psychotropic medication, included the following: ▪ The following 11 individuals were selected because of the acuity of their psychiatric illness, or secondary to observations made during the onsite review: Individual #376, Individual #84, Individual #179, Individual #333, Individual #158, Individual #56, Individual #2, Individual #175, Individual #246, Individual #344, and Individual #3; and ▪ Of the records that were produced in response to the pre-review document request, the Facility considered the following ten individuals to be stable: Individual #254, Individual #194, Individual #417, Individual #183, Individual #332, Individual #146, Individual #154, Individual #353, Individual #16, and Individual #135; o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS, with scores and completion dates for all individuals followed in Psychiatric Clinics; o The MOSES and DISCUS evaluations for the prior year for the individuals prescribed Reglan who were not also prescribed a psychotropic medication; o Copies of the training materials utilized to train the nurses on the administration of the DISCUS and the Attendance Sheet for the in-service; o Presentation Book for Section J; o Minutes of the monthly Polypharmacy Committee Meetings for the prior six months, as well as the 11/6/12 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;

	○ List of meetings and rounds Psychiatrists attend; ○ List of individuals receiving anticholinergic medication, with names of medication(s) prescribed, start/stop dates, and duration of use; ○ Facility-wide data regarding polypharmacy, including intra-class polypharmacy; ○ Minutes of the Pre-Treatment Sedation Committee for the last six months; ○ List of individuals prescribed psychotropic medication, including medication and psychiatric diagnosis; ○ List of individuals prescribed intra-class polypharmacy; ○ Separate lists of individuals receiving each of the following medications: a) anti-epileptic drugs being used for psychotropic purposes; b) lithium; c) tricyclic antidepressants; d) Trazodone; e) beta blockers being used for psychotropic purposes; f) Clozaril/Clozapine; g) Mellaril; and h) Serentil; ○ List of individuals with tardive dyskinesia; ○ List of individuals receiving benzodiazepines, with names of medication(s) prescribed, start/stop dates, and duration(s) of use; ○ Chemical restraint data for the following episodes of chemical restraint: Individual #74 (9/20/12), Individual #74 (9/21/12), Individual #74 (9/24/12), Individual #19 (10/1/12), and Individual #1 (7/19/12); and ○ Minutes and ancillary material distributed at the 11/6/12 Polypharmacy Committee Meeting. ▪ **Interviews with**: ○ Jose Levy, Director of Behavioral Services, and George Race, M.D., Section Chief for Psychiatry, on 11/5/12; ○ Judi Stonedale, D.O., Psychiatrist III, on 11/7/12, in the context of the Psychiatric Clinic; ○ Scott Murry, M.D., Psychiatrist III, on 11/6/12, in the context of the Psychiatric Clinic; ○ Kenda Pittman, Director of Pharmacy Services, Guy Campbell, Pharm.D., and Brea Barover, Pharm.D., on 11/5/12; ○ Rhonda Stokley, DDS, Director of Dental Services, and Sue Neel, Dental Hygienist, on 11/5/12; ○ Nicole Hinojosa, Human Rights Officer, on 11/6/12; ○ George Race, M.D., Section Chief for Psychiatry, on 11/5/12 and 11/7/12; and ○ The following individuals were present during an extended meeting to review the Facility self-assessment process, which took place on 11/7/12: George Race, M.D., Section Chief for Psychiatry; Scott Murry, M.D., Psychiatrist; Judi Stonedale, D.O., Psychiatrist III; Philippa Alexander, Associate Psychologist I; Kimberly A. Testa, Psy.D., Associate Psychologist V/Compliance; Marti Granger, Psychiatric RN/RN II; Clair Thomason, Associate Psychologist I; and Matt Yordy, Associate Psychologist I. ▪ **Observations of**: ○ Polypharmacy Committee Meeting, on 11/6/12; ○ Psychiatry Clinic with Judi Stonedale, M.D., on 11/6/12; ○ Psychiatry Clinic with Scott Murry, M.D., on 11/7/12; ○ Psychiatry Clinic with George Race, M.D., on 11/7/12;

	o Morning Medical Meeting, on 11/7/12, o Human Rights Committee Meeting, on 11/8/12; and o The following individuals were observed during the visits to the individuals' residences and vocational sites: Individual #84, Individual #352, Individual #137, Individual #91, Individual #393, Individual #220, Individual #243, Individual #367, Individual #403, Individual #272, Individual #59, Individual #444, Individual #135, Individual #406, Individual #267, Individual #291, Individual #288, Individual #412, Individual #148, Individual #272, Individual #184, Individual #355, Individual #7, Individual #273, Individual #133, Individual #140, Individual #234, Individual #371, Individual #219, Individual #208, Individual #414, Individual #204, Individual #458, Individual #88, Individual #244, Individual #142, Individual #263, Individual #333, Individual #160, Individual #33, Individual #6, Individual #179, Individual #445, Individual #57, Individual #56, Individual #183, Individual #359, Individual #105, and Individual #67.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, dated 10/22/12. In its Self-Assessment for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The documents assembled in the Presentation Book indicated the Facility had put a great deal of effort into improving the aspects of psychiatric care enumerated in the Settlement Agreement. On 11/7/12, during the onsite review, these materials, including the Facility Self-Assessment, were reviewed with the Section Chief for Psychiatry, the two Staff Psychiatrists, the Associate Psychologist V/Compliance, the Psychiatry Nurse, and the three Psychiatric Assistants. During that meeting, the methodology and results of the internal Psychiatry Department reviews were discussed in considerable detail. The Psychiatry Department's internal record review process was changed in the August/September 2012 timeframe, due to the availability of the new Section J auditing tool, which DADS State Office had introduced. Specifically, they had utilized different sample sizes, and recently had adopted a procedure utilizing a sample of records equal to 10% of the number of individuals with a Quarterly Psychiatric Review in the prior quarter. This number could change each month, because the quarter was defined as the three-months prior to the index month (i.e., the September sample would be based on the number of reviews in the June-July-August timeframe). At the time of the Monitoring Team's review, 135 individuals were receiving psychotropic medication, so approximately 40 individuals were reviewed at Quarterly Psychiatric reviews each month. The Associate Psychologist V/Compliance randomly selected four records from the list of individuals who had a Quarterly Review in the prior three months. The Associate Psychologist V/Compliance reviewed two of these, and the Psychiatry Department reviewed the other two. The Department still was determining exactly how these reviews would be distributed between the Psychiatry Assistants and the Psychiatrists. An Assessment of inter-rater reliability will be a part of this process moving forward, but was not fully operational at the time of this Monitoring Review. The following narrative discusses specific elements of the Facility Self-Assessment process: ▪ The Facility used monitoring/auditing tools: o The monitoring/audit tool the Facility used to conduct its self-assessment consisted of: the "Section J – Psychiatric Care and Services Monitoring Tool," which the DADS State Office

	finalized on 8/8/12. o This monitoring/audit tool included a number of indicators to facilitate the Facility's assessment of their progress toward compliance with the Settlement Agreement. Specifically, the instrument included a total of 39 indicators, which collectively addressed all 15 provisions of Section J. However, these indicators primarily assessed only the presence or absence of specific items and did not adequately address the important factor of quality. o The monitoring process was based on an adequate methodology, which consisted of the review of approximately 48 records per year (the specific methodology is described above) by two independent reviewers, with an assessment of inter-rater reliability. o The Self-Assessment sample(s) sizes were composed of 10% of the individuals who underwent Quarterly Reviews in the prior quarter, and were adequate to consider them representative samples. o The audit tool contained limited instructions and guidelines to prompt consistency in monitoring and the validity of the results. However, the tool was not constructed in such a manner as to stand alone in this regard. As noted below, the Psychiatry Department had developed an informal training process. o The following professionals were responsible for completing the audit tools: The Associate Psychologist V/Compliance would review half of the records and the other half would be distributed within the Psychiatry Department by a mechanism still to be determined. o The team was actively addressing the issue of competence, but there was not a formal process to assess competency. This topic was specifically discussed with the Psychiatry Compliance Team during the 11/7/12 interview, during which the team indicated that the Section Chief for Psychiatry provided training for the other members of the team in assessing for quality as well as the presence/absence of items. o With regard to inter-rater reliability, in general, the method the Facility plans to use appeared to consist of comparing the results of the two different ratings to ascertain to what degree they were in agreement. ▪ AUSSLC used other relevant data sources to augment its monitoring activities. The additional sources of data primarily consisted of the databases and spreadsheets used to track the Facility's progress in the completion of documentation needed to fulfill various sections of the Settlement Agreement. Examples of this were the Reiss Screen spreadsheet (as discussed with regard to Section J.7), the MOSES/DISCUS completion-tracking spreadsheet (as discussed in relation to Section J12), and the Comprehensive Psychiatric Evaluation (CPE) completion database. ▪ In some ways, the Facility consistently presented data in a useful way. However, problems were noted. The following summarizes and positives and negatives: o On a positive note, the Facility Self-Assessment consistently presented the Facility's findings in a simple, straightforward "yes/no" dichotomous manner, with the exception of the spreadsheets alluded to above, where the results were reported as completion rates, which were then translated into percentages. o Of concern, the reviews primarily focused on the presence or absence of items, and not the quality of the documentation. For example, the reviews checked for the presence of the

	psychiatric diagnosis, the consistency of the diagnosis that was listed in different sections of the individual record, as well as if there were symptoms listed to support the diagnosis. However, during the onsite interview, the team indicated that they did not check with reference material to ensure that the diagnosis met all of the necessary criteria for that diagnosis. o The Facility did not distinguish data collected by the QA Department versus the Psychiatry Department. The work of the QA Department for Section J was completely integrated in the self-assessment process of the Psychiatry Department. As indicated in the narrative description of the process above, the Associate Psychologist V/Compliance worked closely with the Psychiatry Department. In reviewing the individual sections of the Self-Assessment, it was noted that the Facility had relied on the results of their internal audits for a number of provisions. The specific sections in which the results of the internal audits were discussed were as follows: Sections J.3, J.6, J.8, J.9, J.10, J.12, J.13, J.14, and J.15. For the other provisions, the Facility primarily relied on their related spreadsheet/database. ▪ The Facility rated itself as being in substantial compliance with the following subsections of Section J: Sections J.1, J.5, J.7, J.11, and J.15. These findings were consistent with those of the Monitoring Team, with the exception of Section J.7, for which the Monitoring Team found noncompliance. The primary reason for this discrepancy was the Facility's exclusive focus on the completion of the Reiss evaluation for all individuals who did not receive psychotropic medication, whereas the Monitoring Team also assessed the evidence that these had been performed for all individuals with a change in status, as well as CPEs being conducted for individuals with an elevated Reiss score. ▪ The Facility Self-Assessment identified areas where more improvement was needed. This observation was true for all of the provisions for which the Facility Self-Assessment indicated a current status of noncompliance. For most of these areas, the Facility indicated that some action was being taken to address the issues (e.g., completion of CPEs, changes in responsibility/process). However, it would be helpful for the Facility's Self-Assessment to reference the particular action plans the Facility had in place to address outstanding issues. In summary, the Psychiatry Department was actively engaged in the process of self-assessment. As noted above, in the August/September 2012 timeframe, the Department's self-assessment process had changed with the utilization of the DADS Central Office monitoring tool. The evolving self-assessment process should be fully functional by the Monitoring Team's next review.
	Summary of Monitor's Assessment: The Facility had continued to make progress in a number of areas related to psychiatric care. At the time of the Monitoring Team's November 2011 review, the detailed, Quarterly Review format was still in the process of being implemented consistently for all individuals prescribed psychotropic medication. As of the current review, these comprehensive documents were being consistently implemented. The Quarterly Review documentation and the CPEs collectively addressed 10 of the 15 provisions of the Settlement Agreement. The Department's spreadsheet indicated that, currently, 63 CPEs had been

	completed, which would equate to 47% of the 135 individuals receiving psychiatric medications. However, only 39 of these had been completed or updated within the past year (29%). The Psychiatry Team expressed confidence that they would have CPEs completed and updated for all of the individuals prescribed psychotropic medication by the first quarter of 2013. The Psychiatrists had begun to attend the ISPs of the individuals prescribed psychotropic medication. However, the documentation in the ISPs did not reflect the necessary information described in the Settlement Agreement. In addition to the completion of the CPEs, the Psychiatry Department also will need to ensure that the Psychiatrist's contribution to the ISP meetings is clearly documented in the ISP. This is particularly relevant to the risk-benefit discussions related to the use of psychotropic medication, and the successful integration between the Departments of Psychiatry and Psychology. The Settlement Agreement is clear that if the individual's psychotropic medications can be justified, their continued use is acceptable. The Department had compiled the necessary evidence to support the utility of the prescription of multiple psychotropic medications for a significant number of the individuals whose regimens met the criteria for polypharmacy. The Psychiatry Department, working in conjunction with the Psychology Department had made considerable progress toward rectifying the previously identified problem of the dual description of the behaviors as both being present on a behavioral basis and being listed as a target behavior of the psychotropic medication. In summary, AUSSLC had made progress in a number of areas, and appeared to have viable plans to address the areas that required further improvement.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	As recently as five 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 four years ago, and the Facility subsequently added two additional full-time Psychiatrists: Dr. Judi Stonedale and Dr. Nilima Mehta. Dr. Tushar Desai also had continued to provide three hours per week of psychiatric consultation. Dr. Mehta left the Facility last year. However, in May of 2012, Dr. George Race joined the Facility as the Section Chief for Psychiatry. The Psychiatrists who practiced at AUSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. 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. This was apparent in the conduct of the Psychiatric Clinics, the Polypharmacy Committee Meeting, and in the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		individual discussions with the Psychiatrists. The past experience of Drs. Stonedale, Murry, and Desai was described in prior reports. Dr. Race indicated he had experience with this population through the approximately five-year period when he worked in the MH/MR Clinic System. During that time period, a portion of his clinical time was devoted to treating individuals with both ID/DD and mental illness. Dr. Race also had spent several years as a reviewer for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This experience also should prove to be valuable in his administration of the AUSSLC Psychiatry Department. The finding of substantial compliance for this provision was made, because all of the Psychiatrists who provided services to the individuals at AUSSLC were Board Certified by the American Board of Psychiatry and Neurology, and had extensive experience in providing care to individuals with ID/DD. This was consistent with the finding from the last compliance review in November 2011.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	At AUSSLC, a total of 135 individuals were prescribed psychotropic medication. A sample of individuals was selected for the current review, as described in the section above listing the documents reviewed. This included 21 individuals, or 16%, of the 135 individuals prescribed psychotropic medication. As noted above, at the time of the review, the Psychiatrists who diagnosed and treated the individuals at AUSSLC were all Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. 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. As noted in the Monitoring Team's prior reports, 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 prescribed psychotropic medication. The review of the current sample of 21 individuals receiving psychotropic medication determined that completed CPEs that complied with the specifications of the Settlement Agreement could be found in the records of the following five individuals (24%): Individual #353, Individual #179, Individual #33, Individual #183, and Individual #332. However, the CPE had been completed within the last year for only two of these individuals: Individual #179 and Individual #353. The status of the Facility's current overall completion rate for the CPEs is discussed in more detail with regard to Section J.6.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The diagnostic section of the CPE contained important information regarding the rationale and documentation for the individuals' psychiatric diagnoses. However, the Quarterly Review documentation at AUSSLC also contained very detailed information related to the symptoms that supported the individuals' psychiatric diagnoses. For many individuals, this included a complete listing of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR)* criteria for the diagnosis, and identified the specific criteria that applied to the individual. The individual records that did not contain the actual listing of the diagnostic criteria did contain a listing of all of the symptoms of the diagnosis that the individual manifested. This documentation appeared in the diagnostic section of the Quarterly Review, and was sufficient to support the diagnosis for 20 of the 21 individuals, but as discussed below, some additional diagnostic issues were identified for two more individuals. The one exception related to identification of the symptoms to support the diagnosis was found in the record of Individual #333. The listed diagnoses for this individual were Autism and Bipolar Disorder. These diagnoses are not mutually exclusive, but there was insufficient evidence to support both Axis I diagnoses. In addition, as noted with regard to Section J.3 and Section J.8, a prior problem with the diagnostic process at AUSSLC had been the dual classification of behaviors as being present on a behavioral basis, and also being classified as a behavioral target of the psychotropic medication. The Facility had largely rectified this problem by joint case formulation between the Psychiatry and the Psychology Departments, which included a separate entry in the Positive Behavior Support Plan (PBSP) and the Structural and Functional Analysis report that discussed the psychiatric diagnosis. The two exceptions in this review were the records of Individual #246 and Individual #56, which did not contain a discussion of the psychiatric diagnosis in the psychological sections of the records. Therefore, the collateral information that would have confirmed the information in the psychiatric Quarterly documentation was not present, nor was there a CPE that would have contained a Bio-Psycho-Social-Spiritual Formulation that might have provided this information. Thus, when these two individuals were also accounted for, the total number of individuals for whom the psychiatric diagnosis could be justified was 18 individuals out of 21 (86%). The Facility did not utilize the "Deferred" terminology to qualify a specific diagnosis as being incomplete. There were only two individuals in the present sample whose diagnoses utilized not otherwise specified (NOS) terminology, which is used for individuals who do not fit the typical pattern for the diagnosis. This is a recognized acceptable practice, and the diagnostic documentation for Individual #146 and Individual #344 met accepted criteria for the use of this terminology. As indicated above, the Facility had shown substantial progress in the documentation of the psychiatric diagnoses, despite the deficiencies in the completion rate of the CPEs.	

#	Provision	Assessment of Status	Compliance
		This progress was due to the strength of the documentation in the Quarterly Review and the collaboration with the Psychology Department. However, the Facility remained out of compliance due to the fact that adequate justification for the diagnoses was not provided for 14% of the sample.	
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 21 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 Monitoring Team's previous reports indicated that for a number of individuals, the behaviors identified as the "target behaviors" of the psychotropic medication also were identified in the Structural and Functional Assessment and related PBSP as being present on a behavioral basis and/or related to environmental factors. This observation suggested that, for these individuals, the prescribed psychotropic medications 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. During the onsite interview with the Director of Behavioral Services and the Section Chief for Psychiatry, the former indicated that the Psychology Department had developed a systematic approach to address this problem. This consisted of including a specific section in both the PBSP and the Structural and Functional Assessment to address the individuals' psychiatric diagnosis, as well as the impact of that disorder on the individuals' behavioral presentation. The Psychiatry Department also had added a section in their Quarterly Review documentation. In this section the derivation of the target behaviors of the psychotropic medication was discussed, and the link between these target behaviors and the symptoms of the psychiatric disorder. This topic also was discussed in the Bio-Psycho-Social-Spiritual Formulation section of the CPEs. As indicated with regard to Section J.6, the CPEs only had been completed within the prior year for 10% of the sample of 21 individuals. However, documentation in the Psychology section of the record and the Quarterly Psychiatric Reviews was sufficiently detailed to ascertain that the prescribed psychotropic medications were not being used overtly for punishment or for the convenience of staff for 19 of the 21 individual records reviewed (90%). The two exceptions were the records of Individual #346 and Individual #56. The records of both	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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of these individuals did not contain the aforementioned discussion of the individuals' psychiatric disorder in the Psychology section of the record. In addition, concerns related to the quality of the PBSPs are discussed with regard to Section K.9 of the Settlement Agreement.

The use of chemical restraint also could be construed as punishment, because it frequently involved the intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of chemical restraint was extremely important in differentiating between the necessary 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 chemical restraint at AUSSLC, the following sample of chemical restraint data was reviewed:

<table>
<tr><th>INDIVIDUAL</th><th>DATE</th><th>TIME</th><th>MEDICATION</th></tr>
<tr><td>Individual #74</td><td>9/20/12</td><td>19:05</td><td>Ativan 2 milligrams (mg) IM</td></tr>
<tr><td>Individual #74</td><td>9/21/12</td><td>19:51</td><td>Ativan 2mg IM</td></tr>
<tr><td>Individual #74</td><td>9/24/12</td><td>19:38</td><td>Ativan 2mg IM</td></tr>
<tr><td>Individual #19</td><td>10/16/12</td><td>17:52</td><td>Zyprexa 10mg by mouth (PO);
Benadryl 50mg IM</td></tr>
<tr><td>Individual #1</td><td>7/19/12</td><td>8:40</td><td>Ativan 2mg IM</td></tr>
</table>

The individual restraint data was reviewed for the presence and quality of the 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:
▪ 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 completed for all of the individuals/uses of chemical restraint. However, the only summary that provided adequate documentation of these events was the 9/20/12 restraint for Individual #74 (20%). The documentation for the other individuals only described the overt behavior that preceded the restraint and did not discuss the antecedent events.
▪ The section that followed the prompt to describe: "Interventions attempted to avoid restraint" also was reviewed. This section was completed for all of the individuals/uses of chemical restraint (100%).
▪ The portion of the documentation in which the physiological post-restraint monitoring was completed for all of the individuals in this sample (100%).
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#	Provision	Assessment of Status	Compliance
		▪ The face-to-face post-restraint debriefing was completed for all five of the individuals/uses of chemical restraint (100%). ▪ 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 and was completed for all five individuals/uses of chemical restraint (100%). ▪ The Chemical Restraint Clinical Review Form was completed for all of the individuals, except Individual #1, for whom this documentation was missing. There was also a prolonged delay in the review of the 9/20/12 restraint for Individual #74 (Pharmacist 10/8/12 and Psychiatrist 10/9/12); the 9/21/12 restraint for Individual #74 (Pharmacist 10/8/12 and Psychiatrist 10/9/12); and the 9/24/12 restraint for Individual #74 (Pharmacist 10/8/12 and Psychiatrist 10/9/12. This material was completed and reviewed in a timely manner for only Individual #91 (20%). 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 (0%). Accordingly, although no instances were found in which the documentation showed chemical restraint was definitively used as punishment, the documentation should be improved to allow Facility staff as well as external reviewers to determine that it was not used as punishment or for the convenience of staff. The Facility had made substantial progress in the differentiation of maladaptive behaviors that were derived from a psychiatric disorder, as opposed to being related to environmental and/or behavioral factors. As noted above, the chemical restraint documentation was insufficient and without this it was not possible to conclude that chemical restraint was not being used inappropriately for punishment or, in some cases, for the convenience of staff. However, it also should be noted that there was no overt evidence that it was being used for these inappropriate reasons. The Facility was found to be in noncompliance with this provision.	
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	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 the Psychiatry, Medicine, Pharmacy, Dental Services, and Psychology Departments. 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:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		

Months 2012	# of Attended Appointments	# and % of No Sedation Required	# and % of Oral Sedation	# and % of IV Sedation
April	57	45 (78.95%)	0 (0%)	12 (21.05%)
May	67	48 (71.7%)	6 (8.9%)	13 (19.4%)
June	78	68 (87.2%)	0 (0%)	10 (12.8%)
July	95	83 (87.3%)	3 (3.2%)	9 (9.5%)
August	75	70 (93.3%)	1 (1.3%)	4 (5.3%)
September	69	50 (72.5%)	0 (0%)	19 (27.5%)
TOTALS	441	364 (82.53%)	10 (2.3%)	67 (15.2%)

The Dental Services staff indicated that it was important to note that this data was reported on a per-appointment basis. 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 oral 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 for dental procedures indicated that the orders were for Lorazepam (Ativan) in a range from 0.5 milligrams to 2.0mg. There was one order for Halcion 0.375mg and one order for Ativan 2.5mg. These were conservative dosages, and during the 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 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 was begun 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, 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

#	Provision	Assessment of Status	Compliance
		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 with regard to Section Q of this report. As noted above, the Facility was devoting a great deal of 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 8/1/12 to 10/31/12 indicated that the majority of pre-treatment sedation at AUSSLC was utilized for medical appointments. The utilization data for oral pre-treatment sedation related to dental procedures is described above. The review of the utilization data for medical problems consisted of inspection of the orders for medical oral pre-treatment sedation, which were obtained from the Pharmacy. This raw data had not been tabulated, and, thus, was somewhat difficult to interpret. For example, medication for pre-treatment sedation might be dispensed by the Pharmacy, but then not administered due to the individual refusing the medication, or the appointment being cancelled. The Director of Pharmacy Services explained that this would appear on the Pharmacy data as a second entry with a minus sign before the dosage amount. A conservative review of this data, which was constructed to only count entries for which there was no ambiguity concerning whether or not the medication had been administered, indicated that from 8/1/12 to 10/31/12, there were 51 administrations of pre-treatment sedation for medical procedures. To a certain extent, the ambiguity in the interpretation of the raw data was not significant, because it was obvious that the utilization of oral pre-treatment sedation for medical procedures was magnitudes greater than the corresponding utilization rate for dental procedures. However, it had received much less attention than had been devoted to dental pre-treatment sedation. The medications utilized for oral pre-treatment sedation for medical procedures indicated that the orders were primarily for Ativan in the range of 0.5mg to 2.5mg, followed by Benadryl in the range of 25mg to 100mg, and Chloral Hydrate in the range of 1,000mg to 1,500mg. On 11/7/12, a member of the Monitoring Team was able to attend the Pre-treatment Sedation Committee Meeting, and also reviewed the minutes of these meetings for the prior six months. This was a productive meeting with active participation of the different professionals who were present. Much of the focus was on the plan for further deployment of the Treatment Plans developed as a result of the Dental Task Analysis. The Team had focused on developing complete functioning plans for the individuals who reside in specific residences, and then utilizing this experience as a basis for expanding the initiative throughout the Facility. There also had been an effort to develop specific	

#	Provision	Assessment of Status	Compliance
		plans for medical procedures, but this initiative was only beginning. The quality of the Desensitization Plans is discussed with regard to Section C.4. The Facility remained in noncompliance with this provision. Although the Facility had made some progress in developing and implementing Pre-Treatment Desensitization Plans for dental procedures, actual plans had been implemented for a small number of individuals. The efforts to develop corresponding plans for medical procedures and appointments were just in the beginning stages. In addition, the data collection related to the use of pre-treatment sedation for medical procedures was not as developed as that for dental appointments. The initiative to develop desensitization or other strategies for individuals requiring pre-treatment sedation for medical procedures would benefit from a similar comprehensive organization of the related data to what the Facility completed in relation to the use of dental pre-treatment sedation. The construction of this data should also take into account the type of medical appointment/procedure and whether the appointment took place at the Facility or at an external site.	
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, 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 135 individuals were receiving psychotropic medication. Thus, if the caseloads were divided equally, each of the full-time Psychiatrists would be responsible for less than 50 individuals (without taking into account the three-hour time commitment of the one part-time Psychiatrist). The Psychiatry Department had prepared an analysis of the time commitment of the Psychiatrists. The time analysis worksheet took into account the time necessary to complete the CPE, Quarterly Review documentation, Treatment Plans, information needed for the informed consent process, and the annual summaries required for the ISP reviews. The review also accounted for the time necessary to attend the Morning Medical Report, the annual ISPs, the Quarterly Review Meetings, as well as the monthly follow-ups, and the urgent psychiatric consultations required at times. The written analysis did not translate these findings into a mathematical equation that concluded there was a sufficient number of Psychiatrists to support the clinical work at AUSSLC. However, this was discussed during the onsite interviews with the Section Chief for Psychiatry. Based on this discussion, it was clear that AUSSLC did employ an adequate number of psychiatrists to provide clinical services to the individuals who resided at AUSSLC. At the time of the last compliance review in November 2011, the Facility was found in substantial compliance. The Facility remained in substantial compliance, because the Facility was found to have a sufficient number of qualified Psychiatrists to provide	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 Monitoring Team's review of the medical records of 21 individuals receiving psychotropic medication identified a completed CPE that met the formatting requirements specified in the Settlement Agreement for five of the 21 individuals (24%). However, only two of these, Individual #179 and Individual #353, had been completed within the last year. As a result, this equated to an overall completion rate of 10%. The dates of completion for the other three individuals were as follows: Individual #33 (8/9/11), Individual #183 (3/29/11), and Individual #332 (6/7/11). The records of the other individuals in the sample did not contain a CPE. At the time of the Monitoring Team's previous reviews, the Facility had revised the format of the CPEs to ensure that it was consistent with the format specified in the Settlement Agreement. The review of the CPEs undertaken at the time of the November 2011 review, as well as the current review, indicated that the CPEs that had been completed were quite thorough and uniformly met the standards of the Settlement Agreement. The spreadsheet the Facility maintained to track the status of the completion rate of the CPEs, dated 11/7/12, identified 63 individuals with CPEs. The earliest completion date listed was 8/13/09, and the most recent was 11/1/12. The spreadsheet contained additional columns entitled "Annual Update" and "ISP Date." The purpose of these two columns was to record the annual updates of the CPEs that were prepared to coincide with the individuals' ISP date. Tabulation of the CPE dates, coupled with the information in the annual update column, indicated that 39 of these 63 CPEs (62%) had been completed or updated within the past year. This timely completion rate of 39 translated to 29% of the 135 individuals receiving psychotropic medication. The finding of noncompliance for this provision was directly related to the Facility not completing CPEs for a significant number of individuals prescribed psychotropic medication, because the quality of the CPEs clearly met both the content and quality requirements of the Settlement Agreement. The members of the Psychiatry Department were confident that they could both complete all the remaining CPEs by the first quarter of 2013, and update the ones that were over a year old so that they would be current. In support of this belief, they further indicated that some initial work had been done for all of the remaining CPEs.	Noncompliance

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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.	A spreadsheet, updated on 9/24/12, listed the individuals to whom the Reiss Screen for Maladaptive Behavior had been administered from 5/13/08 to 9/21/12 (most recent date). The Monitoring Team's initial three reports included the results of an analysis of a distinct 20% 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 on the spreadsheet was 100% accurate, and thus, a similar study was not repeated again this time. The Monitoring Team's previous reports 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 the Monitoring Team's previous review. The review of the current spreadsheet indicated that the Reiss Screen had been administered to 17 individuals in 2012. The Reiss protocol indicated that individuals with elevated scores on the Reiss Screening instrument should be referred for a mental health evaluation. AUSSLC responded to these evaluated scores with a CPE. Accordingly, a request was made for all CPEs completed within the last six months as a result of an elevated Reiss score. The individuals with a CPE as a result of an elevated Reiss Screen (date of CPE) were Individual #91 (6/27/12) and Individual #99 (9/2/11). The latter evaluation occurred over one year ago and, thus, was prior to the timeframe identified in the request. At the time of the Monitoring Team's November 2011 review, the Director of Psychological Services indicated 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 not receiving psychotropic medication, because the Psychiatry Department would have evaluated those individuals receiving psychiatric medication. During the Monitoring Team's current review, it was reported this plan was still in effect. However, no evidence was available to document the progress on this initiative. As noted above, when it was suspected that an individual's status might have changed to necessitate use of psychotropic medication, Facility staff indicated they would use the Reiss screening instrument, as well as conduct a psychological evaluation. For those individuals for whom this was done whose scores on the Reiss screen were above the clinical cut-off score, documentation was presented to show a Psychiatrist completed a CPE in a timely manner. In addition, the Facility had developed a plan to reevaluate all of	Noncompliance

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		those individuals who had not been assessed with the Reiss Screening instrument in several years, but was unable to show documentation of the status of these efforts. The finding of noncompliance was related to the lack of progress with the reevaluation initiative. In addition, although the one individual the Facility reevaluated with the Reiss screen in the prior six months had experienced a change in their psychiatric status, it was not clear if there was a mechanism in place to assess individuals for a 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 interviews with the three Psychiatrists, as well as the interview with the Director of Behavioral Services. These interactions also were visible in the observation of the Psychiatric Clinics of each of the three 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 data was available in both tabular and graphic formats and was discussed during the course of the meeting. There was also a discussion of interpersonal and environmental factors that might be affecting the individual's presentation. Where appropriate, a member of the nursing staff would comment on any recent medical issues that might be having an effect on the individual's presentation. There was also an attempt to review the efficacy of the prescribed medications with a view toward challenging medications for which there was any doubt about their continued necessity. The observations of the Psychiatric Clinics and the related documents illustrated the active collaboration between the two disciplines of Psychology and Psychiatry. A prior deficit in this collaboration, in terms of case formulation, had been the co-identification of the same behaviors as being both a target behavior of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional Assessment and the PBSP. It is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. The Psychiatry Department, working in conjunction with the Psychology Department, had developed a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation, as stipulated in this provision, which it had begun to implement. This subject is also relevant to Section J.9 of the Settlement Agreement, where it is discussed in more detail. The discussion with regard to Section J.9 also describes the considerable progress that the Psychiatry and Psychology Departments had made in rectifying these problems.	Noncompliance

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		The primary disciplines that attended the Psychiatric Clinics were Nursing, Psychiatry, Psychology, direct support professionals, and the QDDP. Disciplines such as Speech Therapy, Occupational Therapy, and Physical Therapy were not able to attend the Psychiatric Clinics, due to the additional constraints on their time allocation. However, these disciplines often did attend the individual ISP meetings. The Psychiatrists also had begun to attend these meetings. The attendance at the annual ISP meetings, as well as the content, was reviewed for the 21 individuals in the sample. This review indicated that a member of the Psychiatry Department had attended a recent individual ISP meeting for 13 of the 21 individuals (62%). The specific records that contained this documentation were those of Individual #417, Individual #84, Individual #56, Individual #254, Individual #333, Individual #154, Individual #158, Individual #344, Individual #246, Individual #175, Individual #33, Individual #194, and Individual #353. The ISP documentation contained in the records of Individual #16 and Individual #135 did not contain a signature sheet. Although the Psychiatry Department had begun an initiative to attend the individuals ISP meetings, the documentation from these meetings adequately reflected the psychiatric aspects of the individuals' treatment in none of the individual records reviewed (0%). Usually, the records contained a brief discussion of the psychological treatment plan and reference to the individuals' psychotropic medications. However, no information was included reflecting the specific psychiatric aspects of their presentation, nor was any mention made of the contributions to the meeting the member of the Psychiatry Department made. Moreover, action plans did not describe the psychiatric treatment plan, or the roles and responsibilities of various staff in the collection and monitoring of data necessary for decision-making related to the treatment plan. Integration of Psychiatric supports with other supports was not evident in the individuals' ISPs. The psychiatric treatment plan should be integrated with other treatments, and reflected in the ISP action plans. The Facility remained out of compliance with this provision. Although a member of the Psychiatry Department had begun to attend the individual ISP meetings, this still had not been accomplished on a regular basis for a significant number of individuals who were prescribed psychotropic medication. In addition, the documentation contained in the ISPs did not fully reflect the integration between psychological and psychiatric services as specified in this provision of the Settlement Agreement.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for	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 often in the documentation found in the sample of 21 records of individuals who were prescribed psychotropic medication. When making	Noncompliance

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	individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	decisions about potential changes in an individual's 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. The Monitoring Team's previous reports identified a deficiency in this process related to the degree to which behaviors identified as being targets of a psychotropic medication also were identified in the Structural and Functional Assessment Report and the PBSP as being present on a learned/behavior 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 potentially being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the corresponding Psychology Behavioral Treatment Plans had been developed through parallel processes that were not fully integrated. The Monitoring Team's review of the sample of the records of 21 individuals prescribed psychotropic medication indicated the Facility had substantially rectified this problem through combined assessment and case formulation. The Psychiatry Department previously had addressed this problem by identifying the symptoms of the psychiatric diagnosis in their revised Quarterly Review documentation, which had been implemented in 2011. This information also discussed the derivation of the behaviors identified as targets of the psychotropic medication in those instances where the monitored behaviors also were not overt symptoms of the psychiatric disorder. However, in prior reviews, this information was not reflected in the Psychology sections of the record. During the interview with the Director of Behavioral Services, he indicated that the Department had added a specific section to both the PBSP and the Structural and Functional Assessment report to address this issue, and they would work in conjunction with the Psychiatry Department in formulating this information. The review of the 21 records in the sample indicated this information was included in the aforementioned sections of the record and was consistent with the information contained in the psychiatric section for 19 of the 21 individuals (90%). The exceptions were the records of Individual #246 and Individual #56 for whom the psychological sections of the record did not contain this information. The differentiation of the maladaptive behaviors with which the individual presented was related directly to the concluding requirements in this provision addressing: "the need to minimize the need for psychotropic medication to the degree possible." The misidentification of behaviors that were in reality related to behavioral/environmental factors as being linked to a psychiatric disorder would increase the risk the individual	

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		would be prescribed unnecessary psychotropic medication. In addition, the individual might not receive the behavioral supports appropriate to address the problem. Alternately, the appropriate identification and differentiation of these factors, as was found during this review, decreased (if not eliminated) the risk that a psychotropic medication would be inappropriately utilized to suppress learned behavior. In a corollary manner, it also assisted in ensuring the least intrusive and most positive interventions were used to address the individual's challenging behaviors. AUSSLC had made significant progress in addressing the aforementioned problems. However, the Facility was found to be in noncompliance with this section of the Settlement Agreement due to the insufficient discussion in the individuals' ISPs of the teams' deliberations with regard to whether the use of psychotropic medications represented the least intrusive approach to address the individuals' target behaviors. As discussed with regard to Section J.8, the ISP documentation also will need to contain more detailed descriptions of the rationale for the use of psychotropic medications and the considerations that went into those decisions. This information should specifically include a discussion of whether psychotropic medication represented the least intrusive and most positive intervention, and should also identify the role of behavioral and/or programmatic interventions also being utilized. As indicated with regard to Section J.8, although the Psychiatrists had begun to attend the ISP meetings, their contributions were not identified in the ISP documentation, and their absence was still noted for many of the meetings. Thus, the Facility should focus on including these aspects of the individuals' psychiatric treatment considerations into the ISP discussions, as well as the documentation of the deliberation on which such decisions were based.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than	This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The Monitoring Team's initial 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 identified as the targets of the psychotropic medication. Previously, the discussion of these factors primarily occurred in the Human Rights Committee section of the record, as well as the PBSP. However, additional detailed discussions of this subject had been added to the psychiatric quarterly documentation. The previous Section Chief of the Psychiatry Department had made extensive revisions to the form utilized to document the Quarterly Review of the individuals' clinical status. This initiative was discussed in the Monitoring Team's prior reports. The revised format contained a section related to an empirical, individualized, risk-versus-benefit analysis.	Noncompliance

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	the medications.	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 being treated with these medications, and the degree to which the prescribed medications had been effective in diminishing the symptoms and maladaptive behaviors 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 prescribed psychotropic medication, is discussed with regard to Section J.13. Working in conjunction with the Psychology Department and the members of the IDT in attendance at the Psychiatric Clinics, the Psychiatrist formulated this information. It discussed both the realized and potential side effects of the medication, and then weighed them against the realized and potential benefits of the medication. These reviews were completed for each individual medication the individual was prescribed. For most individuals, the actual realized benefits could be documented, but for newly-prescribed medications, a rationale was provided regarding what benefits would be expected. The current review found an adequate discussion of the risk-versus-benefit analysis in all 21 individual records in the sample (100%). As noted above, the documentation included a discussion of both the potential and realized side effects of the medication, as well as the benefits. In those situations where the individual was already receiving the medication, the actual benefits were described, and if the medication had not been started and/or the effects had not yet been realized, the expected benefits were discussed, as well as the expected timelines for realizing those benefits. (There is further discussion of this process below with regard to Sections J.13 and J.14.) A member of the Monitoring Team attended the 11/8/12 meeting of the Human Rights Committee (HRC) and also interviewed the HRC Officer. The reviews performed at this meeting, as well as those the Monitoring Team observed during previous onsite reviews, were very detailed. There were instances in which the HRC rejected behavioral plans because of insufficient information. The Monitoring Team's review of the ISP documentation for the sample of 16% of individuals prescribed psychotropic medication did not document a discussion of these important issues (that was commensurate with the detailed information that routinely appeared in other portions of the individuals' records) occurred in the context of the individuals' annual ISP meetings. In addition, the risk-versus-benefit discussions that appeared in the individual records could benefit from an extended discussion of the potential risks-versus-benefits of other alternate forms of treatment that had been considered by the IDT, as referred to in the text of this provision of the Settlement Agreement.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The Facility was found to be in noncompliance with this provision. The Settlement Agreement specifies that the Interdisciplinary Team should weigh the risk-versus-benefit considerations and 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.” At the time of the review, the documentation was not adequate to show that teams were engaging in this discussion and documenting the results.</td><td></td></tr>
<tr><td>J11</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.</td><td>AUSSLC had continued its policy of reviewing every individual whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The Monitoring Team reviewed the “Monthly Psychiatry Polypharmacy Reduction Meeting Notes” 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 each individual whose psychotropic medications met the criteria for polypharmacy. On 11/6/12, a member of the Monitoring Team observed the November meeting of this Committee.

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 11/6/12 meeting provided a summary of the Facility’s progress as of 10/30/12, towards minimizing polypharmacy. The total number of individuals meeting the criteria for polypharmacy was 21. This included those receiving two or more medications from the same class and/or three or more medications regardless of class.

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><th>OCT. 2012</th></tr><tr><td>Number of individuals receiving two or more medications from the same class</td><td>13</td><td>8</td><td>8</td></tr><tr><td>Number of individuals receiving three or</td><td></td><td></td><td></td></tr></table></td><td>Substantial Compliance</td></tr>
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more medications regardless of class or indication	49	31	20
Number of individuals receiving both I & II	12	7	7
Total number of individuals on polypharmacy	50	32	21
Total number of individuals receiving psychotropic medication	184	160	135
Percentage of individuals prescribed psychotropic medication who met the criteria for polypharmacy	27%	20%	16%

This provision of the Settlement Agreement also states 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. During the 11/6/12 Polypharmacy Committee Meeting, the discussions of the remaining 21 individuals whose psychotropic medication regimens continued to meet the criteria for polypharmacy indicated the psychiatric team believed many of these medications were essential for the individuals' stability.

At the time of the November 2011 review, the Monitoring Team's report indicated that the Facility's progress in reducing polypharmacy could be enhanced by dividing the individual data on the remaining individuals prescribed polypharmacy into the following four categories: 1) those individuals admitted from the community on polypharmacy within the last year, with notation of the progress made since their admission in reducing the number of medications they receive; 2) delineation of those individuals 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; 3) the individuals continuing to receive polypharmacy, but for whom there was a plan in place to challenge those medications that might not be necessary; and 4) those individuals (if any) that did not fit into one of the prior three categories. The rationale for this suggestion was that the compilation of the data in the categorical format described above would provide a more accurate representation of the Facility's progress in reducing polypharmacy.

The data presented at the 11/6/12 Polypharmacy Committee Meeting indicated the Facility had implemented these recommendations. As the Facility had not had any new admissions since the last review, the two categories utilized were those of "Active" and "Justified." The "Active" notation was utilized to categorize those individuals whose active tapering processes were in progress, or the individual was not clinically stable,

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		and their medications were still being adjusted. The "Justified" category was utilized for those individuals for whom the Facility had been able to assemble historical data to document the utility of the medication. This evidence was presented in a separate column on the Polypharmacy Committee data sheets entitled: "Evidence of Efficacy." The information contained in this section of the summary tables was detailed and reported the improvement in the individual symptoms/behaviors as a percentage. This information also was included for those individuals in the "Active" category. For many of those individuals, some of their prescribed medications had been justified, and they had been placed in this category only because of a continuing taper of a remaining medication whose efficacy had not yet been proven. Thus, within the "Active" category there was a distinct subcategory of individuals on tapering schedules that would result in a medication being removed in the next few months. If this were not possible due to a behavioral deterioration, the process would have generated the data necessary to justify its efficacy. The summary of this information is contained in the following table: **11/6/12 Polypharmacy Categories** **JUSTIFIED** / **ACTIVE** Individual #2 / Individual #151 (T) Individual #42 / Individual #382 (T) Individual #435 / Individual #93 (T) Individual #249 / Individual #175 (CC) Individual #409 / Individual #179 (T) Individual #333 / Individual #98 (T) Individual #152 / Individual #374 (CC) Individual #56 / Individual #33 (CC) Individual #75 / Individual #283 (T) / Individual #344 (T) / Individual #158 (CC) / Individual #7 (X) T = Active tapering of medication in process CC = Clinical complexity X = Individual was scheduled to have the remaining dosage of Klonopin discontinued during the week of the onsite review, which would remove him from the Polypharmacy List. The Settlement Agreement is clear that polypharmacy regimens that can be justified are acceptable. The Facility currently reported 21 individuals whose regimens met the criteria of polypharmacy, and eight of these were clinically justified. Twelve individuals	

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		were still receiving polypharmacy regimens that had not been justified (9% of the 135 individuals who were prescribed psychotropic medication). If as planned, Individual #7's polypharmacy were reduced the week of the onsite review, this would reduce it further to 11 out of 135 individuals (8%). As noted above, many of these individuals also were actively being tapered from a psychotropic medication. The Facility's polypharmacy statistics did not provide any indication of the number of individuals who had been completely removed from psychotropic medication. The complete discontinuation of an individual's psychotropic medication can actually increase the Facility's polypharmacy rate, because this rate is calculated as a percentage of the total number of individuals receiving psychotropic medication. Thus, when the total number of individuals receiving psychotropic medication is decreased by the removal of an individual receiving one psychotropic medication, the percentage of individuals prescribed polypharmacy will increase slightly due to a reduction in the total number. As the Polypharmacy Minutes did not include data on this subject, a request was made for information related to the number of individuals who had been completely removed from psychotropic medication. The response indicated that, as of October 2012, 36 individuals had "been discharged from Psychiatry Clinic as a result of discontinuation of psychotropic medications." However, the start date for this analysis was not presented. A corollary tabulation indicated that the total number of individuals classified as receiving polypharmacy with psychotropic medication was 62 individuals in January 2009, as compared to 21 in October 2012. As noted above, the Psychiatry Department had made substantial progress over a number of years in reducing the use of polypharmacy with psychotropic medications at AUSSLC. The Facility was found to be in substantial compliance with this provision, because they continued to actively assess individuals' need for continued polypharmacy on a monthly basis, as well as in the Psychiatric Clinics. In addition, the rate of polypharmacy that could not yet be justified with the empirical data had been reduced to nine percent of the total of individuals prescribed psychotropic medication at AUSSLC. As noted above, many of these individuals were on tapering schedules.	
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	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 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 the nurse completed the exam, and subsequently, the prescribing physician reviewed the documentation.	Noncompliance

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	psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The review of the sample of the records of 21 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for all but the following three individuals (followed by most recent MOSES completion date): Individual #417 (no second page for 6/6/12 MOSES and none in record prior to that), Individual #332 (gap between 6/29/11 and 3/30/12), and Individual #194 (only one in file dated 9/28/12). Thus, the MOSES was completed on schedule for 18 of the 21 individuals (86%). The records of the 21 individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for all but three individuals. Those individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #158 (2/1/11 to 3/3/11), Individual #2 (8/4/12 to 10/11/12), and Individual #254 (2/22/12 to 3/24/12). Thus, the MOSES evaluations were reviewed in a timely manner for 18 of the 21 individuals (86%). 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 21 individuals indicated the following seven individuals were not prescribed an antipsychotic medication: Individual #194, Individual #376, Individual #332, Individual #84, Individual #353, Individual #154, and Individual #16. The review of the records of the remaining 14 individuals indicated that the DISCUS had been completed within the prior three months and at three-month intervals prior to that for all but the following six individuals (gap between DISCUS evaluations): Individual #56 (12/12/11 to 7/9/12), Individual #158 (most recent dated 7/6/12; gap between 11/30/11 and 5/22/12), Individual #2 (1/30/12 to 5/8/12), Individual #246 (2/2/12 to 8/20/12), Individual #33 (2/14/12 to 8/4/12, and 10/3/11 to 2/14/12), and Individual #417 (12/30/11 to 7/18/12). Thus, the DISCUS had been completed as specified for eight of the 14 individuals (57%). The DISCUS evaluation had been reviewed in a timely manner by the prescriber for 11 of the 14 individuals (79%). 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 #2 (8/8/12 to 8/24/11/12); Individual #246 (8/20/12 to 9/14/12); and Individual #417 (7/18/12 to 8/6/12). 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	

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		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 MOSES and DISCUS also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties similar to those of antipsychotic agents. A list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to create a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of four individuals (100% of those meeting this criteria) was selected, and included: Individual #454, Individual #200, Individual #169, and Individual #239. The review of the records of these individuals in relation to the MOSES indicated that the examination had been performed as required for the following three individuals (75%): Individual #454, Individual #169, and Individual #239. The record of Individual #200 did not contain any MOSES evaluation prior to 8/12/12. The review of these records for the timely review and signature of the prescriber indicated that this criterion had been met for the following three individuals (75%): Individual #200, Individual #169, and Individual #239. The only exception found in the record was that of Individual #454, for whom the signature sheet from the 3/6/12 examination contained only the month of the prescriber review, which appeared as "3." 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 for only one of the four, Individual #454 (25%). More specifically: ▪ The record of Individual #200 contained only one DISCUS in the record, dated 9/7/12, although it had been reviewed in a timely manner by the prescriber. ▪ The record of Individual #169 also contained only one DISCUS, which was date stamped 6/18/12, but did not contain the date or signature for either the nurse that completed the evaluation or the prescriber. ▪ The record of Individual #239 contained only the DISCUS dated 6/21/12, and none prior to that. This evaluation had been reviewed in a timely manner. The discrepancy was significant between the results of the completion of the MOSES and DISCUS for the individuals receiving psychotropic medications, and those prescribed Reglan and no traditional psychotropic medication.	

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		As indicated in the Monitoring Team's report for the review conducted in November 2011, the responsibility for performing the DISCUS recently had transitioned from the Psychiatric Nurses to the RN Case Managers from individuals' residences. Accordingly, during the current onsite review, a request was made for evidence supporting the training of the nurses responsible for performance of the DISCUS. The materials submitted in response to this included a number of written documents, as well as a copy of the PowerPoint presentation dated 11/6/12. The first slide indicated that the subject matter was "psychopharmacological medication side effects," which an RN, BSN presented. The Facility also produced a list of the 52 nurses that had completed this training on one of the following dates: 1/18/11, 2/22/11, 10/18/11, 10/26/11, 11/16/11, 5/25/12, or 6/21/12. During the Monitoring Team's previous 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 prescribed Reglan, but not also a psychotropic agent clearly needs to be improved, because this medication can cause significant side effects. These may include acute extrapyramidal motor side effects, which might require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. The Facility was found to be in noncompliance with this provision. This related to the deficiencies in the completion of these important side effect monitoring tools for individuals prescribed Reglan, deficiencies with regard to the timely completion of the DISCUS for individuals prescribed psychotropic medication, delays in the prescribing practitioners' reviews, as well as the lack of a method to document that any sudden significant changes in an individual's side effect status was immediately reported to the prescribing practitioner.	
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	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." Based on a review of the records of a sample of 21 individuals (16% of those receiving psychotropic medication), a description of the specific symptoms supporting the psychiatric diagnosis(es) of record could be identified for 20 individuals, but additional problems	Noncompliance

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	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.	were noted with two individuals as described below. As noted with regard to Section J.2, the one exception in relation to the identification of the specific symptoms was found in the record of Individual #333. However, there were also two individuals whose records did not contain adequate differentiation of the behavioral and psychiatric disorders, which decreased this percentage to 86%. (This is discussed with regard to Sections J.2, J.8 and J.9.) This provision also addresses the Facility's ability to measure and monitor "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy." The Quarterly review forms carried forward several months of behavioral data presented in tabular and graph form. The behavioral data that was monitored was specific to the individual and included the overt behavioral manifestations of the psychiatric disorder and, where relevant, the specific symptoms of that disorder. The mechanism by which the overt behavior was derived from the psychiatric disorder was reviewed in the section of the Quarterly Review documentation, entitled: "Target Behavior/Monitored Symptoms." The Facility had standardized this process so that the material was present in 100% of the individual records reviewed. The Behavioral Data was actually collected by direct support professionals and maintained by members of the Psychology Department. It first appeared in the BSP reviews and then was transferred to the Quarterly Review documents. It is important to note that as discussed in further detail with regard to Section K.4, significant concerns existed with regard to the data collected. As a result, important clinical decisions were made based upon data that is very likely inaccurate and unreliable. The discussions regarding which behaviors were derived from the psychiatric disorder occurred in the context of the Psychiatric Clinics, as well as informal discussions between the Psychology and Psychiatry staff. The section of the Quarterly Psychiatric Review labeled: "Current Psychiatric Medications" included a discussion of the timelines when positive effects of newly prescribed medication could reasonably be expected to occur and also would indicate if that time had passed due to the length of administration. It was in this section that the addition of a new medication or the change in the dosage of an existing medication would be documented and then elaborated on in the narrative section of the document. It also should be noted that the addition of a new medication or a change in the dosage of an existing medication would automatically trigger a follow-up review in one month during which the effects of that change would be monitored and discussed. These reviews were performed in addition to the Quarterly Reviews and did not replace a Quarterly Review. Thus, an individual whose medication was actively being titrated would be followed on a monthly basis in between the scheduled Quarterly Reviews. This information also was routinely incorporated into the Quarterly Review document format so that it was uniformly present in 100% of the records reviewed.	

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		AUSSLC Psychiatry and Psychology Progress Notes routinely carried forward more than two years of objective behavioral data. This was extremely valuable and clinically useful historical information. The utility of this information could be greatly enhanced by the inclusion of a longer longitudinal summary of the contemporaneous behavioral data that would support the subjective rationale for any medication changes that had occurred. The length of longitudinal data required would vary according to the individual, but could extend back for several years. The Psychiatry Department had summarized this data for the individuals in their "Justified" polypharmacy group to demonstrate the necessity of the medications prescribed for these individuals. The Facility would benefit from the inclusion of this information in the individual records. The final section of this provision relates to the frequency and adequacy with which the Psychiatrist reviewed individuals receiving psychotropic medication. The review of a sample of the records indicated that Quarterly Reviews were performed as specified in this provision for all of the 21 individuals reviewed (100%). The format for the Quarterly meetings in general followed the format of the corresponding form that documented the meeting and the relevant data. In addition to the behavioral and pharmacological data discussed above, this material included basic information such as the individual's weight and vital signs. The laboratory data included the most significant metabolic and hematological lab values, as well as the results of the most recent EKG. If the individual were receiving medication, such as a mood stabilizer that required periodic monitoring of blood levels, these would also be reported. The results of the most recent MOSES/DISCUS evaluations were reported, as well as any significant medical changes or events, including the individual's seizure status, if applicable, and whether they had seen the Neurologist recently. All of this information was available in the Quarterly Review documentation for the team members to review, and would be discussed according to its relevance to the individual's current status. The Psychology staff reviewed the behavioral data with the team members present. Nursing would review the relevant medical and laboratory data. The Psychiatrist chaired the meeting and would provide his/her insights on the current issues and guide the discussion as to whether any medication or programmatic changes might be beneficial. During the onsite review, a member of the Monitoring Team observed the Psychiatric Quarterly Review Meetings of all three of the full-time Psychiatrists. The Psychiatrist usually saw the individuals on the morning of the Clinic or (depending on the schedule) the afternoon before. The results of the Psychiatrist's observations were documented in the Mental Status section of the Quarterly Review form. The duration of the individual reviews ranged from 20 to 30 minutes, with ample time for team discussion. The Psychiatry Department had made progress with several of the requirements	

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		specified in this section of the Settlement Agreement. The Quarterly Review documentation was comprehensive and had been completed consistently. However, the remaining deficiencies in the psychiatric diagnosis resulted in a finding of noncompliance. These are described at the beginning of this section and also with regard to Sections J.2, J.8, and J.9.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the medical records for the sample of 21 individuals receiving psychotropic medication indicated that 14 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 consents for the use of psychotropic medications had been obtained in a timely manner for 19 of the 21 individuals in the sample (90%). The two exceptions were the records of Individual #158 and Individual #56, for whom this documentation could not be located. 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 analysis 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 person providing consent on the behalf of the individual. These discussions did not contain an adequate description of the probability these beneficial effects of the medication would actually be realized, or had been realized for those individuals already 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, but 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 system 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 medications. At the time of the current onsite review, the Psychiatry Department was on the verge of assuming the responsibility for the consent process from the Psychology Department. Previously, the Psychology Department would coordinate the process of obtaining both	Noncompliance

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		the verbal and written consents for the medication. However, the prescribing Psychiatrist frequently would attempt to obtain verbal consent by calling the guardian after the recommendation to utilize the medication was finalized in the corresponding Psychiatric Clinic meeting. As indicated above, the Psychiatry Department had developed a sophisticated risk-versus-benefit system and the review of 21 individuals records indicated that this analysis was consistently applied to each medication. The documentation for this analysis appeared in the Quarterly Review documentation. The Facility remained out of compliance with this provision, because this documentation was not consistently carried over to the consent process. As noted above, the Psychiatry Department was expected to be assuming the responsibility for the consent process in the near future. This will provide the Psychiatry Department with an opportunity to redesign the Consent/Human Rights process in a manner that more fully reflects the thoroughness of the risk-benefit discussions found in the Quarterly Review documentation.	
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 Psychiatrists began attending the Neurology Clinics so that they could be present to discuss the individual's care with the Neurologist. The Section Chief for Psychiatry 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. The Psychiatry Team indicated that the note, which was contained in the Psychiatry section, also was duplicated in the Integrated Progress Notes. The rationale for the dual filing of the note in these two separate locations was to ensure that those clinicians who needed to be aware of this documentation could readily see and locate it. In addition, if it were difficult to locate in the Integrated Progress Notes, it could be found easily in the Psychiatry section of the individual's record. Neurology Consultation Notes were located in the Consultation section of the record for the following six individuals: Individual #84, Individual #158, Individual #246, Individual #179, Individual #2, and Individual #353. 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	Substantial Compliance

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		Neurology Consultation in the Psychiatry section of the record also was assessed. The information that provided the most complete description of the interaction between the Neurologist and the Psychiatrist appeared in the Integrated Progress Notes the Psychiatrist prepared soon after the neurology consultation. This note also was reproduced as a freestanding document in the Psychiatry Section of the individual record to make it easier to locate. This note usually consisted of a full paragraph, and described the clinical issues discussed with the Neurologist in the context of the consultation and the conclusions of that discussion with regard to any necessary changes to the individual's medication. The documentation the Psychiatrist had attended the Neurology Clinic and verified this with a descriptive note in the individual's record was verified for all six individuals in the sample (100%) who had received a Neurological Consultation in the prior year. This finding that the Psychiatrists had attended the Neurology Consultation and had produced corresponding documentation also had been noted in the Monitoring Team's report for the review conducted in November 2011. The Facility was found to be in substantial compliance with this provision of the Settlement Agreement. This was due to the findings that the Psychiatrists continued to regularly attend the Neurology Clinic appointments for the individuals for whom they were clinically responsible. They also maintained related documentation. This documentation showed that they had engaged in adequate processes to coordinate the use of those medications 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. These documents also need to be updated within the prior 12 months. (Sections J.2 and J.6)
2. The initiative to include a distinct section related to the individual's psychiatric disorder in the Structural and Functional Assessment, as well as the PBSP should be expanded to include all individuals who are prescribed psychiatric medication. (Sections J.2 and J.8)
3. AUSSLC should fully, adequately, and timely complete the documentation they developed to justify and monitor the administration of chemical restraint. (Section J.3)
4. The physiological monitoring related to the use of pre-treatment sedation for dental procedures should be more streamlined, including potentially consolidation of the information within one record that would then follow the individual throughout their dental experience. (Section J.4)
5. The data related to the administration of pre-treatment sedation for medical procedures should be organized in a manner similar to the method used for dental pre-treatment sedation so that the utilization can be more accurately monitored. (Section J.4)
6. The implementation of the Pre-Treatment Desensitization Plans and other strategies for individuals requiring pre-treatment sedation for dental procedures should be expanded with future modifications being based, as appropriate, on the results of the experience the Facility gained from its pilot project. (Section J.4)

7. The Facility should address the development of Pre-Treatment Desensitization Plans and other strategies for individuals requiring pre-treatment sedation for medical procedures, as well as the physiological monitoring following the use of pre-treatment sedation for medical procedures. (Section J.4)
8. The Facility should adhere to the plan the Psychology Department developed to provide psychological reassessment, including the Reiss Screening instrument for individuals who have not been evaluated with the Reiss Screen in several years. In addition, the Facility should develop a mechanism to ensure individuals with changes in status that might result in the need for psychiatric intervention (e.g., stroke, signs of dementia, significant personal loss, etc.) are screened using the Reiss screening instrument. (Section J.7)
9. Additional information concerning the psychiatric medication and the related Treatment Plan should be included in the individual's ISP or ISPA documentation. This documentation should state explicitly whether or not the use of psychotropic medication for the individual: a) represents the least intrusive and most positive intervention; b) whether the individual will be best served primarily through behavioral, pharmacological, or other interventions; and c) identify non-pharmacological treatments and supports that are being used to address the signs and symptoms of the disorder. The deliberations and evidence that led the team to these conclusions also should be stated explicitly, rather than a simple statement/opinion that these criteria have been met. In addition, the ISP action plans should include measurable objectives to ensure the collection of data necessary to evaluate any medication's efficacy. (Sections J.8, J.9, and J.10)
10. The risk-versus-benefit analysis contained in the documentation generated by the Psychiatry Department also should appear in other sections of the individual's record where applicable, including the PBSP, HRC, and ISP documentation. (Sections J.8, J.9, J.10 and J.14)
11. 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. This should also be discussed in the annual ISP. (Section J.10)
12. The Facility should ensure that the MOSES and DISCUS evaluations are completed according to the schedule specified in the Settlement Agreement and reviewed by the prescriber in a timely manner. (Section J.12)
13. The Psychiatry Department should devise a reliable method to document that any significant changes in the MOSES and DISCUS evaluations are immediately reported to the prescribing practitioner. (Section J.12)
14. The Facility should implement the plan to transfer the responsibility for obtaining the consents for psychotropic medication from the Psychology Department to the Psychiatry Department. The Psychiatry Department should take this opportunity to redesign the Consent/Human Rights process to one that more fully reflects the thoroughness of the risk-benefit discussions found in the Quarterly Review documentation. (Section J.14)

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation of Section K at entrance meeting, on 11/5/12; o Presentation Book for Section K; o Tracking of Applied Behavior Analysis (ABA) course completion for Associate Psychologists, updated 10/19/12; o Psychology Department Meeting minutes, from 3/27/12 to 10/30/12; o Behavior Therapy Committee (BTC) meeting minutes, from 3/26/12 to 9/17/12; o Draft Policy for Behavior Lab; o External Peer Review Committee meeting minutes, from 3/10/12 to 10/12/12; o Positive Behavior Support Plan Progress Note and Psychiatry Clinic Monthly Review, for the following: Individual #273, Individual #175, Individual #210, Individual #369, Individual #160, Individual #184, Individual #154, Individual #263, Individual #325, Individual #450, Individual #246, Individual #146, Individual #357, Individual #435, Individual #319, Individual #123, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #140, Individual #318, Individual #141, Individual #220, Individual #4, Individual #291, Individual #33, Individual #75, Individual #389, Individual #83, Individual #202, Individual #7, Individual #360, Individual #341, Individual #444, Individual #376, Individual #56, Individual #98, Individual #280, Individual #382, Individual #327, and Individual #73; o Antecedent-Behavior-Consequence (ABC) Data Sheets (tracking PBSP identified problem behavior), for the following: Individual #273, Individual #175, Individual #210, Individual #369, Individual #160, Individual #184, Individual #154, Individual #263, Individual #450, Individual #146, Individual #357, Individual #435, Individual #123, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #140, Individual #318, Individual #141, Individual #220, Individual #4, Individual #291, Individual #33, Individual #75, Individual #7, Individual #360, Individual #341, Individual #444, Individual #376, Individual #56, Individual #98, Individual #280, Individual #382, and Individual #327; o Partial Interval (one hour) Behavior Data Sheets (tracking PBSP identified problem behavior), for the following: Individual #325, Individual #246, Individual #389, Individual #83, Individual #202, and Individual #73; o Behavior Data Sheets from 11/5/12 through 11/9/12, for: Individual #369, Individual #450, Individual #304, Individual #421, Individual #140, Individual #4, Individual #219, and Individual #73; o Psychological Evaluations for: Individual #273, Individual #175, Individual #369, Individual #160, Individual #184, Individual #154, Individual #263, Individual #450, Individual #213, Individual #246, Individual #146, Individual #357, Individual #435, Individual #319, Individual #123, Individual #335, Individual #101, Individual #283,

	Individual #16, Individual #133, Individual #140, Individual #318, Individual #141, Individual #220, Individual #4, Individual #291, Individual #33, Individual #75, Individual #389, Individual #83, Individual #202, Individual #7, Individual #360, Individual #341, Individual #444, Individual #376, Individual #56, Individual #98, Individual #280, Individual #382, Individual #327, and Individual #73; o Counseling Tracking Sheet, updated 11/8/12; o List of individuals receiving counseling and participating in social skills group; o Counseling Treatment Plans for: Individual #291, Individual #158, and Individual #7; o List of individuals with Positive Behavior Support Plans, updated 9/26/12; o Positive Behavior Support Plans for: Individual #273, Individual #175, Individual #210, Individual #369, Individual #160, Individual #184, Individual #154, Individual #263, Individual #325, Individual #450, Individual #246, Individual #146, Individual #357, Individual #435, Individual #319, Individual #123, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #140, Individual #318, Individual #141, Individual #220, Individual #4, Individual #291, Individual #33, Individual #75, Individual #389, Individual #83, Individual #202, Individual #7, Individual #360, Individual #341, Individual #444, Individual #376, Individual #56, Individual #98, Individual #280, Individual #382, Individual #327, and Individual #73; o Human Rights Committee meeting minutes, from 4/5/12 to 10/25/12; o Identification of Challenging Behavior form developed by the Director of Behavioral Services at Lubbock SSLC, revised 4/18/12; o On-the-Job Training packet, revised 6/8/12; o Psychological and Behavior Services Unit Orientation Training; and o Positive Behavior Support Plan Treatment Integrity Form (adapted from Reid & Parson, 2002), including forms completed between 6/5/12 and 11/9/12. ▪ **Interviews with**: o Group of Direct Support Professionals, on 11/5/12; o Jose Levy, Director of Behavioral Services, on 11/6/12, 11/7/12, and 11/8/12; and o Department of Behavioral Services staff, including Associate Psychologists and Psychological Assistants, on 11/8/12. ▪ **Observations of**: o Residence 729, Residence 732-Dove, Residence 732-Eagle, Residence 732-Phoenix, Residence 779-Falcon, Residence 779- Hummingbird, Residence 779-Roadrunner, Residence 781, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; o Workshop 503, Workshop 527, Workshop 544, and Workshop 779; o Day Habilitation Center 510, Day Habilitation Center 512, Day Habilitation Center 532, and Day Habilitation Center 533; o Computer Lab; o In-service training conducted by L. LeBlanc, Psychology Assistant, on 11/5/12; o Behavior Therapy Committee meeting, on 11/5/12;

	o ISP Preparation meeting for Individual #6, on 11/6/12; o Psychology Department meeting, on 11/6/12; o Restraint Reduction Committee meeting, on 11/7/12; o Pretreatment Sedation Committee meeting, on 11/7/12; o Human Rights Committee (HRC) meeting, on 11/8/12; and o QA/QI Council meeting, on 11/8/12.
	Facility Self-Assessment: The Facility provided the Monitoring Team with a copy of its Self-Assessment, dated 10/22/12. Section K.1 included a review of current Associate Psychology staff and their progress towards professional certification. Although significant progress was noted, this section was rated out of compliance, because the majority of the Associate Psychologists had not yet completed the requirements for certification as behavior analysts. For this same reason, the Facility rated itself as being in noncompliance with Section K.13. The Facility found itself to be in substantial compliance with Section K.2, because the Director of Behavioral Services met the requirements outlined in the Settlement Agreement. The Facility also rated itself as being in substantial compliance with Section K.3, but for reasons noted below, the Monitoring Team did not agree with this rating. For all other subsections of Section K, the Facility had selected a sample of individuals for whom relevant documents were reviewed. ▪ For Sections K.4 through K.7, and Sections K.9 through K.12, the sample consisted of 20 individuals who had a Positive Behavior Support Plan. This sample represented 6% of the total census of the Facility and 13% of the individuals the Facility had identified with PBSPs. ▪ As evidenced by the samples provided to the Monitoring Team, the Facility was using the document "Settlement Agreement Cross Referenced with ICF-MR Standards" to complete their audit. Sections K.1, and K.4 through K.12 were reviewed for each individual in the sample. This resulted in a review of data collection and monitoring of progress, the comprehensive psychological assessment, counseling services, and the behavior support plan, including measures of staff training and understanding, data accuracy, and fidelity of treatment implementation. ▪ The monitoring tool was a good step in ensuring compliance with the Settlement Agreement. For additional indicators, the Facility is encouraged to review the Monitoring Team's reports. ▪ As evidenced in the samples provided to the Monitoring Team, Behavioral Services staff members completed the audit. Inter-rater reliability was not assessed. With a newly hired Associate Psychologist with half-time responsibilities to address compliance with the Settlement Agreement, the Facility should assess inter-rater reliability within the department and with quality assurance staff. ▪ The Facility did not provide guidelines for the use of the Monitoring Questionnaire. As such, it was not always clear how compliance was measured. Clearly identified criteria for measuring compliance with the requirements of the Settlement Agreement would enhance the self-assessment process. ▪ The quality of information provided in assessments, behavior support plans, progress notes, and other documents was not reviewed as part of the Facility's Self-Assessment. ▪ The Facility rated itself as out of compliance with all but two subsections of Section K. This was

	consistent with the findings of the Monitoring Team with the exception of Section K.3 noted above and explained in detail below. ▪ The Facility identified broad areas of deficiency in Section K, but did not identify potential causes. The Self-Assessment did not make connections to any action plans that had been developed to address such issues.
	Summary of Monitor's Assessment: At the time of the visit, the Department of Behavioral Services had a full complement of Associate Psychologists and was soon to have all Psychology Assistant positions filled. Although the Department had lost one Board Certified Behavior Analyst (BCBA) level practitioner, the remaining staff continued to make progress toward certification. Psychology Assistant staff had worked with direct support professionals to develop a new data system that was just being introduced campus-wide. However, this new system was in the initial stages of implementation, and some problems persisted. For example, based on the Monitoring Team's review, important behavioral data still was not being routinely recorded. In addition, the new data collection system needed to be individualized to meet the needs of individuals with high intensity behaviors, for example. The Department also was introducing a system to check for inter-observer agreement. Peer review continued through the Behavior Therapy Committee and monthly conference calls with professional staff from other State Supported Living Centers. However, external peer review did not consistently result in monthly review of AUSSLC plans or assessments, and although internal peer review was occurring regularly and a number of recommendations for improvements were made, frequent delays of more than 30 days occurred in staff responding to the recommendations. On a positive note, weekly consultation with one BCBA level Associate Psychologist had begun in an effort to address ongoing review of individual cases. Although improvements were seen with regard to monthly reports, further work was necessary to improve graphing to allow for easier analysis of information, as well as to ensure that when monthly reviews showed issues with either implementation of plans or the plans themselves, appropriate corrective action was taken. Positive Behavior Support Plans had been streamlined, resulting in quicker access for staff to critical information related to preventative and reactive strategies. Staff training on PBSPs also had been expanded to include more individual-specific training with time allowed to become familiar with the plan and the individual. Although in its initial stages of implementation, an introduction of on-the-job competency-based training was a significant addition to staff training. Psychology staff also had begun conducting monitoring of PSBP implementation. Observations were conducted of staff as they worked with individuals focusing on critical components of the PBSP. Although some improvements were needed, this provided a forum for written positive feedback and constructive criticism followed with recommendations for future performance.

	In general, there were many positive changes observed during this most recent onsite review of the Facility.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the review, the Department of Behavioral Services employed a total of 15 Associate Psychologists, all of whom had a graduate degree. The Director of Behavioral Services and two of these 15 Associate Psychologists (13%) were Board Certified Behavior Analysts. An additional Associate Psychologist had completed all necessary coursework, and recently had taken the exam. One recently hired Associate Psychologist had completed all of the coursework and supervision requirements prior to joining the staff at AUSSLC. Six other Associate Psychologists were enrolled in the required courses, and one was planning on enrolling in the near future. Four of the newly hired Associate Psychologists had agreed to pursue certification. All coursework was being completed through the University of North Texas, with supervision provided by the Director of Behavioral Services or another BCBA level staff member. The Associate Psychology staff were supported by eight Psychological Assistants, seven of whom had bachelor's degrees. When surveyed, several of these assistants indicated an interest in obtaining certification as Assistant Behavior Analysts. While not required by the Settlement Agreement, the training and supervision required for this certification would certainly enhance the skills of staff who provide much of the ongoing training and support to direct support professionals as they implement Behavior Support Plans. The State and Facility should consider support for this level of certification. As noted in the last report, the State is commended for the support offered to existing staff to complete the certification process and for its efforts to continue recruitment of psychologists who already are certified. Additional support was announced at the Department meeting a member of the Monitoring Team attended during the week of the onsite review. The State had agreed to provide staff who had completed the coursework and supervision with additional study materials as they prepared for the exam. The State and the Facility are commended for the continued support offered to staff as they pursue certification. To help maintain staff who are board certified, the State and Facility should consider supporting continuing education efforts through assistance with conference/ workshop fees, online coursework, and home-based learning. The Facility was rated as being out of compliance with this provision of the Settlement Agreement because the majority of the professionals in the Department of Behavioral Services were not yet demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification. Equally important, the quality of the behavioral programming offered at the Facility remained an area of concern. This is	Noncompliance

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		addressed in detail throughout this report.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	Jose Levy remained as the Director of Behavioral Services. He was a Board Certified Behavior Analyst and a Texas State Licensed Psychological Associate. Additionally, he had over five years experience working with individuals with developmental disabilities. Mr. Levy met all requirements for his current position as outlined in the Settlement Agreement. As a result, the Facility was found to be in substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The Monitoring Team requested the Behavior Therapy Committee meeting minutes for the six-month period before the scheduled onsite review. The Facility provided minutes for 22 meetings held between 3/26/12 and 9/17/12. The minutes noted the members present, including behavioral services staff, speech pathologists, and an identified registered nurse. An analysis of the minutes indicated that the Director of Behavioral Services or his assistant was present at 19 of the 22 meetings, at least one Associate Psychologist was present at 20 of the 22 meetings, at least one speech pathologist was present at 21 of the 22 meetings, and the designated nurse was present at 11 of the 22 meetings. The topics for the current meeting were listed. Additionally, a list was kept of previously reviewed documents with identified due dates for resubmission. Individual document review reflected continued use of a template to review Comprehensive Psychological Assessments, Positive Behavior Support Plans, and Safety Plans for Crisis Intervention. After each review, there was an indication of the committee's disposition, findings, and recommendations. Recommendations often included guidelines for the author to "address comments above." The Monitoring Team offers several recommendations for the Facility's consideration. First, it might be possible to provide a reduced summary of positive aspects and needed revisions identified during the document review. The template could certainly guide this discussion, but minutes could be greatly reduced with a brief summary for the author's review. This would provide an outline of needed revisions to be addressed by the author. Currently, recommendations often directed the author to "address comments above." This required the author to review five to six pages of feedback, much of which noted that the provision was addressed. More directed feedback in a brief summary of findings from the BST might prove more effective in obtaining completed revisions in the time frame identified. The Facility is also encouraged to invite direct support professionals to participate in these meetings, whenever possible. These staff often know the individual best and can provide valuable contributions to any plan. Lastly, as internal peer review policies and procedures are formalized, it would be helpful to address staff tardiness in completing necessary revisions. The minutes from the last meeting reviewed (i.e., from 9/17/12) indicated that there were 28 assessments or plans with identified revisions	Noncompliance

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		that were overdue to the BTC by more than 30 days. This tardiness in addressing recommended revisions results in a delay in treatment that is not acceptable. One promising practice recently had been introduced that provided a different type of internal peer review. One of the BCBA Associate Psychologists had scheduled time each week to consult with staff to review individual cases. To refer an individual for this consultation, staff were required to fill out a request including a description of the challenging behaviors, previous interventions, and most recent behavioral assessments. Following a range of activities including record review, observation, and completion of additional assessments, the BCBA Psychologist completed a Consultation Report. It was anticipated this would expand opportunities for staff to review individual cases on a regular basis to ensure timely revisions to PBSPs, as appropriate. Evidence was provided to the Monitoring Team of external peer review activities from 3/12 through 10/12. Written feedback regarding plans for two individuals was provided to AUSSLC staff from the Director of Behavioral Services at Lubbock State Supported Living Center. Since 4/12, through telephone conferencing, AUSSLC staff had been participating in external peer review activities with behavioral services staff from other State Supported Living Centers. Minutes listed the participants involved, including staff from the Abilene SSLC, Austin SSLC, Corpus Christi SSLC, and Lubbock SSLC. Documentation included a brief summary of the individual presented, including reason for referral to external peer review, and feedback provided by committee members. During the seven meetings held between 4/12 and 10/12, it appeared that staff from AUSSLC presented at only four of these meetings. Some of the minutes were difficult to read, because they contained incomplete words. The cover sheets to the minutes did not identify the cases reviewed, and therefore, it would be helpful if the minutes for each individual case were dated. Each Facility should present individual cases at these monthly meetings. Agendas could be distributed prior to the scheduled telephone call in an effort to prepare participants for a focused and efficient discussion. It will also be necessary to develop a Facility-specific policy outlining the internal and external peer review processes in place at AUSSLC. The policies should include: a) identification of internal peer review membership, including direct support professionals and staff from other disciplines; b) mechanisms for on-going review of individual cases; c) identification of external peer review membership; and d) description of the external peer review process, including response to the feedback provided. In its comments on the draft report, the State indicated that much of this already existed in policy. The Monitoring Team again reviewed the policy in place at the time of the review, and found it inadequately defined these components. Due to these issues with the internal and external peer review process, the Facility remained out of compliance with this provision.	

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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.	The Monitoring Team identified 44 individuals residing at AUSSLC in the sample used to assess compliance with Sections K and S. The Facility provided completed data sheets used to track the identified problem behavior for 43 of the individuals who had a Positive Behavior Support Plan (PBSP). (Individual # 213 did not exhibit problem behavior that required a PBSP.) For 37 of these 43 individuals, behavior occurrence was tracked using an ABC (antecedent-behavior-consequence) form. Comments and concerns related to this format have been reported previously. Since the Monitoring Team's last visit, the Facility had worked with direct support professionals to develop a more manageable data sheet for tracking identified problem behavior. A data work group, consisting of the Director of Behavioral Services, one to three Associate Psychologists, and two Psychological Assistants, had been formed and had met each month between 6/12 and 9/12. With the Psychological Assistants soliciting feedback from direct support professionals, a new data sheet had been developed and piloted in two residences. Some changes were made to the data sheet, with additional piloting conducted in eight residences. At the time of the Monitoring Team's visit, this new data sheet was being used across campus. Using a partial interval time sampling method, staff were now expected to record the presence (Y) or absence (N) of specific behavior(s) within one-hour intervals, 24 hours each day. The data sheet header consisted of time, targeted problem behavior(s), antecedent conditions (left blank for narrative description), replacement behavior(s), and staff initials. In the documents provided, there were samples of data collected for seven individuals using this new format. Initially, three separate data sheets, representing three shifts, were provided for each day. Eventually, the data was combined so that one sheet was used to record behavior from 6:00 a.m. to 6:00 a.m. For the purpose of analysis, a total of 277 daily data sheets were reviewed. A summary of findings is provided below: ▪ For none of the seven individuals (0%) was data recorded across all 24-hour intervals. Specific examples from the month of 10/12 included the following: o Over a 31-day period, data was recorded across all three shifts for 16 days for Individual #325. o Over a 31-day period, data was recorded across all three shifts for four days for Individual #246. o Over a 31-day period, data was recorded across all three shifts for two days for Individual #202. o Over a 31-day period, there were no days during which data was recorded across all three shifts for Individual #73. While this is a small sample, it is concerning that staff continued to omit data. ▪ For at least two individuals (i.e., Individual #83 and Individual #202), data sheets included tally marks even when data were not recorded for most of the	Noncompliance

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		24 hours. Because one cannot assume that the absence of data translates to the absence of problem behavior, any summary conclusions drawn from these data could likely be inaccurate and could represent an underestimate of the behavior. ▪ As this was a relatively new data system that had just recently been introduced, problems would be expected initially. However, for three of these seven individuals, the partial interval data sheet had been introduced in 8/12, and problems with data collection were still evident in 10/12. As the Facility implements this new system, efforts must continue to ensure that staff are recording behavior as it occurs or shortly thereafter. Caution is also advised with regard to the utility of a partial interval time sampling procedure for tracking all problem behavior. As noted by Cooper, Heron, and Heward (2007), partial interval recording does not provide information on the frequency or duration of the measured behavior. Further, these authors note that partial interval recording "… is likely to underestimate the rate of a high-frequency behavior" (Cooper, Heron, & Heward, 2007, p. 92). This is particularly true when a long interval of time, such as an hour, is used. As with most aspects of treatment provision, data collection should be individualized to meet the needs of the person. Between one and five months of psychology progress notes were reviewed for 42 individuals. (Documentation was not provided for Individual #83, and Individual #213 was not followed by psychology or psychiatry.) This resulted in a review of 121 progress notes. The time period ranged from 3/12 to 10/12. The format for these progress notes was consistent across individuals. Behavioral objectives were listed, response to treatment was described, graphs were depicted, quality of plan implementation was addressed, recommendations were suggested, and psychiatric review/assessment/ planning was noted. A summary of the Monitoring Team's findings is provided below: ▪ Graphs of an individual's target and/or monitored behaviors were presented in every progress note (100%). For 38 individuals (90%), replacement behavior data was also presented. Of the 26 individuals for whom medication was prescribed, bar graphs depicting dosage was included in the graph for 20 individuals (77%). ▪ For eight individuals (19%), data was presented in more than one graph in at least one of the monthly progress notes. In general, the grouping of all target behaviors, replacement behaviors, and in some cases, medication doses, on one graph made for a very difficult analysis of progress. Of the 34 individuals for whom data was displayed on one graph, the total number of variables (e.g., targeted problem behaviors, replacement behaviors, medications) ranged between two and 11, averaging 4.6 data paths per graph. This created difficulty in visual analysis. ▪ Data was presented in monthly totals with the general label "frequency," or	

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		something similar included in the graphs for 34 individuals (81%). For 14 of the 20 individuals (70%) whose medication dosage was presented in bar graph format, one vertical axis was labeled "mgs/day." The vertical axis was labeled "months/years" in the progress notes for 32 of 42 individuals (76%). It is suggested that more complete labeling of axes would be appropriate. For example, frequency of identified target behavior per 24 hours would provide a more accurate description of the time frame. As the Facility moves forward with its new data collection system, it will be important to reconfigure graphs to reflect percentage of 24, one hour during which target behaviors occurred. ▪ Progress notes for 32 of the 42 individuals (76%) included statements that addressed the quality of plan implementation. However, only the October monthly review for Individual #319 referenced measured treatment integrity and inter-observer agreement regarding data collection. ▪ Progress notes were signed for 40 of 42 individuals (95%). This was a marked improvement from previous reports. Comments regarding individual progress notes are provided below: ▪ The monthly reviews for Individual #33 included several noteworthy components. Daily scatter plot data were presented in an effort to identify specific times of day when problem behavior was most likely to occur. Graphs were included that depicted the potential relationship between problem behavior and menstrual cycles or sleep irregularities. Lastly, recommendations were revised as appropriate over the course of three months. ▪ Over two consecutive monthly reviews, Individual #210 displayed increasingly worsening behavior. While the recommendations included increasing his access to activities in the community, along with the presence of an interpreter, there was no identification of the professionals responsible or timelines for completion to implement these recommendations. ▪ Under quality of implementation or treatment integrity in the reports for Individual #325, over two consecutive months, staff noted that the "quality of implementation is still under review and cannot be reviewed at this time." ▪ While specific observations of staff working with the individual were identified in the reports for five individuals, the observations were current only for Individual #16, Individual #389, and Individual #341. For Individual #160 and Individual #263, the observations referenced in the progress notes had been conducted months earlier and did not apply to current treatment integrity. ▪ The quality of plan implementation was noted to be "poor" over three consecutive months for Individual #376 and Individual #98, yet the recommendations did not include suggestions for improving treatment integrity. ▪ Over three consecutive months, the aggressive behavior displayed by Individual #140 was increasing, yet the recommendations did not include an updated	

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		functional behavior assessment or any changes to the behavior support plan. ▪ Five consecutive months of progress notes were reviewed for Individual #318. Included in each report was a recommendation to revise the behavior support plan. It was unclear why this revision had not occurred. The monthly progress report is only helpful if staff are responsive to identified needs and recommendations. As noted in the past, during the week of the onsite review, the Monitoring Team occasionally observed problem behaviors. In only two of nine situations was the observed event recorded on the individual's data sheet. Specific information is provided below: ▪ While not directly observed by the Monitoring Team, workshop staff reported that Individual #421 was upset on 11/6/12 at 2:02 p.m. Yelling could be heard. A check of her data sheet indicated that multiple problem behaviors had occurred and been documented at that time. ▪ Individual #450 was observed in her home on 11/6/12 at 4:25 p.m. She had her shirt in her mouth. Mouthing was recorded at this time on her data sheet. ▪ Individual #369 was observed in his day program on 11/5/12 at 2:45 p.m. He was agitated (disruptive behavior), but no data was recorded between 1:00 p.m. and 10:00 p.m. ▪ On the afternoon of 11/5/12 at 4:30 p.m., Individual #304 was observed repeatedly hitting her head against the wall behind her. There was no record of this behavior on her data sheet. In fact, the data sheet indicated that self-injury had not occurred during this time period. This individual had one-to-one staffing at the time. ▪ Individual #4 was observed in her home at 5:02 p.m. She was crouched on the floor with her one-to-one assigned staff member standing over her. She picked up something from the floor and placed it in her mouth. The member of the Monitoring Team pointed this out to the staff member. There was no record of pica behavior at this time. The data sheet indicated that pica had not occurred. ▪ Individual #140 was observed in his home at 5:23 p.m. He hit a staff member who responded: "Ah, don't hit me (individual)." No data was recorded between 2:00 p.m. and 10:00 p.m. on this day. This same individual was observed at 2:05 p.m. on 11/6/12 in his day program. He was hitting a staff member on the arm, but the recorded data indicated that aggression had not occurred at this time. ▪ Individual #219 was observed hitting himself three times at 5:25 p.m. while in his home. This behavior was not documented, because there was no data recorded between 2:00 p.m. and 10:00 p.m. on this day. ▪ On 11/6/12 at 4:25, Individual #73 was observed in his home. He hit himself twice, yet the recorded data suggested that self-injury had not occurred during the 4:00 p.m. to 5:00 p.m. interval.	

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		It is important to note that none of the data sheets requested for the five-day period of 11/5/12 through 11/9/12 were complete. There was missing and/or incomplete data found for all eight individuals. For three of these individuals, data was tallied at the bottom of the page, although data was missing from one to two shifts. As has been reported in the past, important clinical decisions are made based upon data that is very likely inaccurate and unreliable. While the psychology staff are commended for their efforts to include feedback from direct support professionals in designing data collection systems, they must continue their efforts to ensure that data is collected as target behaviors occur. Staff also should continue to evaluate the accuracy and reliability of the new data collection format. Continued efforts to improve staff training, including assessment of inter-observer agreement, will be necessary. As also discussed above, although improvements were seen with regard to monthly reports, further work was necessary to improve graphing to allow for easier analysis of information, as well as to ensure that when monthly reviews showed issues with either implementation of plans or the plans themselves, appropriate corrective action was taken. For these reasons, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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.	Since the Monitoring Team's November 2011 visit, the Facility had folded the functional behavior assessment into the annual psychological evaluation. A total of 42 reports were reviewed. The reports for Individual #210 and Individual #325 were requested, but were not included in the documents provided. Thirty-nine of the 42 reports had been completed in 2012. The three reports from 2011 had been completed within a 12-month period prior to the individual's ISP date. Forty-one of these 42 reports indicated the presence of problem behavior for the identified individual. A summary of the findings from the review of these 41 reports is provided below: ▪ Thirty of the 41 reports (73%) noted the date that the indirect and descriptive assessments had been completed. However, only 21 of the 41 reports (51%) indicated that information had been gathered within the previous 12-month time frame. Nine of the 30 reports (30%) reviewed functional behavior assessments completed between 2006 and 2010. ▪ Indirect methods of determining behavioral function were clearly identified in 23 of the 41 reports (56%). Typically the instruments used were the *Questions About Behavioral Functioning* (QABF), the *Functional Analysis Screening Tool* (FAST), and the *Functional Assessment Interview Form* (FAIF). When these are used, it is important to identify the staff member's familiarity with the individual and the data of completion. As noted in the past, greater emphasis on structured descriptive methods involving direct observation of the individual would be helpful. Staff should include the date the observation was completed and a brief description of the patterns of behavior observed. ▪ All of the assessments (100%) identified setting events, antecedent stimuli, and	Noncompliance

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		consequences to problem behavior. Summaries of variables likely maintaining the problem behavior also were provided. Staff should clearly identify indirect instruments employed and their dates of completion, and the dates and outcome of descriptive assessment ▪ Twenty-six assessments (63%) included adequate suggestions for replacement behaviors that were functionally equivalent to the problem behavior. This is a critical component of the functional behavior assessment and should be addressed in all reports. ▪ The responsible Associate Psychologist had signed 30 reports (73%). In the remaining 10 the reports (24%), the responsible author was identified, but the reports were not signed. Feedback related to specific reports is provided below: ▪ The reports for Individual #160 and Individual #263 included a description of conditions that promoted positive behavior. This was a commendable addition to the report and should prove helpful in designing supportive environments. ▪ As noted above, not all reports referenced current information when identifying behavioral function. Nine of the 41 reports referenced assessments that were at least two years old. Information from 1998 was quoted in the report for Individual #75. Assessments from other facilities were referenced in the report for Individual #435 (2007) and Individual #98 (2006). The report for Individual #98 referenced several outdated assessments. A 2006 functional analysis and preference assessment conducted prior to the individual's admission to the Facility were referenced in the report. Further, a functional assessment completed within 30 days of admission in 2007 was also referenced. It is possible that behavioral functions might have changed over a five- to six-year period, and preferences might certainly have changed for this adolescent. Staff should update functional behavior assessments on a regular basis and whenever there are changes in the individual's circumstances and/or presentation. ▪ While many reports suggested that information was gleaned from direct observation, there was very little evidence of completion of a structured observation. Only the reports for Individual #273, Individual #369, and Individual #341 described specific events that described observed patterns of behavior. ▪ While many reports identified specific indirect measures used to determine behavioral function, others simply noted staff interviews and record reviews. ▪ Four of the reports were identified as drafts, although report dates were between 11/11 and 8/12. The report for Individual #450, dated 5/12, had not been completed, because there were gaps in the analysis of possible behavioral function. ▪ The report for Individual #7 was dated six days earlier than the date of the	

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		functional behavior assessment. Again, staff should rely more heavily on descriptive assessment rather than indirect assessment. Further, functional behavior assessment should be updated regularly, and should be considered as one option particularly when positive changes are not as robust as one would like to observe, or when behavior remains stable or worsens. Evidence of screening during 2011 or 2012 for psychopathology, emotional and behavioral issues was found in the evaluations of 26 individuals. The Reiss screenings continued to be utilized to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss screening process is discussed above with regard to Section J.7 of the Settlement Agreement. Plans also were underway for the development of a Behavior Lab. As described in the draft policy, the Interdisciplinary Team would refer individuals to this lab for the purpose of conducting structured functional analyses. The goal was to develop a better understanding of behavior(s) function resulting in stronger behavior support plans. Supervision of lab activities would be the responsibility of a BCBA level staff member with Psychologists, who were completing supervision requirements for certification, providing assistance. It will be interesting to observe the progress made with this additional support as staff work to improve the interventions offered to the individuals. As the policy is finalized, suggestions include the following: a) address the points raised by the State Office Coordinator of Behavioral Services; b) change the treatment from "behavior modification" to applied behavior analysis or some other more current term; c) provide a more in-depth description of possible conditions included in the functional analysis; and d) describe the degree to which other disciplines, including direct support professionals, will be involved in the development of services following the structured assessment process. Also, the Director of Behavioral Services described practical labs that would cover topics related to functional behavior assessment, including indirect and descriptive assessment procedures, and methods of conducting preference assessments. Training was to occur for one hour across four weeks. Additional topics were to be identified at a later date. The Facility remained out of compliance with this provision due to concerns with the quality of behavioral assessment, as well as the timely completion of psychological evaluations, which is discussed further with regard to Section K.6.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year,	As noted in the previous section, a total of 42 Psychological Evaluations were reviewed for this report. An analysis of evidence of current psychological assessment is provided below.	Noncompliance

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	each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	▪ Forty of the 42 assessments (95%) noted the most recent completion of the Inventory for Client and Agency Planning (ICAP). For 38 of these 40 individuals (95%), the ICAP had been completed within three years of the evaluation date. The ICAP for Individual #291 and Individual #376 were overdue. An updated ICAP was recommended for Individual #376. ▪ For 31 of the 42 individuals (74%), a standardized assessment of adaptive behavior was referenced. For 16 of these individuals, the assessment had been completed within the previous five years. As a result, only 38% of the sampled individuals had current standardized assessments of adaptive behavior. ▪ A standardized measure of cognitive abilities was referenced in the evaluations for 28 of the 42 individuals (67%). Six of these cognitive assessments were completed within the five-year timeframe. This resulted in only six individuals (14% of the sample) having current assessments of cognitive abilities. It should be noted that staff at the Facility had attempted a cognitive assessment with Individual #263, but she reportedly refused to participate. The Peabody Picture Vocabulary Test (4th edition) had been used to assess Individual #146 and was attempted with Individual #327. As this is not a standardized assessment of cognitive abilities, these individuals were not included in the count. ▪ Four of the individuals in the sample were school-aged at the time of the visit. As the Individuals with Disabilities Education Act indicates that a re-evaluation should occur every three years, the Facility should work with the local education agency to ensure current assessment of adaptive behavior and cognitive abilities. In consideration of the problems with data collection identified in Section K.4, the need for improved and regular functional behavior assessment, and the significant lack of current measures of adaptive behavior and cognitive abilities, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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.	Since the Monitoring Team's last visit, there were no new admissions to the Facility. Standard psychological assessments have been reviewed in detail in Sections K.5 and K.6 of this report. As noted with regard to Section K.5, the completion date of the individual's functional behavior assessment was not always identified, and in some cases, the information that was used to guide behavior support plan development was quite dated. Current standardized measures of adaptive behavior and cognitive skills were found in only a minority of records reviewed (as discussed with regard to Section K.6). Although the Facility was clearly making an effort to address this provision of the Settlement Agreement, the Facility remained out of compliance.	Noncompliance

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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 Monitoring Team asked the Facility to provide information regarding the counseling referral process and policies regarding an individual's refusal to participate. Two brief statements were provided. According to this information, the Interdisciplinary Team would meet and complete a referral through the ISP addendum meeting minutes. There was no further information regarding an expected timeframe for response to the referral, identification of a counselor, or initiation of services. With regard to refusals, the counselor reportedly informed the Director of Behavioral Services, the Director of Residential Services, and the Home Supervisor each week this occurred. Follow-up with the individual's psychologist and QDDP also was to take place. There was no further information regarding action plans or alternative strategies for addressing this problem or guidelines for terminating services. The Facility should develop specific policies and procedures that address all aspects of counseling services, including the role of the Associate Psychologist responsible for co-facilitating therapy for one individual, and providing supervision to other psychology staff as they provided therapy. The tracking sheet the Facility provided, dated 11/8/12, indicated that four individuals were receiving counseling services. However, a list of individuals receiving individual counseling (scanned 10/31/12) did not correspond to this tracking sheet. Four individuals were included on both lists. These were Individual #291, Individual #158, Individual #7, and Individual #109. Individual #180 was listed as receiving services, but the tracking sheet indicated she had been discharged in 8/12. Individual #83 was identified on the list as someone who would begin receiving services, but his referral was not noted on the tracking sheet. In order to effectively track and monitor service delivery, it is essential that documents contain accurate and reliable information. Documents provided for review included the Counseling Treatment Plan for Individual #291, Individual #158, and Individual #7. These plans included the intake date, the reason for referral, assessments, treatment strategies, response to treatment, baseline presentation, counseling objectives, and rational for current intervention. Each had last been revised on 4/9/12. As noted in the past, objectives were not written in observable and measurable terms. 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. Without this degree of specificity, it was difficult to determine how an individual's progress would be objectively assessed. There were also no individual specific criteria for termination of services. The Facility should develop a comprehensive set of policies and procedures regarding the provision of counseling services. All databases should be checked for accuracy and	Noncompliance

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		reliability. Treatment plans should reflect observable and measurable objectives with monthly review of progress. Until these requirements are met, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	According to a document provided to the Monitoring Team by the Director of Behavioral Services, a Positive Behavior Support Plan had been developed for 155 individuals residing at the Facility. While this number will be used in determining sample size, caution is advised, because at least five individuals known to have PBSPs and included in this review were not included on this list. These were Individual #450, Individual #133, Individual #4, Individual #33, and Individual #73. The Facility should check its databases for accuracy. Although the original sample was of 44 individuals, only 42 PBSPs were reviewed, because Individual #213 did not exhibit problem behavior necessitating a PBSP and the PBSP provided for Individual #263 was missing pages. This represents 27% of the individuals identified on the Facility's list of individuals with PBSPs and 13% of the total population of AUSSLC. These individuals are identified in the documents reviewed section above. A summary of the findings is provided below: ▪ Thirty-nine of the 42 plans were dated (93%). These dates were either the date of team approval or the most recent revision date. For the three plans that were not dated, two included objectives with completion dates in 2013, suggesting the plans were written in 2012. ▪ Four plans were outdated. These included the plans for Individual #4 (6/8/11), Individual #33 (9/20/11), Individual #75 (not dated, but with objective due dates of 10/12), and Individual #360 (9/7/11). ▪ Seven of the 42 plans were identified as "drafts." With ISP dates between 5/22/12 and 9/10/12, the delay in finalizing these plans was concerning. Further in the documents sent to the Monitoring Team prior to the visit, notes were attached to an additional 12 PBSPs indicating that revisions and consent had yet to be finalized, although these plans were written between 2/21/12 and 9/17/12. Presumably, the new or revised plan was an improvement over the old plan and its timely implementation was critical. When the Director of Behavioral Services was asked about these delays, he explained that the department had undergone significant changes since the previous visit. With a fully staffed department, it was anticipated that improvements would be made in this area. ▪ Thirty-seven of the 42 plans (88%) employed a new and improved format. The plan was divided into two sections. The first section, Staff Instructions, contained the following information: a) the name and definition of replacement behavior(s), alternative behavior(s), and target behavior(s); b) the function(s) of the target behavior(s) and strategies for teaching/supporting alternative or	Noncompliance

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		replacement behavior(s); c) setting events and antecedent conditions and prevention of challenging behavior(s); d) do's and don'ts (consequences) and how to respond to challenging behavior(s); and e) description of data collection procedures. The second section, Administrative Review, included information related to: a) diagnoses and medical conditions; b) baseline or comparison data; c) behavioral objectives; d) prior intervention strategies and outcomes; and e) rationale for current intervention. In general, this format provided a clearer description of intervention strategies, including methods for supporting appropriate behavior. The information was provided more succinctly and in a format that allowed one to quickly review the document for critical treatment components. The information included in the administrative review was important to the plan, but not information that staff must review when working with the individual. It will be interesting to monitor the use of these plans to determine whether this streamlined document results in improved treatment integrity. ▪ Thirty-eight of the 42 plans (90%) included operational definitions of targeted problem behavior(s). Twenty-nine of the 42 plans (69%) included operational definitions of functionally equivalent replacement behaviors. ▪ All 42 plans (100%) identified the potential function of the targeted problem behavior(s). In the new format this was succinctly summarized to the left of strategies for teaching replacement behavior and/or setting events and antecedent conditions. ▪ Forty-one of the 42 plans (98%) included some description of strategies to address setting events and antecedent conditions. The quality of these strategies varied across plans. The plan for Individual #273 included thoughtful recommendations for interaction first thing in the morning. Similarly, the plan for Individual #246 offered some good suggestions for pre-bedtime conditions. Lastly, the plan for Individual #435 offered observable changes that could be indicative of pain or illness. ▪ While 39 of the 42 plans (93%) included a description of how to teach replacement and/or alternative behavior, only 23 of these plans included specific training schedules. These ranged from every 15 minutes to three times each week. Overall, the opportunities for learning new behavior (replacement or alternative) were infrequent. As many of the problem behaviors displayed by the individual with PBSPs are longstanding concerns, it will take multiple opportunities for these individuals to learn new replacement repertoires. ▪ In every plan (100%), there were clear descriptions of steps to take when problem behavior was observed. ▪ As has been noted in the past, specific schedules of reinforcement were found in only 11 of the 42 plans (26%). This is one area of the plans that remained weak. Staff should consider ways in which more frequent positive feedback could be	

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		included in the plans. ▪ Thirty-nine of the 42 plans (93%) included a description of the data collection systems in use to track behavior occurrences. In 33 of these 39 plans, the use of an ABC (antecedent-behavior-consequence) data sheet was identified or described. In consideration of the new partial interval data sheet that has been introduced across the Facility (as discussed in further detail with regard to Section K.4), it will be essential to update all of these plans. ▪ Twenty-six of the 42 plans (62%) were signed. The author of the plan was identified in 11 of the remaining 16 plans. Concerns regarding individual-specific plans are provided below: ▪ In several plans, reference was made to behavior contracts that were scheduled for discontinuation on 10/1/12. Included were the plans for Individual #210, Individual #283, Individual #83, and Individual #360. In some cases, staff reported that these had appeared helpful to the individual. During the meeting with the psychology staff, there was also concern voiced regarding the discontinuation of this practice. The Facility should examine the variety of reinforcers ▪ Obtaining attention was one of the potential functions of problem behavior identified for Individual #175. Her plan included directions to staff to refrain from talking with her about her problem behavior until she had been "calm" for 45 minutes. However, it appeared that any discussion about her problem behavior might have been contraindicated. ▪ Individual #335 had physical aggression as one of his targeted problem behaviors. A replacement behavior included allowing him to pat a person's back or shoulder, or give side hugs. Unless this individual is able to discriminate familiar people from unfamiliar people and respond accordingly, it might be best to restrict alternative physical contact to handshakes and "high fives." ▪ Lastly, the problem behaviors identified for Individual #133 included inappropriate sexual behavior. His plan suggested that when he wanted to engage in sexual behavior, he could masturbate. It would be advisable to include in his plan clear parameters regarding this alternative behavior. Clearly, the quality of the PBSPs had improved since previous visits. As the Facility continues to change over to the new format, staff are encouraged to pay particular attention to comprehensive strategies for addressing settings events and antecedent conditions, enhanced opportunities for training replacement behaviors, and enriched schedules of reinforcement. Human Rights Committee meeting minutes were reviewed from 4/5/12 through 10/25/12. Three meetings held at the end of April focused on a review of rights	

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		assessments and restrictions with participation by external agencies. These meetings are not included in the analysis that follows. Of the remaining 21 meetings, the Human Rights Officer attended 20, with the Assistant Director of Programs filling her role during one meeting. A community member was present at 21 meetings (100%), an affiliate member (i.e., an individual residing at the Facility) was present at 20 meetings (95%), and a professional with training in medication (e.g., a psychiatrist, pharmacist, or nurse) was present during three of these meetings (14%). Psychologists were in attendance at 14 of the meetings (67%). As noted in the past, the Facility should ensure participation by medical and behavioral services personnel whenever medication or behavior support plans are reviewed, respectively. Since the Monitoring Team's last visit, the Facility had identified a new Human Rights Officer. Observation of the HRC meeting held during the week of the most recent visit reflected a lively and thoughtful discussion regarding the behavior support plans presented. There was active participation by the Facility's psychologists and crisis intervention trainer, and the community representative. Psychology staff are encouraged to listen carefully to the exchange of ideas regarding behavior support plans as often the ideas of those outside of the department can reflect a broader perspective on individual rights and appropriate intervention. For example, a discussion ensued regarding an adult's right to have access to his own highly preferred materials when the psychologist suggested that he should learn to share with his peers. This was a refreshing reminder that most adults do not live with large groups of unrelated individuals and are able to choose with whom they share their possessions, and careful evaluation of the restrictions and expectations placed on the individuals should be ongoing. Another promising practice observed at this meeting was the identification of an expected due date by the Human Rights Officer when plans were approved with recommendations or revisions. Timely approvals and consents remained problematic at the Facility. Many PBSPs were delayed in the internal peer review process, which resulted in delays in HRC presentation and approval. With full staffing in the Department of Behavioral Services, it is anticipated that assessments and resulting plans will be developed and revised in a more timely manner. One promising practice was the anticipated transfer of responsibility for psychotropic medication consent to the Department of Psychiatry. At the time of the visit, promising changes were occurring with regard to PBSPs. However, until there is evidence of these changes system-wide as well as improvements in the timeliness of the approvals, consent, and implementation of PBSPs, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K10	Commencing within six months of	Associate Psychology staff had begun conducting monitoring of PBSP implementation	Noncompliance

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	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.	using a tool adapted from Reid and Parsons (2002). This *Positive Behavior Support Plan Treatment Integrity Form* allowed the psychologist to record a staff member's use of environmental set-ups, antecedent management strategies, and their response to both desirable and undesirable behaviors. The form also prompted the psychologist to record positive feedback, corrective feedback, additional comments/concerns, and finally recommendations. This tool clearly was a good first step in providing ongoing monitoring and training to ensure high treatment integrity. Staff were provided instructions for using the form as well as in-depth descriptions from the text written by Reid and Parsons (2002). A total of 19 completed forms were reviewed. These revealed a range in the quality of feedback provided to staff. The form completed on 10/12/12 for staff working with Individual #212 provided a good example of the psychologist offering praise for skillful interactions, while also providing clear and succinct suggestions for the future. Similarly the 10/19/12 observation conducted of staff working with Individual #74 represented the use of positive feedback to provide encouragement to staff. Psychology staff should use this form to offer positive feedback and constructive criticism as appropriate. The written feedback section on some of the completed forms was blank, while others included the notation "N/A." This is the psychology staff member's opportunity to objectively describe what the direct support professional did well and give supportive feedback to help improve the staff member's performance. Several psychology staff took time to include information regarding the individual's PBSP on the form itself. This might serve as a more effective way to reinforce components of the PBSP than simply advising staff to review the document. Psychology staff also should provide a good model when recording data. Rather than circling information across a 10-minute block of time, psychologists should ensure staff behavior is recorded separately across each minute of observation. Graphs continued to display monthly occurrences of targeted behaviors, which generally precluded adequate analysis. Axes were labeled (often with one word), and data points and paths were displayed. Condition change lines or arrows were used to depict changes in medication, change of residential placement, occasional changes in staffing, missing data, the introduction of new data collection systems, and absence due to hospitalization or furlough. As noted with regard to Section K.4, graphs often depicted multiple measures. With multiple 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 specific changes to behavior support plan strategies. Measures of inter-observer agreement or treatment integrity were also not depicted on any of the graphs.	

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		As noted in the past, 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 provide 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.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	The Facility continued to check plans to ensure they were written at a ninth grade reading level as indicated by the Flesch-Kincaid Reading Level. Further, when asked, direct support professionals generally reported that PBSPs were written clearly. During the in-service training observed on the first day of the visit and described in the next section, it was encouraging to observe newly hired staff describing antecedents and responding accurately to questions about an individual's PBSP. This time to become familiar with the format of the plans and the language used in the plans appeared to be quite beneficial. Equally important was the change made to the format of the PBSP. As noted with regard to Section K.9 of this report, the shorter and more directed format used to relay critical components of the PBSP appeared to hold promise. Until the Facility is able to evaluate the degree to which PBSPs are implemented with fidelity, the Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	During the visit, the Monitoring Team was able to observe in-service training provided by one of the Psychological Assistants to three newly hired direct support professionals. Individual PBSPs were reviewed with the staff, followed by completion of a brief quiz on the same. Staff were encouraged to review the PBSP as they answered questions. As the Psychological Assistant described, this was the initial phase of training for house staff following their completion of new staff orientation. Staff would then spend time observing individuals with whom they would be working and would receive further on-the-job training from the individual's Psychologist. This small group format allowed for greater clarity in understanding the components of the PBSP and offered an opportunity for questions and answers. The Monitoring Team was provided a packet of materials entitled: On-the-Job Training. Included in this packet were the following documents: a) Job Specific Skills – Instructions and Confirmation; b) Time/Leave Keeping; c) Armed Intruder Alert Policy; d) Medical Mock Drill Policy; e) Common Documents; f) Mealtime and Active Treatment Checklist; g)	Noncompliance

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		Mealtime Information; h) Snacks and Active Treatment Checklist; i) Toothbrushing and Active Treatment Checklist; j) Bathing and Active Treatment Checklist; k) Shaving – Safety Razor and Active Treatment; l) Shaving – Electric Razor and Active Treatment; m) Nail Care Checklist and Active Treatment; n) Toileting Checklist and Active Treatment; o) Weights Checklist and Active Treatment; p) Bed Stripping Checklist; q) Bed Making Checklist; r) Housekeeping Checklist; s) Laundry Checklist; t) Specimen Collection; u) Menses Care; v) PNMP In-service; w) Psychology In-service; x) Active Treatment; and y) Records In-service. Trainers were required to sign forms to indicate the employee's competent performance. These documents outlined some very critical job responsibilities, combining an assessment of an employee's knowledge with their demonstration of specific skills. These performance guidelines and training checklists offered a very promising practice in ensuring employee competence. The Psychological and Behavioral Services Unit Orientation Training form provided an outline of seven days of training to be implemented following New Employee Orientation. Psychological Assistants were to spend the first day training staff on observation notes, data sheets, and restraint checklists. Following training, staff were assessed on their ability to complete required forms using written vignettes. This was followed by a visit to the assigned home, followed by more training on basic behavioral principles, relationship building, and simple strategies. The second day was spent training new staff on individual-specific PBSPs. Days three and four were spent with Habilitation Therapy Staff, Home Supervisors, Active Treatment Coordinators, and QDDPs. Days five through seven were spent in the homes with the home Psychologist providing on-the-job training. The Facility is commended for initiating steps to ensure competency-based training of new staff. As noted above, for new staff, this included the basics that would be needed to reach the point of implementing PBSPs, as well as competency-based training on the implementation of individual-specific PBSPs (i.e., the second day following new staff orientation), as well as further on-the-job training with the Psychologist. It remained unclear what action had been taken to ensure the competency of existing staff. Until there is evidence of full implementation of this system, including competency-based training of existing staff, and clear analysis of its efficacy, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of	At the time of the Monitoring Team's visit, 321 individuals were residing at AUSSLC. Fourteen of the 15 Associate Psychologists were assigned caseloads, with support provided by eight Psychological Assistants. This resulted in a ratio of one Associate Psychologist for every 23 individuals with one Psychological Assistant for every 1.75 professionals.	Noncompliance

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	professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	Although not all 321 individuals had PBSPs, this level of support was essential for several reasons. Individuals might develop problem behaviors that require support and intervention, while others might already be displaying problem behaviors that indicate a need for a behavior support plan. Further, repeated documentation was found of individuals refusing to participate in planned activities, be these required self-care or medication routines, counseling services, or day habilitation or work programs. The involvement of the psychologist in addressing these problems is essential. Lastly, behavioral psychologists are critical members of the interdisciplinary team when designing programs of habilitation and training programs. It is a misconception to consider the field Applied Behavior Analysis only in relationship to problem behaviors as the field focuses equally, if not more so, on the development and expansion of new and enhanced skills. The Facility remained out of compliance with this provision, because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as required by the Settlement Agreement. This was evidenced by the absence of professional certification, as well as by issues related to the quality of the programming observed at the Facility.	

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

1. As vacancies become available in the Department, every effort should be made to recruit individuals who are Board Certified Behavior Analysts or who have completed the necessary coursework and supervision to take the exam. The Facility should continue to support Associate Psychology staff as they pursue board certification in Applied Behavior Analysis. (Section K.1)
2. As previously recommended, 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)
3. Consideration should be given to providing support to already certified staff as they work to maintain their certification through conference and workshop attendance, online coursework, or other continuing education activities. (Section K.1)
4. The Facility should develop and implement a more streamlined format for providing feedback on all assessments and plans presented at the Behavior Therapy Committee. (Section K.3)
5. The Facility should develop a policy related to internal and external peer review, including membership information, guidelines for ongoing review of individual cases, the role and format of external review, and review and dissemination of all recommendations, as well as expectations for timely response to recommendations. (Section K.3)
6. The Facility should encourage and support the inclusion and participation of Psychological Assistants, direct support professionals, and staff from other disciplines in the Behavior Therapy Committee. (Section K.3)
7. The Facility should carefully analyze the utility of the new partial interval data system to ensure it is capturing critical information regarding identified problem behavior. In addition, the Facility should continue to work with direct support professionals to ensure that data is recorded as behavior occurs or shortly thereafter. (Section K.4)

8. Inter-observer agreement measures, between the direct support professional and the monitor, should be collected on a regular basis. (Section K.4)
9. When data is not recorded, staff should not calculate daily and/or weekly totals. (Section K.4)
10. When completing psychology monthly progress reports, staff should address the following: a) ensure criteria for progress is clearly identified; b) for applicable individuals, include a report regarding their progress in counseling; c) clearly explain and report behavior support plan monitoring activities; d) when revisions are recommended, implement these in a timely manner; e) minimize the number of data paths included in graphs so that visual analysis of treatment efficacy feasible; and f) ensure that all reports are signed. (Section K.4).
11. Staff should provide 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.). Graphs should be clearly labeled with phase change lines included as appropriate. (Sections K.4 and K.10)
12. Functional behavior assessment should be ongoing, and be considered particularly when positive changes are not observed, when behavior remains unchanged, or when behavior worsens. There should be greater emphasis placed on descriptive assessment of problem behavior and when conducted, functional analysis outcome. (Section K.5)
13. All psychological evaluations should include specific information regarding the activities conducted when completing a functional behavior assessment and the dates of completion. (Section K.5)
14. The Facility should expand the policy regarding the planned Behavior Lab. The Facility should ensure the policy clearly outlines the protocol to be used when conducting a functional analysis of behavior. (Section K.5)
15. The State and the Facility should develop and implement a policy that provides clear guidelines for the completion of formal assessment of cognitive abilities and adaptive behavior. Psychological evaluations should be conducted at a minimum of once every five years. Measures of adaptive behavior are recommended annually. (Section K.6 and Section K.7)
16. The Facility should develop comprehensive policies and procedures related to counseling services. This should include guidelines for tracking referrals and initiation of services, and guidelines for responding to participant refusal. (Section K.8)
17. Initial counseling plans should include identification of the problem, observable and measurable goals, identification of evidence-based intervention, and criteria to identify failure or lack of progress. (Section K.8)
18. Clear behavioral objectives should be identified whenever a person receives therapy or support services in addition to their Behavior Support Plan. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness or lack thereof of the recommended practice. Plans for generalization of learned skills to other individuals and other environments should be addressed. Additionally, ISP teams should meet to review and address repeated resistance to participation. (Section K.8)
19. The Facility should engage in ongoing review of the utility of the new format for Positive Behavior Support Plans. (Section K.9)
20. The Facility should strengthen the Positive Behavior Support Plans through greater emphasis on the following:
    a. Teaching of functionally equivalent replacement behaviors with adequate opportunities for learning, particularly functional communication skills;
    b. Expanded antecedent and preventative strategies;
    c. 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;
    d. Re-introduction of behavioral contracts or other expanded reinforcement programs; and
    e. Evaluation of the consequences that are applied contingent upon problem behaviors. While the Psychological and Behavioral Policy noted that aversive or punishment contingencies would not be employed, the policy also referred to the use of appropriate target behavior reduction strategies (page 4, paragraph #13c). Consideration should be given to the array of strategies that can be used to reduce the occurrence of problem behaviors (refer to Cooper, Heron, & Heward, 2007) that 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)

21. All current Positive Behavior Support Plans should be rewritten to reflect the new data sheet system. (Section K.9)
22. The Human Rights Committee should ensure participation by one staff member trained in medication administration and management. (Section K.9)
23. Consents should be obtained in a timely manner to avoid delays in program implementation. (Section K.9)
24. As psychology staff implement monitoring of treatment integrity with regard to Positive Behavior Support Plans, they should use the monitoring tool to provide positive feedback to staff, specific constructive criticism, and clear recommendations for future performance. (Section K.10)
25. The Facility should engage in ongoing assessment of the effectiveness of the staff training program. (Section K.11)

References:

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

Reid, D.H., & Parsons, M.B. (2002). *Working with staff to overcome challenging behavior among people who have severe disabilities*. Professional Press: Chapel Hill, NC.

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; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all primary care providers that were new to the Facility since last monitoring; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing cardio pulmonary resuscitation (CPR) training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o Since the last onsite review, copy of continuing medical education (CME) for each primary care provider; list of CME credits according to topics reviewed; and list per PCP of total CME credits during this time period; o Any clinical guidelines developed and implemented since the Monitoring Team's last visit; o Minutes of Infection Control Committee meetings during the previous six months; o Minutes of Skin Integrity Committee meetings during the previous six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken, including date of audit from which information was retrieved; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit, and separate reports/data for external medical peer review audits and for internal medical peer review audits; o List of individuals who died since the Monitoring Team's last visit. For each individual, information included date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory for: Individual #3, Individual #95, and Individual #161; o Mortality Reviews (i.e., clinical, administrative, and nursing reports), since Monitoring Team's last visit; o Corrective actions related to Mortality Reviews, including status reports on previous recommendations, for: Individual #3, Individual #199, Individual #43, Individual #1, Individual #95, and Individual #161; o Notes and orders for any Do Not Resuscitate Orders (DNRs) and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (i.e., clinical/administrative) that remain incomplete/outstanding; o Twenty-one most recent annual medical assessments and physical examinations and prior annual assessment and examination for the following individuals: Individual #21,

	Individual #307, Individual #163, Individual #358, Individual #429, Individual #206, Individual #153, Individual #357, Individual #403, Individual #293, Individual #47, Individual #348, Individual #216, Individual #16, Individual #159, Individual #362, Individual #243, Individual #190, Individual #423, Individual #189, and Individual #98; o Specialty clinic schedule per month for past six months; o List of all outside consultations for medical purposes for the past six months, categorized by specialty; o List of individuals: ▪ With tracheostomies; ▪ With fractures, date of fracture, type of fracture (e.g., compound, simple, stress, etc.), bone fractured (i.e., location); ▪ With injuries requiring visit to ER or hospitalization, since the last onsite review; ▪ With pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the last onsite review; o Policies or procedures for medical screening and routine evaluations; o For those over 50, date of last colonoscopy, identification of reason for colonoscopy (i.e., preventive 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 List of all women age 40 or greater with date of birth; o List of all individuals age 50 or greater, with date of birth; o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person (including calcium, Vitamin D, IV bisphosphonate, etc.), date of last DEXA scan or indication if none completed, and copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (e.g., specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (e.g., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake (i.e., based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down syndrome, date of last thyroid test; o For those individuals going to the Emergency Room (ER) and not hospitalized, integrated progress notes from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER and Facility record orders, integrated progress notes/Infirmary progress notes, follow-up to any recommendations, for 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations), for: Individual #324, Individual #201, Individual #65, Individual #409, Individual #99, Individual #13, Individual #19, Individual #190, Individual #63, and Individual #200;

	o For those admitted to the hospital, integrated progress notes from start of signs/symptoms to transfer to ER, ER note, hospital admission history and physical, discharge summary, discharge orders/recommendations from hospital, and Facility record orders, integrated progress notes/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, for 10 individuals most recently hospitalized that have returned for at least 30 days (in order to allow completion of recommendations), for: Individual #175, Individual #324, Individual #375, Individual #430, Individual #381, Individual #182, Individual #226, Individual #296, Individual #416, and Individual #73; o For these same 10 most recent hospitalizations that have been completed, Hospital Liaison Nurse documentation of hospitalization; o Length of stay for Infirmary admissions for past six months, if applicable; o Infectious disease data per quarter by category of infection, for last two quarters; o Summary report or trend analysis of infectious disease/communicable disease, for last two quarters; o Avatar pneumonia tracking forms for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (i.e., amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: a) pneumonia; b) decubitus ulcers; c) urinary tract infections (UTIs); and d) bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) for past year for individuals who have been newly diagnosed with: a) malignancy; b) cardiovascular disease; c) diabetes mellitus; d) sepsis; e) bowel obstruction or bowel perforation; and f) pneumonia; o List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o All policies and procedures related to seizure management; o A list of individuals being treated for seizure disorders, including name of individual, residence/home, diagnosis (i.e., type of seizure), and medication regimen; o For past six months, for four individuals, documentation of seizure management (e.g., neurologist's notes), for: Individual #336, Individual #448, Individual #89, and Individual #158; o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the Monitoring Team's last visit; o List of those with status epilepticus, since the Monitoring Team's last visit; o List of those going to ER for uncontrolled/prolonged/new onset seizure, since the Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals on one, two, three, four, and five antiepileptic

	drugs (AEDs); o Numbers and percentages of persons on older AEDs (i.e., Phenobarbital, Dilantin, Mysoline, Felbamate); o Any tracking of data for individuals who have transitioned to community since the Monitoring Team's last visit, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided. Any documentation of the final transfer between Post-Move Monitor and community service coordinator at 90-day transfer; o For the three individuals most recently transitioned to the community for at least 90 days, seven, 45, and 90-day post-move monitoring reports. For these three individuals, copy of Community Living Discharge Plan (CLDP), most recent ISP, BSP, and subsequent addendums, most recent annual medical exam and most recent nursing assessment for: Individual #350, Individual #165, and Individual #156; o Since the Monitoring Team's last visit, any ethics committee meeting minutes, with attendance rosters, concerning DNR decisions/changes; o Dates of last two completed annual medical assessments and annual physical examinations for all individuals; o Dates of last two completed quarterly medical reviews/IPNs completed for all individuals; o For specialty clinic appointments (on campus and off site), list of appointments that were completed and ones not completed (with reasons); o Numbers of individuals with a diagnosis of seizure disorder on no anti-epileptic medications; o Number of individuals with VNS in place, date of placement, date of replacement, if applicable; o For concerns identified needing closure at medical morning meetings for period of 30 to 60 days prior to the Monitoring Team's visit, any documents providing evidence of closure (e.g., minutes of medical staff meeting, copy of ISPA addressing concern, etc.); o For the last five individuals to whom pre-treatment sedation was administered for a medical procedure, all information related to medical pre-treatment sedation used, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries, including information for following individuals: Individual #123, Individual #394, Individual #202, Individual #414, and Individual #98; o Two most recent PNMT recommendations with physician orders, for: Individual #65, Individual #341; o ISPAs addressing missed appointments or refusals for the past three months (for mammograms and colonoscopies); o List of missed medical appointments with reasons for past six months; o Action Plans Follow up by QA: Internal and External Medical and Medical Management Audits for Round 6; o Presentation Book for Section L; o DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011;

	o For women age 21 to 70, list of individuals with date of last pelvic exam (including whether attempted but unsuccessful), date of last pap smear with determination of adequate reading, sufficient sample, etc., (including whether attempted but unsuccessful), and individuals for whom a pap smear was not indicated (including reason); o For each PCP, two most recently completed quarterly medical reviews from each assigned residence, including those for: Individual #355, Individual #266, Individual #279, Individual #351, Individual #417, Individual #290, Individual #32, Individual #152, Individual #432, Individual #204, Individual #184, Individual #339, Individual #366, Individual #214, Individual #168, Individual #406, Individual #374, Individual #78, Individual #213, Individual #246, Individual #284, Individual #224, Individual #42, Individual #30, Individual #198, Individual #215, Individual #22, Individual #100, Individual #97, Individual #408, Individual #35, Individual #118, Individual #67, Individual #99, Individual #272, Individual #436, Individual #5, Individual #227, Individual #402, Individual #458, Individual #359, Individual #288, Individual #2, Individual #7, Individual #36, and Individual #337; o Minutes of the medical morning meeting for 11/6/12, 11/7/12, and 11/8/12; o For the last year, lists of individuals who have been: seen in the Emergency Room, including the date seen at the ER, and the reason for visit; admitted to the hospital, including date of admission, reason for admission and discharge diagnoses, and date of discharge from the hospital; admitted/transferred to the Facility's Infirmary, including date of admission /transfer, reason for admission/transfer, and date transferred back to home unit; o For each of the following individuals, copies from the active record: DG-1, most current annual medical assessment and physical exam; preventive care flow sheet; most current nursing assessment; past year of IPNs; past year of lab results, x-rays, scans, Magnetic Resonance Imaging (MRIs), and ultrasound reports; hospital discharge summaries for past year; ER reports for past year; consults and procedure reports past year; DNR forms, if applicable; physician orders past year; most recent ISP and subsequent addendums; most recent BSP; and past three medical quarterly reviews: Individual #92, Individual #366, Individual #426, Individual #180, Individual #381, Individual #398, Individual #234, Individual #302, Individual #22, Individual #378, Individual #31, Individual #239, Individual #90, Individual #402, and Individual #62; o AUSSLC Quality Assurance Monitoring for Section L, undated; o For the self-assessment process for Section L, list of monitoring/audit tools used, for each tool the number of the eligible population to be sampled, the number included in the sample (the percentage of the eligible population sampled), the method used to determine how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor/survey/review, and any inter-rater reliability data analyzed for the audit/monitoring review; and o For the self-assessment process for Section L, the databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, documentation of the

	frequency of the data collection. ▪ **Interviews with**: o Chrishanthi Perera, MD, Medical Director; o Archie Smith, MD, PCP; o Alfredo Cisneros, MD, PCP; o Holi Sadler, MD, PCP; o Jodie Friedricks, FNP, PCP; o Curtis Walters, QA Director; and o Kim Ingram, Director of Habilitation Therapy Services. ▪ **Observations of**: o Individual #351, Individual #72, Individual #366, Individual #450, Individual #390, Individual #347, Individual #34, Individual #269, Individual #328, Individual #102, Individual #191, Individual #381, Individual #398, Individual #268, Individual #434, Individual #174, Individual #22, Individual #171, Individual #100, Individual #16, Individual #182, Individual #422, Individual #196, Individual #31, Individual #299, Individual #323, Individual #239, Individual #405, Individual #186, Individual #117, Individual #310, Individual #212, Individual #456, Individual #331, Individual #62, Individual #330, Individual #222, Individual #18, Individual #188, and Individual #363; o Medical morning meetings, on 11/6/12, 11/7/12, and 11/8/12; and o QA QI Council Meeting, on 11/8/12.
	Facility Self-Assessment: For Section L, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the external and internal monitoring tools developed for the non-facility physician review required by Section L.2. o These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the breadth of this section of the Settlement Agreement. These external and internal medical and medical management audits provided an initial step for monitoring quality of care, but needed expansion into all of the Settlement Agreement requirements for Section L. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews. o The AUSSLC Quality Assurance Monitoring chart and the Self-Assessment Process for Section L identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples for the general medical audit. However, the population base varied for the medical management audit. For example, only three records were selected

	for review, regardless of whether the sample population was 30 or 300. This was not adequate for large sample populations. o The questions on the monitoring/audit tools had undergone some changes to improve on the inter rater reliability, as well as provide accurate information for the responses. The Monitoring Team could not determine whether the external peer reviewers were provided instructions. For the internal peer review process, there was no preliminary information concerning the content of any instructions. However, this will be necessary to establish inter-rater reliability, and ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: external peer PCPs from other SSLCs, and AUSSLC PCPs for the internal peer review audits. This was to be changed to a system in which the external peer reviewers were outside physicians that went to all SSLCs. Because there was no exit document from the reviewers, it could not be determined whether the external peer reviewers were from other SSLCs or were non-SSLC reviewers. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. There was no information concerning inter-rater reliability. ▪ There were a number of databases available and the Facility's Self-Assessment indicated some of these would be used in the future as part of the self-assessment process. However, at the time of the review, there seemed to be a lack of documentation of analysis and development of improvement plans based on the analysis. This will be an important consideration as the databases include additional quarters of data. The quality of the data maintained in the databases was noted to be outdated in several examples provided. The actual database structure appeared to be helpful, but the data entry needed focus and review for improvement. ▪ Examples of databases/data sources that were not available or not considered included attendance tracking at medical morning meetings, tracking reasons for missed appointments, and updated preventive screening tracking. ▪ The Facility did not have much opportunity to provide data in a meaningful/useful way, because many of the databases had not been implemented. In the future, the Facility will need to ensure the summary of data is presented based on specific, measurable indicators, and consistently measures the quality as well as presence of items. ▪ All data that was collected and presented was derived from the Medical Department. Data reports were not available from the QA Department. ▪ The Facility rated itself as being in noncompliance with Section L. This was consistent with the Monitoring Team's findings. ▪ The Facility did not have sufficient data available to assist in identifying areas in need of improvement. As mentioned, for data that was tracked, it was often outdated, or if there was data collected, and analyzed, it did not lead to corrective action plans or improvement plans.
	Summary of Monitor's Assessment: In the six months prior to the Monitoring Team's most recent onsite review, progress had been made in numerous areas of medical care and oversight. The medical morning

	meeting had become a well-developed structure that processed changes in health status promptly. These meetings included quality interdisciplinary discussion that was documented. The PCPs provided current and detailed information on acute care issues, with succinct follow-up plans. The Hospital Liaison Nurse also provided updated information that assisted the morning meeting attendees to discuss current issues in a timely manner. The meeting was facilitated efficiently. However, there was need for more delegation of follow-up activities either through assignment of tasks to a meeting attendee, identification of the need for an open record review, or referral of a specific request to the IDT for response. In addition, focus on preventive aspects of care was needed at both the medical morning meeting, and when teams met to discuss ISPAs to address referrals from the medical morning meeting. Time lines to closure needed to be tracked, with most items closed by the end of the month, unless initiated in the last week of the month. Acute care PCPs provided appeared appropriate. However, there was need to begin to monitor specific diagnoses for assessment and treatment, using the clinical guidelines or other national standards as a basis for review. The Ethics Committee was well developed, and had the necessary components to make a decision based on regulatory standards, required documentation, and input from family/guardian and Facility personnel. Attendance was taken and minutes were recorded. Follow-up assignments from the Ethics Committee required improved documentation to closure. One area for which too many conflicting databases existed was pneumonia. Accurate information from these various databases should be condensed into one database to ensure completeness and uniformity. The QA Department did not have a presence in the oversight of the quality of medical care, despite established expectations for QA Department follow-up of external and internal medical peer review audit recommendations. Tracking of corrective action plans did not appear to have a QA component. Overall, there were many new and innovative steps being taken to develop a system of quality medical care and oversight, as well as a quality interdisciplinary system response to acute and chronic needs of the individual. However, the Medical Department was in the initial stages of this complex endeavor, but appeared to have the vision and skill to continue making progress toward these goals. The Facility remained noncompliant with Section L.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, and Do Not Resuscitate Orders.	Noncompliance

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	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.	<u>Staffing and Administration</u> For the census of 326 (as of 10/9/12), there were five PCPs responsible for this population. The Medical Director had a caseload of 17, and supervised a Family Nurse Practitioner (FNP) with a caseload of 57. Other PCPs had caseloads ranging from 82 to 87. There was no vacancy in the department. Since the Monitoring Team's last visit, one PCP was new to the Facility. One of the PCPs was leaving AUSSLC, and a replacement had been recruited. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was submitted 10/9/12, and appeared to have a typographical error. According to the list, of the primary care providers in the department, four out of five (80%) were current in CPR. For one PCP, the date of completion was 6/26/12, and the date of expiration was 6/12. This needed further clarification. The four LVNs and two respiratory therapists in the Medical Department also were current in CPR certification. Of the five PCPs in the Medical Department, a list of CME credits was submitted for four of these PCPs. Over the prior six months, this varied from 10 to 34.5 hours. The purpose of reviewing CME was to determine if the CME focused on diagnoses and topics that would enhance the practice patterns of the PCPs at the Facility. The topics that were covered included a wide range of subjects of which a sample is listed here: delirium review, long-term care/hospice interface, reducing the inappropriate use of antipsychotics in behavioral and psychological symptoms of dementia, physiology of aging, osteoporosis and falls update, improving transitions of care, anticoagulation issues in long-term care facilities, late life depression, wound care update, onychomycosis, treatment of delay of gastric emptying, preventive medicine in adults, evaluation and treatment of premenopausal osteoporosis, manifestations of hyponatremia and hypernatremia, odontogenic infections, developmental defects of the tooth, prevention and control of MRSA, acute treatment of migraine, medical care of diabetes mellitus, antiphospholipid syndrome, subdural hematoma, hypertriglyceridemia, herpes zoster, anti-epileptic drugs and bone disease, management of epilepsy, failure to thrive in elderly adults, subclinical hypothyroidism, various aspects of developmental disabilities (history, terminology, tracking seizures, communication, assembling accurate clinical information, etc.), hepatitis C, evaluation of secondary hypertension, coarctation of the aorta, hypercalcemia, clindamycin overview, treatment of hypercalcemia, patterns of drug induced liver injury, evaluation and management of thrombocytopenia, initial evaluation and management of transient ischemic attack and minor stroke, hemolytic anemia, anemia in the older adult, prevention of arthropod and insect bites, Prader Willi syndrome, treatment of a scalp eruption, classification of sleep disorders, recurrent urinary tract infections in women, diuretics and magnesium balance, deep vein thrombosis and pulmonary embolism, and metabolic syndrome.	

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		The majority of the topics that were covered included areas of importance to primary care and the individuals residing at AUSSLC. It was noted that one PCP did not have any continuing education credit submitted. <u>Physician Participation In Team Process</u> For the three medical morning meetings a member of the Monitoring Team observed, there was a signed attendance roster in three of three meetings. However, there was no typed attendance list with titles, and the signed attendance rosters were difficult to interpret at times. Departments represented at the medical morning meeting on a daily basis included: Medical Department, Pharmacy, Psychiatry, Dentistry, Hospital Nurse Liaison, PT, and/or PNMT. On 11/6/12, it was announced that due to a conflicting meeting, nursing was not present with the exception of the hospital liaison nurse who provided a report. The Campus Coordinator Log was not reviewed due to absence of nursing. However, other nurses' signatures were listed on the attendance log. It was not clear the degree to which these nurses were in attendance or participated. It is recommended that the Medical Compliance Nurse or delegate have a checklist to verify those that attended the entire meeting, or only partially attended, and compare this list to the signed attendance list. It is also recommended that statistics be developed to determine the percentage attendance by the various departments at the morning meeting. The statistics would provide additional evidence of inter-disciplinary integrated discussion at the morning meetings. For the three medical morning meetings observed, there were four instances of individuals being hospitalized. The Infirmary census ranged from three to four. As part of the content of the daily meeting, specific additional topics were covered each day as a weekly review, such as PNMT, PT/OT, etc. Based on the Monitoring Team's observations and review of documentation: ▪ There were no cases in which an assignment was given to a meeting attendee to bring information back to the morning meeting in response to a critical clinical question focusing on prevention that was raised/identified as needing closure. For instance, one individual was hospitalized for pancreatitis, but no assignment was made to the pharmacy to review the medication regimen and provide written documentation of any significant association with pancreatitis or the development of cholelithiasis, nor was an assignment made to an IDT member to review prior illness/labs or any risk factors for cholelithiasis or pancreatic disease (e.g., family history, etc.). ▪ For five cases, inter-disciplinary discussion occurred concerning reason for the	

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		illness, review of clinical information from specific departments, and additional steps to be taken to treat the individual. For one individual, although the problem was identified (fracture), there was detailed focus on post-fracture care. However, no discussion occurred about preventing another fall (i.e., no discussion of supervision level, increased supervision when on uneven terrain, behavior interventions, etc.). ▪ As a subset of those hospitalized, for those with aspiration pneumonia, reactive airway disease, recurrent pneumonia, respiratory failure, or sepsis with undetermined etiology, in none of three cases were assignments made for an open record review for the prior seven to 14 days of the illness to review monitoring of care, positioning documentation, feeding concerns, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the PNMT, listing of preventive areas to be considered based on the diagnosis causing the acute illness, adequacy of medical evaluation or need for further consultation, review of medication and medication side effects, etc. ▪ No open record reviews were discussed during the three medical morning meetings. ▪ There were no prior concerns for which information was brought back to the medical morning meeting for closure. ▪ No brief summary was provided of any ISPAs that had been assigned to IDTs for response to concerns the medical morning meeting group had referred. ▪ During the three medical morning meetings, no infection control updates were presented. ▪ During the three medical morning meetings, no summaries were presented of completed consultations from the prior day. ▪ The Dental Department provided brief updates during three of three medical morning meetings. ▪ The PT and PNMT presented updates during three of three medical morning meetings. ▪ Skin integrity reports were provided at one of three medical morning meetings. Additionally, one individual admitted to the Infirmary also had skin concerns reflected in an interdisciplinary discussion. ▪ For none of three medical morning meetings, a discussion of those individuals with significant weight loss or gain occurred. ▪ The Hospital Nurse Liaison reported an update for four of four hospitalizations during the three observed medical morning meetings. ▪ For the three medical morning meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in three meetings. ▪ The attending PCP for the individual (when not the on-call PCP) participated in the discussions of health status changes/on-call concerns in three of three meetings.	

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		▪ For the three medical morning meetings observed, no assignments for further updates were identified. For the prior month, there were 19 concerns needing closure that were identified. Of these, 13 (68%) were closed. The strengths noted at the medical morning meeting included the following: ▪ Attendance was multi-disciplinary. ▪ Facilitation of the meeting was efficient and effective. ▪ A schedule was set for the week for special reports (e.g., PNMT, infection control, PT/OT, etc.) ▪ Integrated clinical care was reflected in several discussions. ▪ These discussions were documented in the medical morning meeting minutes. ▪ The PCPs had detailed and up-to-date knowledge of the individuals being discussed. The PCPs made acute care rounds prior to the meeting. This additional information was shared at the medical morning meeting. ▪ The Hospital Liaison Nurse reports were current. ▪ The minutes of the medical morning meeting were available after the meeting. Weaknesses and concerns included: ▪ From the minutes, it was difficult to determine the discussion that occurred on any one day. The minutes were formatted as a running commentary for each individual, and were not formatted according to the business each day. Minutes were created for the week, rather than each day. This made it difficult to match the observations and activity of the meeting for any particular day to the minutes. It is recommended that minutes be completed on a daily basis. Each daily meeting should be a "stand alone" document. ▪ A focus on prevention was needed, including, as appropriate, assignments to attendees of the meetings, as well as IDTs. ▪ For all unplanned hospitalizations (e.g., hospitalizations not for completions of tests, planned surgery, etc.), open record reviews should have been conducted for the seven to 14 days prior to the hospitalization. ▪ Percentage attendance per month by discipline should be calculated. ▪ Numbers of concerns needing closure, and the route of closure (e.g., assignment of open book review, ISPA, etc.) should be tracked. ▪ Brief summaries of the ISPAs that were requested should be read to the morning meeting to determine if the IDT response was adequate. If responses are not adequate, further action should be requested from the IDT. ▪ There should be tracking of the timing of the ISPA request to ensure the IDT meets, an ISPA is written, and is brought back to the medical morning meeting within five days.	

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		▪ Consult reports should be summarized by the Medical Compliance Nurse/delegate at the medical morning meeting. ▪ All closure concerns should have written documentation as evidence of the closure. ▪ Percentage concerns identified that were closed per month should be calculated. ▪ Percentage concerns identified that remained open at the end of the month should be calculated. ▪ As data is collected, a quarterly report summarizing the business of the medical morning meetings should be created. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted. Individuals with no prior annual medical assessment date were excluded (10 individuals), as well as those for whom the dates were interpreted as a database error (three individuals). The number of individuals remaining for whom the two most recent dates of completion for the annual medical assessments were available totaled 313 individuals. Of these, 179 out of 313 (57%) of the recent annual medical assessments were completed within 365 days of the prior assessment. Of the 323 individuals listed with current medical assessments, 296 of the 323 (92%) were considered current and had been completed within the prior 12 months. For 21 individuals, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical examination evaluation were submitted for review. Based on review of these documents, the following findings were made: ▪ 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 21 individuals, 20 were in compliance (95%). ▪ An interval history was included as part of the document in 18 of 21 reviews (86%). ▪ The major active problems listed had plans of care addressing each of these problems in 21 of 21 assessments (100%). ▪ All 21 (100%) addressed smoking history. ▪ Family history was adequate/helpful in nine of 21 (43%). ▪ A discussion of requirements for transition to the community was included in 20 of 21 (95%). As part of the monitoring review process, the Monitoring Team selected the medical records of 15 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. Individuals selected were documented to have one or more high-risk rating(s) in relation to the various	

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		health categories. This sampling was done to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included preventive care flow sheet, physician orders for the prior one year, integrated progress notes for the prior one year, the most recent three quarterly medical reviews, most recent BSP, last annual ISP and subsequent addendums, labs, x-ray reports for the past one year, the integrated risk rating form, the most recent health care management plan/risk action plan, the most recent annual medical assessment and physical exam, DNR forms if applicable, the DG-1, the most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From 15 medical records reviewed: ▪ Fourteen of 15 (93%) annual medical assessments had been completed in the prior 365 days. There was one annual medical evaluation for which the date at the start of each page was dated 4/13/10, but the initial page indicated the accurate date of 9/14/12. ▪ Active problem lists appeared to be thorough in 15 of 15 (100%). ▪ Fourteen of 15 (93%) had information about smoking history. ▪ A family history was documented (or attempts at obtaining this information) in six of 15 (40%) records. For one of 15, there was documentation of no family history available due to no existing family. ▪ Eight of 15 (53%) had information discussing requirements for transition. ▪ The DG-1 forms were reviewed. Of the 15 DG-1s reviewed, nine (60%) had updated diagnoses. These 15 medical records also were reviewed to determine whether the physician IPN note used the SOAP format. In 15 of 15 (100%), the SOAP format was used, and included date and time on the IPN. Twelve of 15 medical records (80%) had a PCP quarterly review of medical progress during any quarter in the prior year. For any one quarter of the year, one would anticipate one annual assessment for one quarter of the individuals and a quarterly medical review for three quarters of the individuals. For the past one year, one would expect 15 annual assessments and 45 quarterly medical reviews. Submitted were 19 quarterly medical reviews, for a compliance rate of 19 out of 45 (42%). The Facility submitted a list of the dates of the quarterly medical reviews completed over the prior nine-month time period. There were 326 names listed for 475 quarterly	

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		medical reviews. For 326 names, one would estimate that a quarter of these would have an annual medical evaluation to replace a quarterly medical review each quarter of the year. This would mean 245 quarterly medical reviews should occur per quarter, or 735 in three quarters. The total number submitted for the three quarters was 475 (65%). It was noted that this calculation did not account for those that were no longer at the Facility due to transfer, transition, etc. However, this estimate was based on the data provided. Additions or deletions in numbers would not have a major impact on the final value that showed a considerable lack of compliance with this requirement. It was also noted that the annual medical assessments in some instances was not synchronous with the quarterly medical reviews and were completed in addition to a quarterly medical review. The Facility submitted 46 quarterly medical reviews. It was noted that a template was used per PCP, but that this varied among PCPs. The following summarizes the findings from this review: ▪ Of the 46 reviewed, two of 46 (4%) included the date of the quarterly review completion. This was problematic, because it could not be determined if they were completed in a timely manner. If not completed on a quarterly basis, they would not be available for timely review by IDT members and would have little value. None were signed, which might have meant they were stored on a computer system. However, their accessibility to others potentially would be limited, and they would not be readily available in the record as part of a transfer packet to the ER, etc. ▪ Major diagnoses were listed in 46 of 46 (100%). ▪ Changes in medication in the prior quarter were documented in 46 of 46 (100%). ▪ The most recent three serial weights (if available) were documented in 43 of 46 reviews (93%). ▪ When a seizure disorder was present, the date of the most recent seizure and frequency of seizures appeared to be documented. ▪ Consultations were documented in 42 of 46 reviews (91%). ▪ ER visits, hospitalizations, and Infirmary admissions were recorded. ▪ There appeared to be a lack of documenting significant test results (e.g., scans, mammograms, blood work). At times, the review documented the test or procedure was completed, but no other information was recorded. ▪ The template was completed in 15 of 46 (33%). There were several areas at the end of some of the templates that remained blank. The three quarterlies would potentially make completion of the annual medical assessment easier, in that the entire year of data would not necessarily have to be reviewed, but only the time period from the last quarterly review. The quarterly medical	

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		review was also potentially a tool to be used to ensure all significant areas were identified, and if there was a new finding based on the review, such as a trend of weight gain or loss, this would then be addressed as part of the summary finding. There were no findings in any of the 46 reviews that were followed by further review or evaluation/tests or treatment that was documented during the review process, or areas that were considered to need further review by the IDT. Overall, although it required considerable time and concentration to complete, it appeared that the quarterly medical review might not have been accessible to the IDT, was not complete, and might not have been utilized to its potential value. The process and content of this form should be reviewed to ensure it is of value to the PCPs and IDTs in caring for the individuals. Separately, the Medical Department had a database entitled "AMA, APE, Quarterly Tracking" for Annual Medical Assessments, Annual Physical Exams, and medical quarterly reviews. According to the document, the information was current as of 10/30/12. There was no accompanying analysis or report of findings, or information regarding whether this was shared with the Medical Department staff or generated any corrective action plans. Information from this database would be useful as part of a quarterly report from the Medical Department in providing the completion rate of these periodic routine evaluations. <u>Access to Specialists</u> As part of the database tracking system, a number databases recorded the individuals' onsite clinic visits, along with the date of the visit, and the reason. These clinics included podiatry, optometry, ophthalmology, eye clinic, ear nose throat (ENT) clinic, orthopedics, gynecology, general surgery, neurology, gastroenterology (GI) screening clinic, and gastroenterology clinic. A number of offsite procedures and consultations also were recorded in a database, including colonoscopies, mammograms, and bone density. Missed appointments were also tracked, and the spreadsheet provided room to record the reason for the missed appointment. The clinics that were tracked for missed appointments included optometry, orthopedics, ENT, eye clinic, gynecology, gastroenterology, neurology, surgery, and podiatry. Although this appeared to be a complete list of individuals with appointments completed and reasons for not attending, it did not provide any information as to how the Medical Department was using this valuable source of information in improving the care of the individuals. For instance, requesting IDTs meet to create ISPAs to address missed appointments would be a helpful action step, followed by implementation of the ISPA, and tracking of the outcome. These next steps could be included in the spreadsheet to determine success of the ISPA implementation. Whether a PCP IPN was completed, and completed within five days of receiving the report, could also be added to the spreadsheet.	

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		The offsite appointments were submitted by chronologic date, and not by specialty. The following appointments were completed per month: May 2012 – 24, June 2012 – 18, July 2012 – 27, August 2012 – 29, and September 2012 – 22. Based on this information, he total number of appointments completed was 120. The total number of appointments scheduled was 159, including 120 kept and 39 missed appointments. The completed appointment rate was 120 out of 159 (75%). The following numbers of appointments per specialty were scheduled. As the list provided was according to physician name or building name, some appointments were not included in the specialty numbers. It is recommended that the Medical Department have a method to identify the specialty rather than a physician name or group practice name, etc. The following information was what the Monitoring Team could determine based on the list submitted of off site appointments: ▪ Cardiovascular - 11 appointments; ▪ Dermatology - seven appointments; ▪ EEG - 13 appointments; ▪ Endocrinology – three appointments; ▪ ENT – two appointments; ▪ General surgery – three appointments; ▪ Gynecology – three appointments; ▪ Hematology – 17 appointments; ▪ Infectious disease – two appointments; ▪ Nephrology - nine appointments; ▪ Ophthalmology - two appointments; ▪ Orthopedics – two appointments; ▪ Radiation oncology - two appointments; ▪ Rheumatology - three appointments; ▪ Sleep study - six appointments; ▪ Urology - 19 appointments; and ▪ Wound care – two appointments. Of the 39 appointments missed, 11 occurred in May 2012, 11 occurred in June 2012, five occurred in July 2012, six occurred in August 2012, and six occurred in September 2012. Seven of these were due to refusals. The most common reasons for missed appointments included lack of consent (three), inadequate preparation for procedure, or lack of pre-visit lab/test results (nine), medical illness (seven), and Facility concerns involving staffing, transportation, and scheduling conflicts (eight). Separate from the specialty consultations, individuals were scheduled for IV Reclast on an outpatient basis. Seventeen individuals were scheduled from May through September	

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		2012. There was documentation that for one individual, the appointment was missed. For two other individuals, there was lack of information provided. There was documentation that 14 of 17 (82%) completed this scheduled outpatient procedure. On site, several specialty clinics were held to meet the needs of the individuals. Information was derived from several separate submitted documents. It was not clear the reason for the discrepancies in clinic dates. Percent show rate could only be approximated, because the number of appointments scheduled, appointments completed, and appointments not completed were not considered complete data. On site clinics occurred on the following dates. ▪ Eye Clinic: 4/13/12, 5/11/12, 6/8/12, 7/13/12, 8/10/12, and 9/14/12; ▪ ENT Clinic: 4/12/12, 4/26/12, 5/10/12, 5/24/12, 6/7/12, 6/21/12, 7/5/12, 7/31/12, 8/16/12, and 8/30/12; ▪ GI clinic: 4/10/12, and 8/14/12; ▪ GI screening clinic: 6/22/12, 8/3/12, 8/31/12, and 9/21/12; ▪ Gynecology clinic: 4/27/12, and 5/25/12; ▪ Neurology clinic: 4/9/12, 4/23/12, 4/30/12, 6/18/12, 6/25/12, 7/9/12, 7/16/12, 8/20/12, 9/17/12, and 9/24/12; ▪ Optometry: 4/18/12, 5/16/12, 6/20/12, 7/18/12, 8/15/12, and 9/19/12; ▪ Orthopedics Clinic: 4/16/12, 5/7/12, 5/21/12, 6/11/12, 7/2/12, 7/30/12, 8/13/12, and 9/24/12; ▪ Podiatry Clinic: 4/18/12, 5/23/12, 6/20/12, 7/18/12, 8/15/12, and 9/19/12; and ▪ Surgery Clinic: 4/9/12, 5/14/12, 6/11/12, 6/25/12, 7/9/12, 7/23/12, 8/13/12, 9/10/12, and 9/24/12. Information submitted indicated that 664 appointments were made. Of these 498 appointments were completed (75%), and 166 appointments were missed. It was noted that this was an incomplete list, because some clinic lists were cut short during copying. The missed appointments included some April appointments, and the completed list did not include April 2012 appointments, and might have cut off some May appointments as well. The completed appointment list did not include the ENT clinic. It is recommended a complete and accurate tracking system for on and off-site clinic appointments be created that the Medical Department can use to determine trends and strategies to reduce the missed appointment rate. Of the appointments missed, reasons included: refusals (20), scheduling and communication (13), and reason categorized as not submitted, unknown, or reason left blank (118). The significant number of missed appointments with unknown reasons indicated the need for further system development to determine the cause of the missed appointments.	

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		The quality of the consultation referral process is reviewed as part of the peer review process. This is discussed in further detail with regard to Sections L.2 and L.3. In addition, the Monitoring Team's findings with regard to follow–up on consultations are discussed with regard to Section G.2. <u>Preventive Care</u> Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in 14 out of 15 active records reviewed (93%). Preventive care flow sheets were up-to-date in nine out of 15 records reviewed (60%). Current vision screening was documented within the prior 12 months in 11 out of 15 of the records reviewed (73%), and in 15 of 15 within the prior 24 months (100%). Audiological screening occurred in seven out of 15 records reviewed (47%) in the prior year, in 11 of 15 records reviewed (73%) in the prior two years, and in 14 of 15 records reviewed (93%) in the prior three years. With regard to immunizations: ▪ The influenza vaccination had been given to 14 of 15 individuals (93%) in a timely manner during 2012. One individual refused the influenza vaccine. It was not clear if the IDT met to create a plan, or whether there were repeated opportunities to offer the vaccine. The draft ISP of 11/5/12 did not provide a plan, and the IRRF only mentioned that compliance would be encouraged. ▪ 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 11 of the 15 (73%) active records reviewed. It was noted that an additional three individuals had orders for the varicella titer or vaccine. ▪ Whether the individual needed to receive a hepatitis B vaccine (depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or being tracked for completion), was recorded in 14 of the 14 active records reviewed (100%). One additional individual was a hepatitis B carrier. A list was submitted indicating 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 128 women were identified as being over the age of 40. Of these, there were 13 women aged 70 or greater. The DADS SSLCs policy "Preventive Health Care Guidelines," dated 8/30/11, was to be followed, which meant individuals over the age of 70 did not need mammograms. Of the 115 eligible women, 12 had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for	

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		the test, etc.). Of the remaining 103 women, 88 had mammograms within the prior year. This was a compliance rate of 88 out of 103 (85%). A report was submitted entitled "Client Preventative Screening Tracker," which included the most recent date of mammogram for eligible women at AUSSLC. However, the database did not appear to be current. According to the Medical Department, the preventative care database tracking system was a collaborative effort with the State Office, development was ongoing, and implementation was expected by December 2012. According to the snapshots of the database menu provided, once data was implemented, and training of staff completed, this program potentially had great value to the PCPs, as well as the Medical Department Administration in analyzing trends. As an example, under the "Weight Information" section of the database, it was noted: "All weight information is extracted from Avatar entries the facilities do each day. BMI is calculated to show over/under/obese/normal weight." This information will be available to the PCP (with BMI calculation) from the PCP's office without having to retrieve the active record. Once the database is established, the limiting factor would be the timeliness and accuracy of database entry management. There was no information presented regarding how the timeliness and accuracy of database entry would be monitored. From the sample of 15 medical records reviews, six females were between the ages of 40 and 70. Of these, two had reasons for not pursuing a mammogram. Of the four for whom a mammogram was recommended, four (100%) were up-to-date on mammogram testing. From the sample of 15 active records reviewed, there were seven females ages 21 to 65. Six of seven (86%) had pap smears completed within the prior three years. The Medical Department had developed a plan to begin to include information concerning the date of the last pap smear, in a database entitled "GYN Clinic Spreadsheet," but there was no complete report for all women at AUSSLC available at the time of the request. Additionally, a separate database was submitted entitled "Client Preventative Screening Tracker" that included the date of the most recent pap smear. However, no data had been entered into this field at the time of submission. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, with the reason for the colonoscopy. A total of 217 names were submitted. Of these, 16 were over the age of 75 and for one there was a data entry or typographical error that the individual could not be included in the data. Six had clinical contraindications or family /guardian refusals of consent. Therefore, the eligible population reviewed was 194 individuals. Of these, 138 (71%) completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical	

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		equivalents. Of the 16 individuals for whom a colonoscopy or clinical alternative was indicated after the age of 75, five of 16 (31%) had completed an appropriate procedure within the prior 10 years. This included four as a preventive test, and one as a diagnostic test for an active problem. Of the 15 active records reviewed, there were 11 individuals over the age of 50. Three of these were currently age 50, and would not necessarily have had a colonoscopy completed at the time of the active record review. Of the eight remaining, one had a clinical reason for not pursuing a colonoscopy. Of the seven remaining, six (86%) had a colonoscopy completed in the past 10 years. A database was submitted entitled "Client Preventative Screening Tracker," which included the dates of the most recent colonoscopies for individuals at AUSSLC. However, the data was not current. 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 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. A total of 155 individuals' DEXA scans and medication profiles were submitted for review. The raw data was submitted and reviewed. ▪ Of these, six of the readings were interpreted as normal. The remaining 149 had either osteoporosis or osteopenia (102 had osteoporosis). ▪ For these 149 individuals, 84 of the DEXA scans (56%) were considered current (completed within the prior three years). ▪ Of the 149 individuals, 134 (90%) were treated with a bisphosphonate or alternative medication to treat or prevent osteoporosis. ▪ Of the 149 individuals, 138 (93%) were treated with calcium supplementation. ▪ Of the 149 individuals, 137 (92%) were treated with Vitamin D supplementation. The above information summarized a volume of raw data. Separately, in the Presentation Book for Section L, the Medical Department provided a report for osteoporosis treatment and monitoring, in a database entitled "Client Preventative Screening Tracker." The data did not appear to be updated. However, once current information is included in the database, the document would be useful for analysis and	

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		guidance to the Medical Department. It is recommended that this database be reviewed for accuracy, completeness, and to ensure it includes current information. In the future, it also should accompany any submission of raw data for osteoporosis/osteopenia. Requested for each individual with osteopenia or osteoporosis was any documentation of analysis of daily calcium intake based on diet, average percentage of meal ingestion, feeding formula, etc., to determine the need and amount of calcium supplementation. The Medical Department was unable to provide this documentation. It is recommended that the Dietary Department assist in determining intake of calcium for these individuals with osteopenia and osteoporosis, to assist the PCPs in determining whether calcium supplementation is indicated, and if so, the amount of calcium supplement which the Dietary Department recommends. From the sample of 15 medical records reviewed, 13 completed a DEXA scan. ▪ Of these, 12 of 13 (92%) had a DEXA scan/T score recorded. ▪ Of these, 11 of 12 (92%) had a T score consistent with the diagnosis of osteoporosis or osteopenia. ▪ Of these 11, 11 of 11 (100%) had been prescribed supplemental calcium and vitamin D. ▪ Of these, five of 11 (45%) had a bisphosphonate ordered. ▪ Of these, two of 11 (18%) had Miacalcin prescribed, ▪ Of these, four of 11 (36%) had Prolia prescribed for treatment of osteoporosis or osteopenia. There were two DEXA scan reports indicating prior reports of osteopenia/osteoporosis that had not been repeated in over three years to determine effectiveness of treatment. Treatment was consistent with national and SSLC clinical guidelines. However, monitoring effectiveness at periodic intervals needed review. A list of individuals with Down syndrome was submitted, along with the date of the last thyroid test. A total of 17 individuals were identified with a diagnosis of Down syndrome. From 10/1/11 through 10/1/12, 17 of 17 (100%) had a current thyroid test. A template (untitled) was submitted listing the preventive care provided, whether indicated/contraindicated, and justification/explanation of contraindication. There was no accompanying document to provide an interpretation of this template and how the PCP was to use it, and/or whether it had been implemented. In the 15 active records reviewed, this template was not noted. <u>Acute and Emergency Care</u> The Facility submitted a list of individuals that presented to the ER from 5/1/12 through	

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		9/30/12. The numbers listed per month were as follows: May 2012 – 20, June 2012 – 20, July 2012 – 21, August 2012- 24, and September 2012 – 32. Reasons for the ER visit or hospitalization were categorized according to body system and chief complaint. According to the information provided, they were for: ▪ Trauma - 20 visits; ▪ Respiratory disease - 24 visits; ▪ Gastroenterology concerns – 25 visits; ▪ Genitourinary concerns - 19 visits; ▪ Behavioral issues – three visits; ▪ Infectious disease - six visits; ▪ Endocrine disease – two visits; ▪ Orthopedics - six visits; ▪ Neurological disease – eight visits; and ▪ Cardiovascular disease – three visits. The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room and returned. These individuals are listed in the documents reviewed section. Seven of the 10 had gone to the ER from their residence. None had gone from the Infirmary to the ER. One had gone to the hospital from the school, one from the workshop, and one from the family car. The following summarizes the results of this review: ▪ Information was submitted indicating that the ER was notified of the arrival of the individual with appropriate medical background information provided for one of 10 (10%) records. ▪ Prior to the transfer to the ER, a PCP was on site for three of these transfers. In two of three (67%) records, the PCP had written an IPN that included the date and time. ▪ For one of two PCP (50%) IPNs, vital signs were recorded. ▪ For two of two (100%), the reason for the transfer was documented. ▪ In two of two (100%), the SOAP format was utilized. ▪ A copy of the ER report was available in none of 10 (0%). ▪ Of the 10 ER visits, diagnostic categories included: trauma/injury - four, respiratory - one, infection - one, behavior - one, and hypotension – one. ▪ When the individual returned to the Facility after evaluation at the ER, nine of the 10 active records (90%) had a PCP IPN. ▪ Of these nine, nine of nine (100%) utilized a SOAP format. ▪ These notes included the date and time in nine of nine (100%). ▪ Vital signs were recorded in six of nine of these IPNs (67%). ▪ A summary of ER information and findings was included in nine of nine PCP IPN notes (100%). ▪ When returning to the Facility, two returned to the individuals' residence, and	

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		eight returned to the Infirmary. ▪ Six of the nine records (67%) had additional PCP notes as follow up to the original concern. ▪ For 10 of 10, treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER. Additionally, 10 active records were reviewed for individuals admitted to the hospital. The following provide the results of this review: ▪ Ten individuals returned to the Facility. No individual died while in the hospital. Of the 10 individuals that returned to the Facility, six (60%) had IPNs post hospitalization. ▪ Of the six post hospital IPNs submitted, six (100%) included vital signs. ▪ Six of six (100%) included date, time. ▪ Six of six (100%) had an adequate summary of hospital events and findings. ▪ Six of six (100%) active records used the SOAP format. ▪ Three of 10 active records of the hospitalized individuals (30%) included a copy of the hospital admission history and physical. ▪ Two of the 10 (20%) active records included a copy of the hospital discharge summary. ▪ Three of 10 active records (30%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. A total of 70% included neither a hospital admission history and physical nor a hospital discharge summary. ▪ Eight of the 10 (80%) included Hospital Liaison Nurse notes for the individuals. A separate request included Hospital Liaison Nurse notes for all 10 (100%) admissions to the hospital. It was not determined if some of the Hospital Liaison Nurse notes had not been filed in the active record, but this discrepancy raised concerns regarding whether they were readily available for members of the IDT to review in the record. ▪ For six of the 10 individuals that returned to the Facility (60%), additional PCP notes were included as part of the follow-up. ▪ Of the 10 hospitalizations, three had gastrointestinal problems, two had genitourinary concerns, three had respiratory concerns, one had a neurological change, and one had an endocrine abnormality. AUSSLC had an Infirmary. The admissions of individuals to the Infirmary over the prior six months was as follows: ▪ April 2012 – 23 admissions; ▪ May 2012 – 20 admissions; ▪ June 2012 - 20 admissions; ▪ July 2012 – 21 admissions;	

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		▪ August 2012 – 24 admissions; ▪ September 2012 – 32 admissions; and ▪ October 2012 (through 10/14/12) - 10 admissions. The length of stay varied from less than one day to 34 days. ▪ The number staying less than one day was 58. ▪ The number staying one day was 12. ▪ The number staying two days was six. ▪ The number staying three days was 16. ▪ The number staying four days was seven. ▪ The number staying five days was 12. ▪ The number staying six days was 12. ▪ The number staying seven to 10 days was 15. ▪ The number staying 11 to 20 days was eight. ▪ The number staying over 20 days was one. The reasons for Infirmary admissions included: ▪ Cardiovascular disease – three admissions; ▪ Endocrine/metabolic disease – three admissions; ▪ Gastrointestinal disease – 34 admissions; ▪ Genitourinary disease – 21 admissions; ▪ Hematologic disease- two admissions; ▪ Respiratory disease – 35 admissions; ▪ Neurological disease – 12 admissions; ▪ Orthopedic concerns – 10 admissions; ▪ Other disease/concerns – 13 admissions; and ▪ Trauma - 14 admissions. The Facility reported that one individual had an acute choking spell requiring a Heimlich maneuver. This occurred on 7/30/12. During the time period from May through September 2012, there were eight fracture incidents. Two events involved fractures of two or more bones. Three fracture incidents occurred in June 2012, two fracture incidents occurred in July 2012, two fractures incidents occurred in August 2012, and one fracture incident occurred in September. Locations of fracture included the upper extremity in four incidents (three fingers, one upper arm), one cervical spine fracture, one with multiple ribs fractured, and two incidents involving lower extremity fractures (both bones of the lower leg, toe). During the time period from 5/9/12 through 9/19/12, 15 individuals made 16 trips to the ER or were hospitalized for injuries.	

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		Clinical pathways The 15 medical record reviews included a review to determine whether the evaluation and treatment of osteoporosis and GERD were consistent with the Facility clinical pathways and/or national professional standards. These are found in the sections reviewing these diagnostic categories. Chronic Conditions and Specific Diagnostic Categories *At-Risk Individuals* Based on a review of 15 individual records for whom assessments had been completed to address the individuals' at risk conditions, one of 15 (7%) included an adequate medical assessment to assist the team in developing an appropriate plan. Lapses occurred in routine documentation, such as preventive care flow sheets, but also in further evaluation of recurrent health problems, such as GERD. The following provides an example of an assessment that was not comprehensive: ▪ Individual #31 had a history of esophagitis in 1995. The individual was currently on a proton pump inhibitor, and had anti-reflux procedures, such as head of bed elevation, and a positioning plan requiring the individual be kept upright for one hour after feedings. The individual also had a gastrostomy tube (G-tube) placement. The individual had Duoneb treatments ordered for wheezing. This individual had a history of periodic wheezing, which might have been a sign/symptom of severe reflux and aspiration. There was no further evaluation to identify the severity of GERD in order to determine the need to modify treatment to prevent chronic reflux with aspiration, to ensure optimal positioning, and/or to rule out a Barrett's esophagus. Such information could potentially assist in determining the need for additional medical or surgical options, or physical management. It was not clear at what point further GERD evaluation was to occur. *Pneumonia* Data was submitted from the Avatar database. Information concerning pneumonias was submitted for the time period from 5/3/12 through 9/2/12. There were 18 pneumonias during this time period, although two of the pneumonias clinically represented one pneumonia, because the date of diagnosis was only six days apart. Adjusting for this information, there were 17 pneumonia diagnoses during this time period in 14 individuals. ▪ Of these 17, 12 were categorized as aspiration pneumonia. Off site physicians diagnosed fourteen of these 17 pneumonias. For three, the location at the time of the diagnosis was not provided. All 17 had a chest x-ray completed. For eight of the 17, the chest x-ray confirmed pneumonia (i.e., three bacterial pneumonias, four aspiration pneumonias, and one not categorized pneumonia). For 12 of the	

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		17, data submitted indicated blood cultures were obtained. Blood cultures were negative in 17 of 17. In summary, supportive evidence was found for the diagnosis of pneumonia of any type for eight of 17. Of these eight, two of the Avatar pneumonia database entry forms had this indicator blank for two positive chest x-ray reports. ▪ According to the database, six individuals were taking nutrition by mouth (PO) at the time of the pneumonia. However, on comparing the dates of the pneumonia and dates of feeding tube placement, the database did not capture that an additional individual was taking nutrition PO prior to the pneumonia, and while hospitalized, underwent feeding tube placement. ▪ For five of the seven, there was documentation of a therapeutic diet with varying textures and fluid thickenings. For two of the seven, the Avatar database did not include this information. ▪ Ten of the individuals had a feeding tube prior to the onset of the pneumonia, including eight of the 10 individuals with gastrostomy tubes and two of the 10 individuals with gastro-jejunostomy tubes (G/J-tubes). The formula flow rate for those with gastro-jejunostomy tubes was continuous. For those with gastrostomy tubes, five utilized an intermittent flow rate, and two utilized bolus feeding. For one individual with a gastrostomy tube, the flow rate was not submitted on the Avatar document. ▪ Based on the development of aspiration pneumonia (or the diagnosis of aspiration pneumonia), four of eight with supportive evidence of pneumonia underwent a modified barium swallow study. ▪ Of the 17 pneumonias in 14 individuals, four had fundoplications (three remotely and one as a result of a recent pneumonia), and two had tracheostomies. The Avatar system had ongoing potential to provide the Facility detailed information about those individuals with diagnoses of pneumonia. Some observations were made of the forms submitted for review. There was only one form signed by the individual completing the form. None of the forms were dated. It appeared in one instance the form was completed long after the incident, which potentially increased errors in completion. There was need for training on accurate and timely completion of this form to ensure quality of the database. From an untitled table, dated 9/24/12, pneumonia cases and aspiration pneumonia cases were listed per month. According to this data, for April 2012, there were six pneumonia cases and four aspiration pneumonia cases. For May 2012, there were two pneumonia cases and one aspiration pneumonia case. For June 2012, there was one pneumonia case and two aspiration pneumonia cases. For July 2012, there were two pneumonia cases and four aspiration pneumonia cases. For August 2012, there were two	

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		pneumonia cases and no aspiration pneumonia cases. For a third data set entitled "Individuals Diagnosed with Pneumonia September 2011 thru August 2012," there was documentation of nine pneumonias (three of which were aspiration pneumonias) in April 2012, three pneumonias (two of which were aspiration pneumonias) in May 2012, three pneumonias in June 2012 (two of which were aspiration pneumonias), six pneumonias in July 2012 (five of which were aspiration pneumonias), and three pneumonias in August 2012 (one of which was an a probable aspiration pneumonia). From a fourth database entitled "Hospital Visits Related to Pneumonia," there were recorded a total of 20 pneumonia cases between April 1, 2012 and September 2, 2012. For April 2012 there were three pneumonias (one of which was aspiration pneumonia). For May 2012, there were five pneumonias (two of which were aspiration pneumonias). For June 2012, there were three pneumonias (two of which were aspiration pneumonias). For July 2012, there were five pneumonias (four of which were aspiration pneumonia). For August 2012, there were four pneumonias (two of which were aspiration pneumonias). There was an aspiration pneumonia documented as of September 2, 2012. This documentation only referred to those hospitalized that were diagnosed with pneumonia, and would not include those treated in the Infirmary only, or at the ER only. Once an individual returned to the Facility or during mortality review as applicable, the Medical Department reviewed test results to determine the most accurate diagnosis causing the acute illness. When a test result was positive in a compatible clinical context, then an accurate diagnosis was made. When test results were negative or provided varying results, then the accuracy of a specific diagnosis remained a challenge. However, this was an opportunity to review comorbid conditions that might have had impact on the illness, as well as the need to provide further testing to provide updated information. An individual with GERD and pneumonia with negative test results or inconclusive information might require a further GERD evaluation to ensure this was not leading to reflux, aspiration, and pneumonia/pneumonitis. An aggressive diagnostic work-up might be necessary to rule out such comorbid conditions as GERD or congestive heart failure, as examples. The hospital evaluation might provide the initial work-up, but if results are not conclusive, then the PCP is challenged to evaluate other contributing causes. Another database was entitled "Individuals with pneumonia that take food and liquid by mouth." This listed 10 pneumonias occurring from April through August 2012. For May through August 2012, there were six pneumonias for which individuals were prescribed diet textures or thickened liquids to accommodate their health and safety needs. The Avatar system only listed five individuals with therapeutic textured/thickened liquid	

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		diets. This list indicated for those taking PO therapeutic diets, there were four pneumonias in April 2012, one pneumonia in May 2012, one pneumonia in June 2012, two pneumonias in July 2012, and two pneumonias in August 2012. Information for "infections by homes" in September 2012 was provided at the 11/7/12 Pharmacy and Therapeutics Committee. It was noted that for September 2012, there were six aspiration pneumonias and one pneumonia. It is recommended that the Medical Department review these numerous databases to determine the cause of the various discrepancies. The Facility should have a goal to develop one comprehensive database, with various measurement indices (including which individuals required hospitalization, which ones had PO intake). Nine individuals were diagnosed with sepsis in the past 12 months. Six had been diagnosed from April through August 2012. Three were diagnosed in April 2012, and one each in June 2012, July 2012, and August 2012. <u>*Gastroesophageal Reflux Disease*</u> As part of the review of 15 active records, GERD was reviewed. Of the 15, 11 (73%) were diagnosed with GERD. ▪ Of the 11, four had a fundoplication. ▪ Of the 11, six had a feeding tube. ▪ Of the 11, 11 had appropriate medication prescribed. However, one was also receiving Fosamax for osteoporosis. The PCP had not clearly documented the rationale for choosing an oral bisphosphonate for an individual with GERD. ▪ All 11 had several anti-reflux measures in place, such as elevation of the head of the bed. ▪ One of the 11 had a tracheostomy. ▪ Of the 11, seven of 11 (64%) had periodic procedures and tests for monitoring potential worsening of GERD. Three individuals currently had tracheostomies. *New Diagnoses of Chronic Conditions* Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. No individual was newly diagnosed with diabetes mellitus type II. No individual was newly diagnosed with cardiovascular disease. No case of a newly diagnosed cancer was reported in the past year. *Pica* An updated and complete list of pica or ingestion of inedible objects was submitted for	

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		the time period of May through August 2012. This included 10 events involving seven individuals. No pica incident required an ER visit or hospitalization. *Chronic Constipation* A total of 286 individuals were treated with routine medication for chronic constipation. According to data submitted, seven individuals were diagnosed with bowel obstruction or bowel perforation/complications from 10/1/11 through 10/1/12. Four of these incidents occurred from April 2012 through September 2012. *Jejunostomy Tubes (J-tubes)* The Facility submitted information that two individuals were identified as having jejunostomy tubes or gastro-jejunostomy tubes. A review of the medication profiles was completed. For one individual, the drug regimen review profile indicated a quinolone was administered through the jejunostomy tube. Detail was not available to determine if there was a gastrostomy port used for medication separate from the jejunostomy port. However, the drug regimen review profile indicated the medication was to be administered through the jejunostomy tube. It was documented in the August 30, 2012 Pharmacy and Therapeutics Committee minutes that a list of medications not to be administered through a jejunostomy tube (i.e., Quinolones, Sucralfate, Antacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants) was discussed with the pharmacists, and jejunostomy tube profiles had been flagged in the WORx system. *Skin Integrity* A Skin Integrity Committee did not exist at AUSSLC. It is recommended that a Skin Integrity Committee be formalized and meet at least quarterly to review data related to the occurrence, staging and resolution of decubiti, as well as other skin breakdown conditions. This committee should also provide oversight to skin integrity treatment and identify complex and prolonged cases needing increased monitoring. *Seizure Management* A list was submitted indicating that as of 10/9/12, 148 individuals had a diagnosis of a seizure disorder. The following summarizes related information: ▪ The Facility submitted information concerning antiepileptic medication usage. As of 10/9/12, 148 individuals were prescribed antiepileptic medication. Of these, 63 (43%) were prescribed one antiepileptic medication, 46 (31%) were prescribed two antiepileptic medications, 27 (18%) were prescribed three antiepileptic medications, nine (6%) were prescribed four antiepileptic medications, and three (2%) were prescribed five antiepileptic medications. ▪ Twenty-seven individuals were considered to have a refractory seizure disorder, and all 27 had a VNS implant. There was no individual with a refractory seizure disorder who was currently being evaluated for a VNS.	

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		▪ In the prior six months, three individuals were sent to the ER for an uncontrolled/prolonged/new onset seizure (one in May 2012, one in June 2012, and one in August 2012). ▪ No individual was diagnosed with status epilepticus. ▪ Additionally, the Facility reported that there was no individual with a diagnosis of seizures that was not prescribed an antiepileptic medication. A list was submitted indicating the percentage of individuals prescribed older antiepileptic medications. A total of 27 out of 148 (18%) of individuals with seizures were prescribed Dilantin, none were prescribed Primidone, 16 (11%) were prescribed Phenobarbital, and none were prescribed Felbamate. Additionally, as noted above, 27 individuals had a VNS implant. Neurology clinics were held at AUSSLC on seven scheduled dates from June through September 2012. There was no clinic in May 2012. The following represents the number of completed appointments per clinic date: 6/18/12 – eight appointments, 6/25/12 – 10 appointments, 7/9/12 – 11 appointments, 7/16/12 - 12 appointments, 8/20/12 - 12 appointments, 9/17/12 – 12 appointments, and 9/24/12 - 10 appointments. The Facility submitted neurology consultation notes documenting seizure management for four individuals (five were requested). These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records: ▪ There was documentation that two of the four individuals (50%) had been seen more than once over the past year. ▪ For one of four individuals (25%), the notes indicated a description of the seizures. ▪ For four of four (100%), the notes documented frequency of seizures. ▪ For four of four (100%), the notes documented review of current medications for seizures and dosages. ▪ For three of four (75%), notes included recent blood level values of antiepileptic medications. ▪ For four of four (100%), notes included recommendations. For four of four, there was no recommendation for medication change. ▪ For three of four individuals (75%), reference was made to the presence or not of side effects. ▪ For three of four individuals (75%), reference was made to wellness or adequate/good control of seizures. As of October 2012, as part of seizure management, the Nursing Department had implemented a new protocol for Diastat. On 11/3/12, the protocol was revised.	

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		Do Not Resuscitate Orders A total of 19 individuals at the Facility had DNR orders in place (20 were listed in a document submitted 10/9/12, but one individual subsequently died). The date of the DNR was submitted. DNR orders were initiated for seven individuals in 2012, for three individuals in 2011, for one individual in 2010, for four individuals in 2009, and for four individuals in years prior to 2009. For 15 of 19 (79%), adequate clinical justification was provided for the DNR. Eight individuals had dementia, five had compromised respiratory function, one had a cardiac diagnosis, and one had breast cancer. For four individuals, the reason for the DNR appeared to be vague, listed as "chronic medical problems," "multiple medical problems," or "multiple chronic medical problems." Based on State Office policy, individuals with DNRs should have a terminal diagnosis, and this should be listed to confirm the need for DNR status. The AUSSLC Ethics Committee met on the following dates to discuss specific individuals and to review DNR status: 4/17/12, 5/18/12, 5/23/12, 6/6/12, 7/25/12, 8/1/12, and 8/28/12. At each meeting, one individual was discussed, with the exception of the 8/28/12 meeting, at which two individuals were discussed. Minutes documented the date and time; individual(s) for whom the meeting was called; the members in attendance; a signature sheet; a synopsis of the proceedings, including critical review of information, critical discussion with family/guardian, PCPs, etc.; a recap with recommended action steps; and documentation of any documents signed reflecting the Committee's decision related to DNRs. The Committee appeared to have an efficient and effective process in place to determine the decisions that needed to be made. It appeared from the documented discussions there was adequate time to discuss the issues, and adequate reference material was available. It was not clear where the Ethics Committee minutes were filed (e.g., in the active record, Medical Department office, other Facility office). For action steps that were assigned by the committee, it was not clear how these were tracked to completion and where/how they were to be documented (i.e., discussion with the individual, discussion with the family, etc.). The Ethics Committee appeared to provide value in an area needing structure and a standardized approach focused on facts/data and objectivity. In addition, the Committee provided needed guidance to individuals' families and teams. On 10/10/12, the Medical Department was provided an in-service concerning palliative care by the chief medical officer of a local hospice. Mock Code Drills and Emergency Response Systems 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	Non-facility Physician Case Reviews	Noncompliance

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	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.	During the prior six months, the Facility completed one non-facility physician case review (October 2012). The prior external medical peer review audit had been completed in April 2012. The following represents a synopsis of the information: ▪ For the one external peer review dated 10/18/12, PCP compliance in essential areas ranged from 88% to 100%. For areas considered non-essential, compliance ranged from 95% to 100%. ▪ Areas that appeared to need improvement included answers to the following audit probe questions: "Is the annual physical exam and summary current?" "Is the provider's clinical assessments documentation organized in appropriate SOAP format (including assessment and plan)?" "Have the appropriate immunizations been given?" "Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved?" "Has the provider ordered appropriate consultations for identified need and diagnosis?" "Is the Active Problem List in the correct location according to the Active Record Order Guideline Index?" "Are drug and/or food allergies, intolerances or adverse drug reactions appropriately documented?" "Does the 180 day Physician Orders document indication and duration for each medication?" and "Is there documentation present for not providing preventive services?" ▪ On 10/19/12, an external medical management audit for Round 6 was completed. The three areas of clinical focus were constipation, seizures, and urinary tract infections. Compliance among PCPs ranged from 63% to 100%. ▪ Areas that appeared to need improvement included answers to the following audit probe questions: For constipation, "Is there evidence that the PCP ordered non-pharmacological treatments?" For seizures, "If the individual has uncontrolled seizures, did the PCP, in consultation with the neurologist consider more aggressive means of seizure control such as a VNS, or addition or change in anti-epileptic drugs?" and "Neurology consult obtained at least in the last three years?" For UTI, "Is urinary tract infection listed on the Active Problem List?" "Is there evidence that the PCP followed up the individual's response to treatment and is there documentation in the IPN of that individual's response?" and "Did the provider order a urology consult or other diagnostics if a male individual has had more than one UTI in a year or a female individual has had more than three UTIs in a year?" ▪ No evidence was provided to indicate the external reviewers had provided the Facility with a summary of the review or an exit summary, including aggregate data representing their findings. Each PCP was tracked for compliance. There was no further analysis for compliance per question across the PCP clinical practices. There was no review of audit results to determine the most common areas of noncompliance that might need additional focus. There was no review of audit results to determine the areas of strength in the Medical Department based on the audit results. The external audit review process information	

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		provided for Round #6 did not indicate the number of records chosen for review, nor how the sample was obtained. ▪ A follow-up system was not implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. ▪ The QA nurse/QI Department did not compile compliance data with corrective action plans in a timely manner. ▪ The QA Department did not track corrective action plan resolution every 30 days until resolution for the prior external peer review for the April 2012 review. ▪ For the October 2012 Round #6 of the external peer review, there were 15 corrective action plans identified by the external medical peer review. For Round #6, there were 11 corrective action plans identified by the external medical management peer review. There was no information to indicate these corrective action plans had been tracked for the April 2012 external audit until corrected. There was no information submitted to indicate the number of deficiencies that had been corrected, how many corrective action plans were completed, how many were in progress, and how many corrective action plans were not begun. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death reviews for deaths that occurred more than 30 days from the Monitoring Team's visit. Since the start of the Monitoring Team's last visit, three deaths had occurred: ▪ The average age was 78.7 years (varied from 67 to 88). ▪ None died under the age of 65, and all died at age 65 or greater. ▪ Of the deaths, none were female, and all three were males. ▪ The causes of death were: dementia/failure to thrive, respiratory failure from aspiration pneumonia, and complications of congestive heart failure. ▪ An autopsy was performed in none of the three. ▪ DNR status was ordered while residing at AUSSLC for two of the three, and ordered for one while in the hospital. ▪ One died in a hospital setting. Two died at the Facility. ▪ Two had multiple or prolonged hospitalizations prior to death. All had been hospitalized within four months of death. ▪ One had J-tube placement and one had a G-tube. ▪ Three of three (100%) included documentation indicating they were aggressively treated until a decision for a DNR was made. ▪ Three of three (100%) were enrolled in hospice. ▪ Three of three were ambulatory independently or with assistance. Since April 1, 2012, three clinical death review investigations were completed. Six administrative death reviews were completed. Clinical death review recommendations	

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		were reflected in the administrative death review recommendations. Administrative death reviews included from one to six recommendations, for a total of 18 recommendations. Systemic issues related to potential improvements in medical care accounted for 16 of the 18 recommendations from the administrative death reviews. Systemic issues related to potential improvements in non-medical care accounted for two of the 18 recommendations. Several recommendations referenced the Nursing Department that were completed, and submitted information included training rosters when an in-service was needed. Habilitation Therapy was to initiate one recommendation, but was unaware of the recommendation as well as their leading role in follow-up of that recommendation. The Medical Department is encouraged to use the reviews to focus on areas needing clinical guidance, which may or may not have directly contributed to the death. For instance, two individuals had dementia at the time of death, and this was an opportunity to review that pathophysiologic condition in the IDD population, with practical steps to be considered, including diagnostic work-up, appropriate choice of medications (e.g., new medications, discontinuing medications), changes in environment to reduce confusion, and training of home staff in cueing an individual with this diagnosis. For one individual with valvular heart disease, arrhythmia, and congestive heart failure, it was noted the individual was too medically fragile to tolerate a valve replacement. This suggested the need to review indications and timing of a heart valve replacement, with any decision made more complex when there are other significant comorbid conditions (i.e., would there have been an optimal window of time to replace the heart valve, when would that have been in the past, and what diagnostic work-up would have been needed to make the decision). The Facility submitted follow-up documentation for 11 of 18 recommendations (61%). The two most recent deaths were being processed by the Facility for clinical and administrative death reviews. The Monitoring Team will review them during the next visit. There were no outstanding clinical or administrative death reviews.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends;	<u>Medical Department Internal QA System</u> The data from one internal medical peer review was provided. This occurred on 10/15/12 and 10/16/12. The audit questions were identical to those used in the external medical peer review audit. Although a listing of individuals from each audit was not provided, it was noted that many of the records used in the external medical peer review also were reviewed in the internal medical peer review audit. The review of the same individuals at the same time by both external and internal medical peer review auditors would assist in establishing inter-rater reliability. However, the QA Department	Noncompliance

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	initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	did not provide the inter-rater reliability data for the past six months. The Medical Department provided results of the internal medical peer review that was completed 10/15/12 and 10/16/12. Compliance for PCPs in essential areas ranged from 77% to 100%. Compliance for PCPs in non-essential areas ranged from 90% to 95%. Areas that appeared to need improvement included answers to the following audit probe questions: "Is the annual physical exam and summary current?" "Is the annual physical summary complete including past medical history, family history, and a plan of care?" "Are drug and/or food allergies, intolerances or adverse drug reactions appropriately documented?" "Have the appropriate immunizations been given?" "Is documentation present to identify whether the individual uses tobacco products or does not use tobacco products?" "If the individual uses tobacco products, was there documentation for recommendation for cessation of tobacco use?" "Are the appropriate preventive screening services provided?" "Are all diagnostic test results and consults initialed and dated?" "If a medical treatment was ordered during an acute illness or injury, was an assessment done within 24 hours and was it documented in the progress note?" "Does the 180 day Physician Orders document indication and duration for each medication?" "Are abnormal diagnostic tests that needed interventions addressed by the provider with appropriate follow up documented in the integrated progress note?" "Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received?" and "Is each of this person's progress notes and orders signed, dated and timed?" An internal medical management audit was completed 10/15/12 to 10/17/12, utilizing the same audit questions from the external medical management peer review for urinary tract infections, seizures, and constipation. Compliance among PCPs ranged from 50% to 100%. Areas that appeared to need improvement included answers to the following audit probe questions: For UTI, "Is there evidence that the PCP followed up the individual's response to treatment and is there documentation in the IPN of that individual's response?" and "Is urinary tract infection listed on the Active Problem List?" For constipation, "Is constipation listed on the Active Problem List?" For seizures, "Seizures are listed on the Active Problem List?" "Neurology consult obtained at least in the last three years?" and "If individual's seizures are stable, has the PCP considered and documented the need to continue the same seizure medications versus a reduction in the medication?" It appeared the internal review identified more concerns than the external medical peer review. For the internal medical peer review audit of 10/15/12 to 10/16/12, there were 29	

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		corrective action plans identified. For the internal medical management peer review audit of 10/15/12 to 10/17/12, there were 13 corrective action plans identified. There was no information concerning tracking these corrective action plans to closure. The Facility submitted the "AUSSLC Quality Assurance Monitoring" spreadsheet that listed the various sections of the Settlement Agreement and the responsibilities for follow-up, auditing, data responsibilities, and QA/QI involvement. According to the list, the QA Department was involved in reviewing results, as well as initiating corrective action plans. These were to be computer-generated responses to the deficiencies in the external and internal medical peer review audits. Once these were distributed to the Medical Department for subsequent distribution to the PCPs, the original process developed by the State Office included a QA Department clinical staff review every 30 days to monitor progress in completion of the corrective action plans. This was revised, according to a 7/6/12 document entitled: "External and Internal Medical Provider Quality Assurance Audit." At 90 days following the audit, the QA Department was to generate forms for the follow-up audit, and QA staff were to review records to determine whether the originally distributed corrective action plans had been implemented/ completed. Any deficiencies identified were to be directed to the Medical Director, and no further follow-up by the QA Department was required. At a time when more QA oversight should be encouraged, QA involvement had been decreased. This revised plan was problematic from the perspective of quality of care monitoring. It is important to resolve clinical deficiencies in a timely manner, and to lengthen the time before gathering evidence of correction and compliance did not appear beneficial to ensuring quality of care, and the health and safety of the individuals. In addition, the focus of monitoring appeared to have shifted, with the Medical Department now responsible for tracking follow-up. Although the Medical Department should be involved in tracking and assisting the PCPs to resolve identified concerns, and developing system approaches to prevent recurrence of these deficiencies, these revisions did not provide the independent perspective the QA Department could bring to the process. In addition, given that clinical issues had been identified as deficient, delaying the monitoring and having only a one-time follow-up weakened the quality of the oversight provided. Further, the 90-day interval would then occur at the time of the next internal and/or external peer review potentially resulting in repetitive findings of noncompliance. To make it more confusing to the PCPs and the QA auditing staff, there would now be two sets of corrective action plans (one new from the current review and one 90 days out). The responsibility for the corrective action plan initiative involved four Facility positions, including the Medical Director, Facility Director, Director of Quality Assurance, and	

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		Quality Assurance Nurse. The role of each was not clear from the spreadsheet provided. With more than one personnel assigned responsibility, it was not clear who was responsible for initiating the corrective action plans. With the revision to the quality assurance plan for medical peer reviews, the roles of these four Facility positions were less well defined. Based on the Monitoring Team's review, these plans had not been distributed in a timely manner, and there had not been follow-up distribution of the corrective action plans within 24 hours from the most recent external or internal audits, or the prior audit results. More specifically, the Provision Action Information indicated that an internal and external medical audit and medical management audit had occurred on 4/13/12, but the corrective action plans had not been received unit 5/18/12. There was no data submitted to indicate follow-up on the corrective action plans at 30, 60, or 90 days from the April or July internal and/or external medical peer review audits. On 7/5/12 and 7/16/12, the Medical Department requested feedback from the QA Department for the April 2012 audit and corrective action plans. It was not clear whether the Medical Department received this information. For the 7/16/12 internal medical audit and internal medical management audit, on 8/31/12, the Medical Department contacted the QA Department for the corrective action plans. It was not clear whether these were ever forwarded to the Medical Department. For the most recent internal and external medical audit and medical management audit of 10/16/12 and 10/17/12, it did not appear the corrective action plans were available within 24 hours of completion of the audits. Although there were several interdepartmental administrative meetings addressing this concern on 8/31/12, 9/13/12, 10/5/12, and 10/10/12, the problem appeared to remain unresolved at the time of the Monitoring Team's visit. <u>Medical Department Internal Reviews</u> The Medical Department had implemented the following process for internal peer reviews: Quality indicators were identified for three clinical areas, independent of the audit tools utilized in the internal and external medical peer review and medical management peer review process. Topics included hypertension, seizures, and consultation processing. On 9/1/12, the audit process was to start, but preliminary results were not available at the Monitoring Team's visit. <u>Medical Department Initiatives and Improvement Projects</u> The following steps had been taken by the Medical Department to improve tracking systems and overall internal quality improvement of care: ▪ The Medical Department provided three quarterly reports of data focusing on hospitalizations and ER admissions. For each report, there was documentation of the total number of individuals referred to the hospital, the number of hospital admissions, and the number of ER visits with return to the Facility. Also	

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		tracked were individuals sent to the hospital multiple times. Length of stay during the hospitalization was recorded. The diagnoses associated with referral to the hospital also were recorded, including pneumonia, aspiration pneumonia, injuries, tube placements, malfunctioning feeding tubes, urinary tract infections, seizures, emesis, MRSA, and cellulitis. Admissions and reason for admission were also tracked by home. There was no analysis submitted reviewing the results of these documents or steps to be taken based on this information. As the fourth quarter data for hospitalizations/ER visits becomes available (an entire year), it is recommended that the Medical Department review the four sets of hospitalization admission /ER data to determine any trends or any areas needing focus, from which action plans can be developed and implemented. In summary, it will be essential that the Facility improve responses to both the internal and external review processes. In addition, it will be important to identify additional clinical indicators for a wide range of diagnoses common to the ID/DD population residing at AUSSLC. The development of clinical guidelines with measurement tools to identify success in treatment and resolution of illness or optimization of care would allow more diagnoses to be monitored at periodic intervals. This would guide the PCPs and the IDTs in determining success of treatment or the need to review additional options. The Facility appeared to have begun to make advances in monitoring medical care at AUSSLC, with database information now available for review of hospitalizations and ER visits. However, this process should be expanded to assure quality with other areas of medical care, including routine care, preventive care, timely care for early change in health status, acute care, post hospital care, and palliative care. As part of Section L.3 requirements, the Medical Department will be required to analyze the data once it is collected, to determine trends, define potential reasons for the trends, and implement action steps to improve care, or to change a system of care, etc., depending on the concern identified. Once action steps are defined, the response to action steps should be monitored to determine if the desired outcome is achieved, and adjust the action plan according to the outcomes. Providing a quarterly report would allow the PCPs, other professional departments, and the Facility Administration to understand the strengths of the department, and identify areas in which a more interdisciplinary approach might be more effective.	
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	Since the Monitoring Team's last visit, there were no new policies/procedures/protocols developed or implemented concerning additional clinical guidelines. In order to be consistent with State Office policy and guidelines, the Medical Department approved a policy entitled: Medical Care, Policy Number III.A.15, effective October 2012.	Noncompliance

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	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.	Additionally, the Medical Department reviewed the HealthCare Guidelines, May 2009. A competency based training roster was submitted, dated 10/17/12, signed by the five PCPs. A draft policy for preventive care was being created. It was entitled: AUSSLC – Health Services: Preventive Medicine, dated 7/16/12. As the State Office develops and issues clinical guidelines, AUSSLC will need to be prepared to implement them, and modify its policies and procedures to be consistent with the guidelines. It will be important for the Department to ensure the policies and procedures reflect the system changes. For instance, a policy should be created to reflect the process of the medical morning meeting, the referral process to the IDTs, the response of the IDT within a certain time period with the creation of an ISPA if applicable, critical review of the ISPA to ensure it answers the concern of the morning meeting team, and the documents required to reflect closure. Additionally, assignment of tasks to the members of the committee with deadline due dates should be another part of the policy. Clinical guidelines also should be expanded to include the common medical diagnoses of the population residing at AUSSLC. This can be determined by reviewing the active problem lists to determine the most common diagnoses, and beginning to develop guidelines with the goal of uniformity of timeliness of response, standard work-up, initial treatment options, and a determination of what consultants might be needed (on site and off site), as well as when they would be consulted. The guidelines would also be useful to Section L.3 when clinical indicators and measurement tools are incorporated in tracking progress of treatment. In summary, the Medical Department had created some processes, and there should be policies and procedures that reflect these endeavors. Additionally, expanding the clinical guidelines to other common diagnoses would ensure provision of medical care across a broad range of diagnoses, once these guidelines are implemented.	

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

1. With regard to medical morning meetings:
    a. The minutes should be completed on a daily basis. Each daily meeting should be a "stand alone" document.
    b. The group should focus on prevention, including, as appropriate, making assignments to attendees of the meetings, as well as IDTs.
    c. For all unplanned hospitalizations (e.g., hospitalizations not for completions of tests, planned surgery, etc.), open record reviews should be conducted for the seven to 14 days prior to the hospitalization. Such review should evaluate the quality of care, including,

for example, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the PNMT, positioning documentation, feeding concerns, listing of preventive areas to be considered based on the diagnosis causing the acute illness, adequacy of medical evaluation or need for further consultation, review of medication and medication side effects, etc.

d. Percentage attendance per month by discipline should be calculated.
e. Numbers of concerns needing closure, and the route of closure (e.g., assignment of open book review, ISPA, etc.) should be tracked.
f. Brief summaries of the ISPAs that were requested should be read to the morning meeting participants to determine if the IDT response is adequate. If responses are not adequate, further action should be requested from the IDT.
g. There should be tracking of the timing of the ISPA request to ensure the IDT meets, an ISPA is written, and is brought back to the medical morning meeting within five days.
h. Consult reports should be summarized by the Medical Compliance Nurse/delegate at the medical morning meeting.
i. All closure concerns should have written documentation as evidence of the closure.
j. Percentage concerns identified that were closed per month should be calculated.
k. Percentage concerns identified that remained open at the end of the month should be calculated.
l. As data is collected, a quarterly report summarizing the business of the medical morning meetings should be created. (Section L.1)

2. The Medical Compliance Nurse or delegate should use a checklist to verify those that attended the entire medical morning meeting, or only partially attended, and compare this list to the signed attendance list. Statistics should be developed and reviewed to determine the percentage attendance by the various departments at the morning meeting. (Section L.1)
3. In addition to ensuring complete quarterly medical reviews are completed timely for all individuals, changes to the template/process should be considered to ensure they are utilized to their potential value by both PCPs and IDTs. (Section L.1)
4. A complete and accurate tracking system for on and off-site clinic appointments should be created that the Medical Department can use to determine trends and strategies to reduce the missed appointment rate. (Section L.1)
5. The significant number of missed appointments with unknown reasons indicates the need for further system development to determine the cause of the missed appointments. Once such causes are identified, actions should be taken to address preventable causes to the extent possible. (Section L.1).
6. The osteopenia/osteoporosis database should be reviewed for accuracy, completeness, and to ensure it includes current information. (Section L.1)
7. Monitoring should occur of the effectiveness of osteoporosis treatment at periodic intervals. (Section L.1)
8. The Dietary Department should assist in determining intake of calcium for individuals with osteopenia and osteoporosis to assist the PCPs in determining whether calcium supplementation is indicated, and if so, the amount of calcium supplement needed. (Section L.1).
9. Training and/or supervision related to accurate and timely completion of the Avatar pneumonia data form should occur to ensure quality of the database. (Section L.1)
10. The Medical Department should review the numerous pneumonia databases to determine the cause(s) of the various discrepancies. The Facility should have a goal to develop one comprehensive database, with various measurement indices (including which individuals required hospitalization, which individuals had PO intake). (Section L.1)
11. A Skin Integrity Committee should be formalized and meet at least quarterly to review data related to the occurrence, staging and resolution of decubiti, as well as other skin breakdown conditions. This committee should also provide oversight to skin integrity treatment and identify complex and prolonged cases needing increased monitoring. (Section L.1)
12. Based on State Office policy, individuals with DNRs should have a terminal diagnosis, and this should be listed to confirm the need for DNR status. (Section L.1)
13. For action steps the Ethics Committee assigns, a system should be devised to ensure they are tracked to completion and to define where/how they will be documented (i.e., discussion with the individual, discussion with the family, etc.). (Section L.1)
14. External reviewers should provide the Facility with a summary of the review or an exit summary, including aggregate data representing their

findings. (Section L.2)

15. An analysis should occur of the external medical peer reviews to track compliance per question across the PCP clinical practices to determine the most common areas of non-compliance that might need additional focus. Additionally, a review of audit results to determine the areas of strength in the Medical Department based on the audit results is recommended. (Section L.2)
16. The Medical Department should use the clinical death reviews to focus on areas needing clinical guidance, which may or may not have directly contributed to the death. (Section L.2)
17. The Medical Department should review the four sets of quarterly hospitalization/ER admission data to determine any trends or any areas needing focus, from which action plans can be developed and implemented. Written documentation of the analysis and follow-up action plans and implementation results should be part of a follow-up report. (Section L.3)
18. Clinical indicators should be determined to monitor quality care from a variety of perspective (e.g., timeliness of treatment, lab tests completed, medications chosen, documentation, consents, outcomes for individuals, etc.). Priority should be on those clinical issues that lead to ER visits, hospitalizations, and poor quality of life. (Sections L.3 and L.4)

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o AUSSLC's Section M Presentation Book; o AUSSLC's Self-Assessment; o AUSSLC's nursing staffing data; o AUSSLC's Table of Organization; o AUSSLC's Nursing monitoring data; o AUSSLC's QA monitoring data; o Pharmacy Medication Room spot checks; o Environmental/Infection Control Surveillance Reviews; o Infection Control Committee meeting minutes, dated 6/28/12, 7/24/12, 8/30/12, 9/13/12, and 9/27/12; o AUSSLC's Medical Emergency Drills tracking data; o Competency Training and Development (CTD) Department's schedule for conducting Mock Drills; o The medical portions of records for the following individuals: Individual #251, Individual #128, Individual #296, Individual #375, Individual #253, Individual #16, Individual #72, Individual #353, Individual #122, Individual #34, Individual #147, Individual #456, Individual #337, Individual #79, Individual #338, Individual #369, Individual #429, Individual #179, Individual #403, Individual #405, Individual #342, Individual #350, Individual #395, Individual #165, Individual #241, Individual #326, Individual #52, Individual #187, Individual #242, Individual #156, Individual #402, Individual #65, Individual #113, Individual #228, Individual #212, Individual #341, Individual #455, Individual #127, Individual #260, Individual #381, Individual #351, Individual #117, Individual #310, Individual #268, Individual #186, Individual #90, Individual #254, Individual #10, Individual #71, Individual #279, Individual #172, Individual #53, Individual #107, Individual #290, Individual #309, Individual #344, Individual #425, Individual #146, Individual #202, Individual #335, Individual #378, Individual #152, Individual #358, Individual #294, Individual #41, Individual #126, Individual #124, Individual #448, Individual #59, Individual #219, Individual #73, Individual #214, Individual #385, Individual #306, Individual #223, Individual #147, Individual #103, Individual #402, Individual #454, Individual #409, Individual #340, Individual #21, Individual #23, Individual #433, Individual #358, Individual #417, Individual #222, Individual #169, Individual #18, Individual #366, Individual #405, Individual #390, Individual #102, Individual #422, Individual #113, Individual #456, Individual #72, Individual #385, Individual #100, Individual #268, Individual #115, Individual #147, Individual #336, Individual #101, Individual #22, Individual #239, Individual #1, Individual #375, Individual #2, Individual #304, Individual #127, Individual #28, Individual #370, Individual #57, Individual #333, Individual #450, Individual #53, Individual #194, Individual #234, Individual #101, Individual #99, Individual #274,

	Individual #204, Individual #248, Individual #429, Individual #325, Individual #399, Individual #137, Individual #17, Individual #91, Individual #378, Individual #433, Individual #243, Individual #306, Individual #453, Individual #73, Individual #402, Individual #65, Individual #113, Individual #228, Individual #212, Individual #341, Individual #455, Individual #127, Individual #260, and Individual #381; 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 Data summaries for Infection Control; o Real Time Infection Control raw data; o AUSSLC's lists of individuals who were seen in the emergency room, and hospital; o AUSSLC's At Risk lists for health indicators; o AUSSLC's tracking sheet for Medication Administration Observations; o AUSSLC's Medication Pass Observations data reports and raw data; o Pharmacy and Therapeutics (P&T) Committee meeting minutes, dated 5/9/12, and 8/30/12; o Incident Management Meeting minutes, from 9/4/12/ through 11/8/12; o Emergency Competency Checklists from Nurse Educator; o Mock Medical Drill agenda, dated 7/31/12; o SSLC Emergency Drill Instructor Training curriculum; o Residence Emergency Equipment Schedule for 2012; o Training curricula for Infection Control; o Immunization data; o Weekly Infection Control Reports; o AUSSLC's medication variance data by nurse, building, severity index, and staff; o AUSSLC's Medication Error Trend reports by Nurse, Home, Agency/Facility staff, Severity Index, and type of error; o Medication Variances Due to Excess/Shorts reports; o Medication Variances Due to Physicians Orders Not Processed report; o Emails between pharmacy and nursing addressing the medication administration systems; o Medication Observation schedules for 2012; and o Nurse Case Manager Orientation Agenda. ▪ **Interviews with**: o Michelle Head-Blalack, RN, Chief Nurse Executive; o Amy Van Vleet, RN, Program Compliance Nurse; o Lori Z. Cordova, RN, Case Manager Supervisor; o Brittany LaBarreare, RN, BSN, Infirmary Nurse Manager; o Mary LeFebvre, RN, Nurse Operation Officer; o Melissa Ann Klopf Sawyer, RN, Quality Assurance Nurse; o Richard D. Sambrook, RN, BSN, Nurse Educator;

	○ Chrishanthi Perera, Medical Director; ○ Kenda Pittman, PharmD, Director of Pharmacy; ○ Tom Cochran, Acting Director of Competency Training and Development Department; ○ Ernest Coleman, Risk Manager; ○ Jennifer Russell, Director of Incident and Risk Management; and ○ Valerie Kipfer, RN, MSN, State Office Nursing Services Coordinator. ▪ **Observations of**: ○ Medication Administration at Castner Residence; ○ Demonstration of the emergency equipment in the Infirmary, and Residences 729 and 795; and ○ Medication Variance Committee Meeting on 10/6/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section M, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. At the time of the review, the Facility had only implemented a few of the nursing monitoring tools, because the Facility had experienced significant turnover in nursing staffing as well as in key leadership positions for nursing. However, based on a review of the Facility's Self-Assessment: ○ It was unclear why some of the initial findings generated from each tool implemented were not reflected in the Facility's Self-Assessment, including what the specific criteria for compliance constituted for the different areas audited. ○ In many of the sub-sections for Section M, the items presented did not reflect the requirements of the specific provision or the quality of the documentation for each area upon which the Monitoring Team's findings focused. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ In addition, there was no inter-rater reliability established for any of the monitoring tools. An important component of inter-rater reliability is ensuring that the current monitoring/audit tools have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Without establishing inter-rater reliability, it was likely that different auditors would score compliance differently. ○ The Self-Assessment did not identify the sample sizes used for the initial monitoring including the description of the overall population from which the sample was selected (N) and a percent sample size. Samples sizes should be adequate to consider the data reflective of the population they represent. ○ In addition, it was not always clear which staff/positions were responsible for completing each of the audit tools. ○ It also was not clear from the documentation provided that the staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools

	and/or were programmatically competent in the relevant areas. o The Self-Assessment frequently indicated: "analysis of these data were in progress by QA Department." Clearly, the Nursing Department was confused regarding QA's role related to the monitoring data. The Quality Assurance Department should aggregate the monitoring data into a format to facilitate its interpretation. However, it is the role of each discipline to analyze their own data regarding the trends in clinical practices reflected in the data and implement plans of correction for problematic areas. ▪ Although no data was contained in the Facility's Self-Assessment, the Facility did not have a plan for consistently presenting data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings based on specific, measurable indicators. For example, as noted above, at times, it was unclear what criteria had been used to determine adequate documentation without citing a standard such as a nursing protocol as the criteria for compliance. In addition, at times, indicators combined more than one item, so that if data were presented, it would have been impossible to determine which of these requirements had been met and which had not. o Did not address the quality as well as the completion of documentation. o The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. In addition, for some of training activities that were cited in the Self-Assessment, the Facility did not provide the associated training rosters indicating how many staff was required to attend, and how many of those staff actually attended the training. It did not provide a description, and curriculum of all the training provided. Thus, the Monitoring Team could not always verify the quality of some of the trainings. ▪ The Facility rated itself as being in compliance with none of the sub-sections of Section M. This was consistent with the Monitoring Team's findings. ▪ The Facility's data identified some of the areas that were in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, barriers to improvement, or connecting any monitoring findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: Since the last review, AUSSLC's Nursing Department experienced an increase in staff turnover as well as in the key leadership roles. Due to these staffing issues, the Facility had suspended the auditing processes for most of the nursing monitoring tools and only recently had implemented some monitoring at the time of this review. AUSSLC had a number of staffing changes regarding the Nursing Department and nursing positions, which included: ▪ A new Chief Nurse Executive was appointed in March 2012; ▪ A new Nurse Operations Officer was hired in May 2012;

	▪ A full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position in May 2012; ▪ A new full-time Hospital Liaison was appointed in May 2012; ▪ A Program Compliance Nurse was hired in October 2012; ▪ All 17 Case Manager positions were filled as of October 2012; ▪ The Facility hired a full-time nurse for Quality Assurance in April 2012; ▪ The Infection Control Nurse position had been vacant since August 2012; and ▪ Recruitment efforts were in place to fill a second full-time Nurse Educator position. In addition, at the time of the review, the Nursing Department had a total of 135 allotted positions. The nursing vacancies included two Registered Nurse (RN) positions and five Licensed Vocational Nurse (LVN) positions. Although the Facility had experienced not only an increase in staff turnover as well as significant changes in key nursing leadership positions, at the time of the review, the overall nursing staffing issues had begun to stabilize at AUSSLC. On a very positive note, the Monitoring Team's observations of nursing staff demonstrating emergency equipment checks in the Infirmary, and Residences 729 and 795 found that all staff were familiar with the use and operation of the emergency equipment. This was a significant improvement from previous reviews. Also since the last review, the Medication Variance Committee was reinstated and was meeting monthly. From discussions with the CNE and the Director of Pharmacy, the Facility has taken a positive step forward by beginning to critically review a number of the systems addressing medication administration and medication variances. In addition, although considerably more work was needed, the Monitoring Team noted considerable improvement regarding medication administration from the previous reviews regarding telling the individuals the medications they were receiving, providing privacy during medication administration, and listening to lung sounds before and after medication administration, as appropriate. Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, and the unreliable systems regarding medication variance data were very concerning at this juncture in the review process.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records,	Noncompliance

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	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.	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. As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. In assessing its progress, AUSSLC indicated in the Facility's Self-Assessment that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ Since the last review, the Nursing Department experienced an increase in staff turnover as well as in the key leadership roles. Due to these staffing issues, the Facility had suspended the auditing processes for most of the nursing monitoring tools. ▪ Although a number of problematic methodology issues were noted in the monitoring process described in the Self-Assessment for Section M, the Facility indicated it recently had implemented the State Monitoring Tools for Hospitalizations and Acute Illness and Injury, and the Quality Assurance Department was in the process of analyzing these data. However, no information was provided in the Facility's Self-Assessment addressing any initial findings generated thus far. ▪ The Facility's Self-Assessment indicated that activities regarding reviews of random documentation for change of status/acute illness/injury to ensure that interventions, and notifications of practitioners was completed and followed through to resolution had not yet been implemented. In addition, reviews of documentation reflecting that identified issues were brought to the interdisciplinary team and followed through to resolution had not yet been implemented. ▪ Regarding staffing issues, the Facility indicated that a spreadsheet had been completed and was reviewed weekly addressing staffing issues. It included information such as the minimum ratios, hours of overtime, the number of full-time positions for Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) by shift and by total, and the number of unfilled positions by type. ▪ The Facility's Self-Assessment indicated that since the last review, weekly audits of Nurse Case Manager case loads were being reviewed and revised as needed. Although this was a positive step forward, there was no additional information provided in the Self-Assessment or Section M Presentation Book reflecting what type of revisions were made to the case loads since the process was initiated and how this process affected the	

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		nursing care for individuals at the Facility. Self-Rating: The Facility's Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance." Staffing At the time of the review, AUSSLC had a census of 321 individuals. Since the last review, AUSSLC had a number of staffing changes regarding the Nursing Department and nursing positions, including: ▪ A new Chief Nurse Executive was appointed in March 2012; ▪ A new Nurse Operations Officer was hired in May 2012; ▪ A full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position in May 2012; ▪ A new full-time Hospital Liaison was appointed in May 2012; ▪ A Program Compliance Nurse was hired in October 2012; ▪ All 17 Case Manager positions were filled as of October 2012; ▪ The Facility hired a full-time nurse for Quality Assurance in April 2012; ▪ The Infection Control Nurse position had been vacant since August 2012; and ▪ At the time of the review, recruitment efforts were in place to fill a second full-time Nurse Educator position. In addition, at the time of the review, the Nursing Department had a total of 135 allotted positions. The nursing vacancies included two Registered Nurse positions and five Licensed Vocational Nurse positions. In addition, a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive indicated that since the last review, AUSSLC had experienced significant turnover in nursing staffing for both RN and LVN positions. However, although the Facility had experienced not only an increase in staff turnover as well as significant changes in key nursing leadership positions, the CNE reported at the time of the review that the overall nursing staffing issues had begun to stabilize at AUSSLC. In addition, the CNE reported that the following actions had been taken: ▪ Two nurses dedicated to performing laboratory blood work were hired; ▪ In October 2012, the Mosby Physical Assessment Training Class had begun for the RNs; and ▪ All newly hired nurses received a five-day orientation, including competency-based training prior to reporting to their assigned units. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements	

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		of the Settlement Agreement. Also, as previously recommended, as AUSSLC policies and systems are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions. <u>Quality Enhancement Efforts</u> From discussions with the CNE and Quality Assurance Nurse, since the last review, the following activities had been initiated: ▪ Prior to the last review, the Facility had suspended most of the monitoring for nursing due to changes in nursing administration and key leadership positions, and problematic issues related to nursing staffing. At the time of the review, the CNE and QA Nurse reported they were in the initial process of reviewing the nursing monitoring tools to determine which addressed the Facility's priority needs and only recently had initiated some monitoring in select areas in nursing in order to determine the status of these systems related to the provisions of Section M of the Settlement Agreement. Consequently, little data was available for review or analysis. ▪ At the time of the review, the CNE reported that a number of nurses such as the Infirmary Manager, the Case Managers, the Hospital Liaison, the Nurse Operation Officer, the Nurse Educator, and the Program Compliance Nurse were being assigned to monitor a number of different areas for nursing. However, there was no plan in place to ensure that each nurse conducting audits was competent in the specific area to which they were assigned in order to generate accurate data. ▪ Also, the CNE reported essentially no instructions had been developed for the nursing monitoring tools. Such instructions likely would be necessary to establish inter-rater reliability for each of the monitoring tools. ▪ In addition, the nursing protocols had not yet been integrated into the instructions of the monitoring tools for auditing the nursing documentation. This will be a critical step in order for the Facility to generate accurate data. ▪ Discussions with the CNE and review of the documentation contained in the Facility's Self-Assessment indicated review and analysis of data from the monitoring tools related to nursing care had not been conducted. This was because little data was available due to the fact that most nursing systems were in the developmental stages. At the time of the review, Nursing Administration was clearly focused on conducting baseline reviews to determine the status of a number of the nursing systems, as well as compliance with the requirements of the Settlement Agreement. This initial process was necessary prior to the development of a prioritized plan for moving forward. As the CNE candidly reported, since the last review, the challenges in stabilizing the nursing coverage related to staff turnover, and the necessary changes made in the nursing	

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		leadership positions had prevented the Facility from making more progress regarding Section M of the Settlement Agreement. However, it is the hope of the Monitoring Team that the time the Facility took to assess its nursing systems will result in an appropriately prioritized plan with sustainable positive systems and outcomes. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility indicated that the following steps had been implemented to address the nursing assessment and documentation of individuals with acute changes in health status: ▪ Although as noted above, the Facility reported that the State Monitoring Tools for Documents, Protocols, and for Hospitalizations and Acute Illness/Injury data had been implemented recently, no analysis of the initial data was provided in the Facility's Self-Assessment. In addition, the Monitoring Team found no evidence that the protocols were being used to develop health management plans (HMPs) and guide nursing care and documentation. A review of 10 individuals' medical records (i.e., Individual #402, Individual #65, Individual #113, Individual #228, Individual #212, Individual #341, Individual #455, Individual #127, Individual #260, and Individual #381) who had been transferred to a community hospital, the Facility's Infirmary, or emergency room found: ▪ Nurses promptly and consistently performed a physical assessment on an individual displaying signs/symptoms of potential or actual acute illness in none (0%) of the cases. ▪ Licensed nursing staff timely and consistently 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 alignment with nursing protocols 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 10 individuals found essentially the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past reviews. The overall problematic issues included: ▪ There was a consistent lack of recognition that the symptoms the individuals	

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		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 behaviors, vital signs, oxygen saturations, and recurrent health problems; ▪ The lack of consistent nursing documentation made it impossible to accurately determine when changes in status were initially occurring; ▪ There was a consistent lack of follow-up for health issues noted in previous nurses' progress notes; ▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of PRN medications (as needed medications); ▪ There were consistent inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ The nursing notes lacked specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There was a lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any associated changes in mental status from physical changes in status; ▪ There were few mental status assessments documented during status changes; ▪ There was a consistent lack of documentation indicating that lung sounds were regularly assessed and documented for individuals with significant acute and recurrent 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; ▪ 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; ▪ A consistent lack of communication was noted between shifts regarding status changes, and the need for regular assessments and follow up; ▪ There was inadequate documentation or no documentation noted regarding individuals' status and assessment at the time of transfer to the hospital or emergency room; ▪ In the progress notes, there was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility; ▪ In the nursing notes, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented;	

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		▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ There was a consistent lack of regular follow-up days after the individual returned from the hospital for symptoms related to the initial reason for the hospitalization; ▪ Nursing Care Plans addressing health issues were consistently inadequate with regard to individualized goals and nursing interventions, and were not effectively modified after hospitalizations or in alignment with nursing protocols; ▪ Dates and times were not consistently documented for progress notes; ▪ A significant number of nursing progress notes and signatures were illegible; and ▪ There was inconsistent documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. Although the Facility reported that nursing protocols had been implemented, the Monitoring Team found no indication that they were being used to guide nursing assessments and documentation. 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 continuation of the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group, mentoring and supervision of nurses should focus on the use of the protocols. As noted from past reviews, due to the number of individuals with complex medical needs at AUSSLC, this area should be considered a priority for Facility review, and the development and implementation of action plans addressing the significant deficits that exist in the nursing care. The Facility's Self-Assessment indicated that it was not in compliance with these elements of this requirement, which was consistent with the Monitoring Team's findings. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that some of the Comprehensive Nursing Assessments and HMPs were missing from the active records. 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 August 2012, the Infection Control Nurse position had been vacant. In addition, the	

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		CNE reported that since the position had been vacant, the Facility had been unable to access much of the information contained in the Infection Control database and consequently, the following systems had not been accurately maintained: ▪ The Facility had not continued to utilize the process for ensuring data reliability to accurately identify the Facility's trends related to infectious and communicable issues. At the time of the review, the Drug Utilization Discrepancy Reports had not been used to generate data regarding discrepancies between different databases and data producing systems. Thus, the Facility had no system in place to monitor and track discrepancies to ensure data reliability and the accuracy of the documentation contained on the Infection Control Reports the residential staff completed. In addition, according to the Infection Control Committee Meeting minutes dated 7/24/12 and 9/27/12, discrepancies were found between data contained on the Antibiotic Usage versus the Infection Control Data Report regarding the percentages of antibiotics not reported for June, July, and August 2012. Without a reliable system in place to ensure data reliability regarding infection control issues, the Facility had no mechanism to ensure infectious illnesses were timely and clinically appropriately addressed, data analyses were timely completed, and that problematic issues were accurately identified and remedied. ▪ The Facility's Immunization database was not able to be accessed and was in the process of being reconstructed and entered on to a spreadsheet. Thus, at the time of the review, accurate information regarding individuals' immunizations was not available. In addition, the Facility had not been able to track, trend, or analyze any of the Facility's immunization data. Also, the Facility could not generate a list of all the individuals whose past immunizations had been researched, and were updated, as appropriate. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. However, on a positive note, since the past review, the Facility had completed 99% of individuals' Tuberculosis screenings. ▪ The documentation the Facility provided indicated 37 individuals had been diagnosed with conjunctivitis since the last review. Although training rosters were provided indicating some in-service trainings were conducted in response to this outbreak, no timeline or investigation was conducted regarding this outbreak to determine if notifications and treatments were timely conducted, or if possible causative factors were identified and adequately and timely addressed. Consequently, no review was conducted regarding this outbreak of a contagious illness. Of major concern and consistent with the same significant issues found during the previous reviews was the lack of nursing care plans and/or adequate nursing care plans found regarding infectious diseases,	

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		especially for the outbreak of conjunctivitis (more specific details of the Monitoring Team's findings are discussed with regard to Section M.3). Of the 37 individuals diagnosed with conjunctivitis, only 16 (43%) were found to have had an acute HMP addressing the infectious issue. Of the 16 Nursing Care Plans reviewed, none were found to be adequate (0%). ▪ In addition, the documentation the Facility provided showed 39 individuals had been diagnosed with MRSA, although the dates of occurrences were not provided to indicate if the timeframe of these incidents constituted an outbreak. Again, there was no indication the Facility had conducted a thorough review of these cases to determine causative factors in order to ensure problematic issues had been timely and adequately addressed. Of the 39 individuals diagnosed with MRSA, only 14 (36%) were found to have had an acute HMP addressing the infectious issue. Of the 14 Nursing Care Plan reviewed, none were found to be adequate (0%). ▪ Although Facility staff reported they recently had initiated the "Real Time" Infection Control monitoring tool, a review of the raw data indicated that of the care plans found, they were found to be clinically appropriate which was not consistent with the Monitoring Team's findings. In addition, there was no indication these data were being aggregated and analyzed along with other monitoring data addressing IC issues, and data regarding actual infection rates in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. Such analyses and related discussions about action plans implemented or potential solutions should be included in the minutes of the Infection Control Committee meeting minutes. ▪ The Facility had been conducting a number of Environmental Surveillance Checklists, and a number listed several specific problems. However, there was no documentation indicating that any of these problematic issues had been addressed. In addition, there was no trending or analysis of these data found in the Infection Control Meeting minutes. At the time of the review, a significant amount of work was yet to be done regarding infection control, especially regarding nursing care plans addressing the clinical care of individuals who experienced an infectious illness. As noted in previous reports, 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 and the Settlement Agreement, as well as providing professional feedback regarding the quality and completeness of the Infection Control Program.	

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		Mock Code Drills and Emergency Response Systems Since the last review, AUSSLC indicated the following steps were initiated regarding this area: ▪ Emergency Drills and the Emergency Drill Committee had been reinstated with the associated data analysis of the Emergency Drills in progress. However, from discussions with the Acting Director of the Competency and Training Department (CTD), the CNE, the Risk Manager, and the Director of Incident and Risk Management, the Emergency Drill Committee meetings had not taken place since July 2012 when the Facility began reporting on the Emergency Drills in the Incident Management Meetings. Thus, it was unclear to the Monitoring Team how data addressing actual medical emergencies and the Emergency Drills were being reviewed and analyzed regarding clinical and systematic issues. ▪ On a very positive note, the Monitoring Team's observations of nursing staff demonstrating emergency equipment checks in the Infirmary, and Residences 729 and 795 found that all staff were familiar with the use and operation of the emergency equipment. This was a significant improvement from previous reviews. In addition, the Nurse Educator was including information regarding oxygen flow rates when conducting the quarterly nursing emergency equipment drills. Although the Facility had begun to implement some positive steps to address the Emergency Response System, there were a number of problematic issues found that should be addressed in order for additional progress to be made: ▪ Since the State Office Emergency Response policy was implemented in December 2011, there had been various interpretations regarding the role of the Risk Manager and checking the emergency equipment to ensure it was present or to see if it was operational. At the time of the review, the Risk Manager reported he had been checking the emergency equipment to verify it was operational. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the requirement addressing checking the emergency equipment. ▪ Since the last review, the Facility had not conducted the required number of Emergency Drills largely due to staffing issues in the CTD. Although CTD reported that they still had one position vacant, an additional CTD staff member recently was hired to conduct drills during the evening and night shifts. This should assist in ensuring the Facility conducts all required Emergency Drills going forward. ▪ Although CTD had initiated a tracking form including the date, time, pass or fail status, and reason for any failed drill, the problematic issues were generically coded as one of the following categories: equipment, skills/knowledge, and participation. Without specific information addressing the reason for the failed	

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		drill, the data from the tracking form was impossible to accurately analyze to identify problematic trends and generate specific plans of correction. ▪ The data for August, September, and October 2012 indicated the pass rate for the Emergency Drills was 0%, 65%, and 29%, respectively. ▪ Consistent with past reviews, the Facility had not been conducting alternative scenarios, such as heat stroke, bee stings with anaphylactic shock, or head injuries. ▪ No analysis was found regarding actual medical emergencies in relation to clinical or systematic issues or in conjunction with the data addressing Emergency Drills. ▪ Although the CTD staff reported improvement, review of the documentation on the drills conducted indicated some staff, including nurses, were resistant to participating in the Emergency Drills. ▪ No system was in place to track when CDT recommended staff attend the CPR class in response to poor performance during the Emergency Drills to ensure staff had actually attended and passed the class, and to identify possible problematic trends. ▪ At the time of the review, it was unclear how many Automated External Defibrillators (AEDs) were currently at the Facility and the location of each AED. Consequently, the Monitoring Team was not able to determine if there were areas in the Facility that did not have an AED or quick access to one. The Facility should consider assessing the need for acquiring additional AEDs to ensure that emergency equipment is readily available. At the time of the review, the Facility was in the process of reviewing and rebuilding many of the systems related to AUSSLC's Emergency Response System. However, there continued to be some problematic issues as noted above that needed to be addressed.	
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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. AUSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ Regarding activities related to specific and detailed nursing documentation and discharge procedures necessary to maintain continuity of care in the community, the Facility Self-Assessment indicated that these activities had not yet been started. However, the Facility's Self-Assessment indicated that a review of the documentation validated that the Nursing Discharge Summary form had been used for all discharges to the community after 1/1/12. ▪ Although the Facility's Self-Assessment indicated that the State Monitoring Tool for Nursing Annual Assessments was implemented and the Quality Assurance	Noncompliance

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		Department was in the process of conducting data analysis, no data was provided addressing any initial findings. In addition, although a copy of a new tracking spreadsheet regarding the timely completion of quarterly/annual Comprehensive Nursing Assessments was provided, the color-coding indicating which assessments were timely completed was not reflected on the copy contained in the Section M Presentation Book. Thus, the Monitoring Team could not interpret the information. However, discussions with the Chief Nurse Executive (CNE) indicated that due to the number of vacant Case Manager positions during the review period, several Comprehensive Nursing Assessments had not been completed. In response to this problem, the Facility implemented a very positive action regarding the use of the Case Manager Tracking Calendar that included a written procedure addressing specific timeframes for when the assessment information was to be sent to the Case Manager Supervisor for review. In addition, in June 2012, the Facility developed and implemented a procedure to ensure that all individuals were assigned a Case Manager in the event of a vacancy or absent Case Manager position. This appeared to be a promising system to quickly identify the need to reassign the Case Manager duties in efforts to avoid gaps in nursing oversight and the associated documentation. ▪ The Facility's Self-Assessment indicated Training Compliance Rosters were completed for the Physical Assessment Class and Documentation Class to show the percentage of compliance. However, no information was provided in the Presentation Book for Section M or in response to the pre-review document request addressing the percent of compliance with this training. In addition, information contained in the Presentation Book for Section M.2 indicated that on 8/1/12, training was provided to the Case Managers regarding the Comprehensive Nursing Assessment and annual process. However, since there was no curriculum or training rosters included or provided in response to the pre-review document request, the Monitoring Team was unable to validate the quality of the training and the percentage of attendance. ▪ In a positive step forward, the Facility provided documentation demonstrating a plan was in place to address nurses who were delinquent in training, and the projected date for completion of the required training. ▪ Regarding any data analysis addressing the Nursing Comprehensive Assessments, the CNE indicated that at the time of the review, this system was in the developmental stages. <u>Self-Rating</u> The Facility's Self-Assessment indicated that: "Based on the findings from this assessment, this provision is not in substantial compliance."	

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		Although the Facility's finding of noncompliance was consistent with the Monitoring Team's findings, the reasons for the Monitoring Team's finding of noncompliance as noted below, were based on specific findings related to the significant problems with the quality and content of the Comprehensive Nursing Assessments, not just timeliness issues. As noted previously with regard to Section M.1, challenging staffing issues and a major turnover in the Nursing Department's leadership had precipitated the Facility to cease most of the nursing monitoring that had been initiated to some degree in the past. Discussions with Nursing Department leadership indicated that by the next review, some nursing monitoring would be implemented based on priority areas in an effort to generate accurate data regarding specific nursing practices in alignment with the Settlement Agreement. Although the Monitoring Team supported this reasonable and thoughtful strategy, a major concern for the Monitoring Team was that thus far in the review process, AUSSLC had not yet developed clinically appropriate curricula addressing the quality of the documentation contained in the Comprehensive Nursing Assessments. Even without internal monitoring to show this was a high priority, the Monitoring Team's findings have consistently shown this to be an issue in need of attention. The Facility's Action Plan addressing Section M.2 indicated that competency-based training was to be provided addressing "quality nursing assessments and adequate clinical analysis of the individual's progress." However, no specific curriculum was provided outlining how the training was being conducted or identifying the process for assessing competency regarding this area. The Quarterly/Annual Nursing Assessments for 20 individuals the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #251, Individual #128, and Individual #296 for dental issues; Individual #375, Individual #253, and Individual #16 for urinary tract infections; Individual #72, Individual #353, and Individual #122 for weight issues; Individual #34, Individual #147, and Individual #456 for skin issues; Individual #337 for constipation; Individual #79, and Individual #338 for circulation issues; and Individual #369, Individual #429, Individual #179, Individual #403, and Individual #405 for falls. ▪ Of the 20 individuals' nursing quarterly assessments reviewed, 10 (50%) were timely completed. Assessments not timely completed included those for: Individual #296, Individual #253, Individual #353, Individual #147, Individual #456, Individual #337, Individual #79, Individual #369, Individual #403, and Individual #405. ▪ 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.	

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		▪ There was an adequate assessment of the high and medium 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. Although the Facility's Self-Assessment indicated the Facility had begun using a spreadsheet to track the timely completion of the Comprehensive Nursing Assessments, the color-coding reflecting timely and late completion of the assessments was not represented on the black and white copy provided in the Section M Presentation Book. Thus, the Monitoring Team could not accurately interpret the Facility's data regarding timeliness. However, the Monitoring Team found that essentially no progress had been made regarding the quality of the quarterly/annual Comprehensive Nursing Assessments. Consistent with the findings from the previous reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate or appropriate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving, maintaining, or getting worse. Although during interviews, the CNE candidly reported the challenging problems regarding nursing staffing and the turnover in key nursing positions, which warranted a great deal of time and effort since the last review, the significant lack of progress the Monitoring Team found regarding the quality of the Comprehensive Nursing Assessments was concerning due to the potential impact it had on the health and wellbeing of individuals the Facility supported. Although the Facility had established a promising action plan to address this requirement, at the time of the review, most of the steps had not been started. This area should be considered a priority for the new Nursing Department's administration. It is crucial that nurses responsible for completing the quarterly/annual Comprehensive Nursing Assessments have the ability and understanding to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health status. The Facility should provide appropriate competency-based training regarding the Quarterly/Annual Comprehensive Nursing Assessments from a competent source to ensure the nursing assessments include an adequate clinical analysis of the individuals' progress. As noted in previous reports, without providing adequate and appropriate competency-based training and ongoing mentoring regarding the process and documentation of a clinical analysis, it is unlikely improvement will be seen in the quality of the Comprehensive Nursing Assessments as required by the Settlement Agreement. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the nursing notes and Nursing Discharge Summaries for 10 individuals including: Individual #342, Individual #350, Individual #395, Individual	

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		#165, Individual #241, Individual #326, Individual #52, Individual #187, Individual #242, and Individual #156 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental issues in none (0%) of the cases reviewed. As noted in previous reports, a number of problematic issues found during past reviews continued to be found in all 10 Nursing Discharge Summary Assessments reviewed, including: ▪ A lack of a comprehensive and specific nursing assessment for individuals being discharged/transitioned to the community; ▪ A significant lack of clinical assessments for clinical health indicators; ▪ A lack of an analysis of the individuals' health/mental health issues; ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments; ▪ A lack of clear information addressing the nursing interventions that were needed to care for individuals; and ▪ Incomplete and/or discrepancies in recommended treatments and services between the nursing documentation and documentation from other disciplines that was not discovered and/or reconciled prior to the community transition. Discussions with members of Nursing Administration indicated that nursing staff were not familiar with the Community Living Discharge Plan (CLDP) process, and reported that at times, they had very little notice that an individual was scheduled transition to the community. During the review week, members of the Nursing Department's leadership met with the Assistant Director of Programs and noted that there was no procedure in place describing the Nurse Case Managers' role and responsibilities regarding the CLDP process. In addition, they found inconsistencies regarding the documentation provided to the receiving community providers. On a positive note, in response to some of the problematic issues the Facility identified, an initial plan of action was developed to include the use of a checklist outlining the process and required documentation. However, it is essential that AUSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. Due to AUSSLC's increased focus and the actual	

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		number of individuals being transitioned to the community, the consistent problematic findings regarding nursing transition/discharge documentation identified through the Monitoring Team's review were extremely concerning. Since the past review, the problematic issues regarding the quality and content of the nursing assessments for discharges/transitions to the community had not been positively impacted by the implementation of a new statewide form. In addition, it was troubling that due to the poor quality of the Risk Action Plans/Health Management Plans (as discussed with regard to Section M.3), the Monitoring Team found no nursing documentation that provided specific guidance regarding the type and frequency of nursing interventions the individuals required. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision. This was consistent with the Facility's finding in its Self-Assessment.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. AUSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ From discussions with the Assistant Director of Programs and the Chief Nurse Executive, since the Monitoring Team's last review, the Facility had only recently received the initial statewide training regarding the modifications to the At Risk and ISP process. Additional training for these areas was to take place sometime after the review week. Thus, at the time of the review, the Facility had not made the transition from using the Health Management Plans to address high and medium health and mental health risks to using an Integrated Health Care Plan that will ultimately replace the current Risk Action Plans and Health Management Plans. Although the future use of an Integrated Health Care Plan will be a very promising clinical move forward for AUSSLC, it was of major concern to the Monitoring Team that the quality of the existing HMPs and Acute Care Plans had not improved since the past reviews as discussed in detail below. In addition, as the new system is implemented, the Facility needs to address how nursing interventions for certain chronic conditions that do not rise to the level of a high or medium risk or are not acute issues would be accounted for in the integrated plan of care. <u>Self-Rating</u> The Facility's Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance."	Noncompliance

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		The records of 20 individuals the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #251, Individual #128, and Individual #296 for dental issues; Individual #375, Individual #253, and Individual #16 for urinary tract infections; Individual #72, Individual #353, and Individual #122 for weight issues; Individual #34, Individual #147, and Individual #456 for skin issues; Individual #337 for constipation; Individual #79, and Individual #338 for circulation issues; and Individual #369, Individual #429, Individual #179, Individual #403, and Individual #405 for falls. Of the 20 individuals' Nursing Care Plans/Health Management Plans reviewed: ▪ Twelve (60%) were found to have a HMP addressing their high-risk health/mental health indicator. Individuals who did not have a related HMP included: Individual #251, Individual #128, Individual #296, Individual #34, Individual #456, Individual #338, Individual #403, and Individual #405. ▪ None (0%) of the nursing goals listed in the 12 HMPs were clinically appropriate. ▪ None (0%) of the nursing interventions contained in the 12 HMPs indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. ▪ None (0%) of the 12 HMPs were found to be clinically adequate. The overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. Also, the nursing interventions listed in the HMPs reviewed were not in alignment with the nursing protocols addressing the specific health issues. ▪ None (0%) of the 12 HMPs contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 12 HMPs were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 12 HMPs, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. As noted above, the Facility reported that they were in the initial training stages regarding the new process of transitioning from using the traditional nursing care plans (Health Management Plans) to an Integrated Health Care Plan. Although the transition to the use of an integrated care plan was a promising step forward, the Facility had not yet addressed a number of problematic issues that could compromise this new system resulting in essentially the same significant problems as noted above within the current system. Specifically, some of the issues the Monitoring Team identified in the HMPs it reviewed that the Facility will need to ensure are not repeated in IHCPs included the	

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		following: ▪ The rationale for several risk levels did not include the needed clinical justification to support the designated level. Consequently, it was difficult for the Monitoring Team to determine the accuracy of the risk levels and the need for action steps addressing the health risk. ▪ The nursing goals listed in the HMPs reviewed did not address the etiology of the health problem as an objective clinical indicator to focus on. Consequently, most action steps found in the HMPs did not address the underlying cause of the health issue and had no association with the nursing goals listed. ▪ None of the nursing action steps found in the HMPs were in alignment with the clinical assessments the nursing protocols required for the specific health issues. ▪ The action steps contained in the HMPs did not include specific information regarding who would implement the intervention, such as the RN, LVN, or Speech Therapist; how often they were to be implemented, such as on which shift if daily; consistently noting where they were to be documented; how often they would be reviewed; and/or when they should be considered for modification. Overall, most of the nursing action steps continued to be meaningless in that they were at times generic, and non-specific to the individual's health care needs. ▪ At the time of the review, the HMPs reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, and were not adequately individualized. Although the use of the IHCP had not yet been implemented, many of the problematic issues noted above that have been found consistently and not resolved within the existing HMPs have the potential of being transferred to the new IHCP system. Regardless of the system and system changes made to the Facility's overall plans of care, it is essential that the Facility address the lack of clinically adequate care plans for the individuals under their care. The Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at AUSSLC Regarding nursing care plans addressing infectious illness, the documentation the Facility provided to the Monitoring Team indicated there were 20 individuals with chronic infectious issues (i.e., Individual #53, Individual #194, Individual #234, Individual #101, Individual #99, Individual #274, Individual #204, Individual #248, Individual #429, Individual #325, Individual #399, Individual #137, Individual #17, Individual #91, Individual #378, Individual #433, Individual #243, Individual #306, Individual #453, and Individual #73). ▪ Of the 20 individuals, eight (40%) were found to have had HMPs addressing the infectious issue. The individuals without an HMP addressing the infectious issue included: Individual #101, Individual #274, Individual #248, Individual #429,	

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		Individual #325, Individual #399, Individual #17, Individual #91, Individual #378, Individual #433, Individual #243, and Individual #453. ▪ Of the eight Nursing Care Plans reviewed, none were found to be adequate (0%). Regarding nursing care plans addressing other infectious illness, the Facility list indicated that since the Monitoring Team's last review, 39 individuals were diagnosed with MRSA (i.e., Individual #351, Individual #117, Individual #310, Individual #268, Individual #186, Individual #90, Individual #254, Individual #10, Individual #71, Individual #279, Individual #172, Individual #53, Individual #107, Individual #290, Individual #309, Individual #344, Individual #425, Individual #146, Individual #202, Individual #335, Individual #378, Individual #152, Individual #358, Individual #294, Individual #41, Individual #126, Individual #124, Individual #448, Individual #59, Individual #219, Individual #73, Individual #214, Individual #385, Individual #306, Individual #223, Individual #147, Individual #103, Individual #402, and Individual #454), and 37 individuals were diagnosed with Conjunctivitis (i.e., Individual #409, Individual #340, Individual #21, Individual #23, Individual #433, Individual #358, Individual #417, Individual #222, Individual #169, Individual #18, Individual #366, Individual #405, Individual #390, Individual #102, Individual #422, Individual #113, Individual #456, Individual #72, Individual #385, Individual #100, Individual #268, Individual #115, Individual #147, Individual #336, Individual #101, Individual #22, Individual #239, Individual #1, Individual #375, Individual #2, Individual #304, Individual #127, Individual #28, Individual #370, Individual #57, Individual #333, and Individual #450). ▪ Of the 39 individuals diagnosed with MRSA, 14 (36%) were found to have had an acute HMP addressing the infectious issue. The individuals who did not have an HMP addressing the infectious issue were: Individual #351, Individual #310, Individual #186, Individual #90, Individual #254, Individual #10, Individual #172, Individual #53, Individual #344, Individual #425, Individual #202, Individual #335, Individual #378, Individual #152, Individual #294, Individual #41, Individual #124, Individual #448, Individual #59, Individual #219, Individual #73, Individual #214, Individual #385, Individual #306, and Individual #103. ▪ Of the 14 Nursing Care Plan reviewed, none were found to be adequate (0%). ▪ Of the 37 individuals diagnosed with conjunctivitis, 16 (43%) were found to have had an acute HMP addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #409, Individual #340, Individual #21, Individual #23, Individual #417, Individual #222, Individual #169, Individual #422, Individual #100, Individual #268, Individual #336, Individual #239, Individual #1, Individual #375, Individual #366, Individual #127, Individual #28, Individual #370, Individual #57, Individual #333, and Individual #450.	

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		▪ Of the 16 Nursing Care Plans reviewed, none were found to be adequate (0%). At the time of the review, 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 concerning to find that a significant number of individuals with contagious/infectious illnesses did not have care plans or adequate care plans addressing these illnesses. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurse when hired, should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. In order for the Facility to make progress regarding this provision of the Settlement Agreement, the HMPs/Integrated Health Care Plans should: ▪ Be in alignment with interventions and assessments from the nursing protocols; ▪ 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; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized for plans of care. Overall, there had been basically no progress made addressing this provision of the Settlement Agreement. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. With regard to this provision, AUSSLC's Self-Assessment indicated the following actions were implemented: ▪ At the time of the review, the Facility's Self-Assessment indicated that a review was in process regarding all nurse training, new policies, procedures, protocols, and forms. In addition, the Self-Assessment indicated that since the last review, systems had been developed and were in the process of being implemented regarding having the Nurse Educator track the nursing training and education using the statewide nursing education curriculum and competency check –off materials. ▪ Regarding nursing training, it was unclear to the Monitoring Team if random interviews, walkthroughs, spot checks, and random competency skills checks	Noncompliance

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		actually had been implemented at the time of the review with the nurses to ensure the training had been effective and that nurses were knowledgeable of process that had been implemented as noted in the Facility's Self-Assessment. No information or data was provided in the Presentation Book or in responses to relevant document requests to address this area. ▪ Although the Self-Assessment indicated that education had been provided to the campus regarding the statewide Protocol Cards, there was no training curriculum or training rosters included in the Section M Presentation Book or in responses to relevant document requests for the Monitoring Team to validate the quality of the content, the methods used, and percent of attendance regarding the training that was provided. In addition, the Self-Assessment indicated that follow-up monitoring was to be done regarding nursing documentation in alignment with the Nursing Protocols. However, no initial data was provided in the Self-Assessment or the Presentation Book for Section M addressing this area. ▪ The Facility's Self-Assessment indicated that activities had not yet been implemented regarding conducting random interviews to ensure that all nurses were knowledgeable of the location of the Lippincott Manual of Nursing Practice and other State and local Facility policies, procedures, and protocols; or that all nurses at the Facility were knowledgeable regarding how to access nursing procedures, protocols, guidelines, and forms on the Facility's SharePoint system. <u>Self-Rating</u>: Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "Based on the findings from this assessment, this provision is not in substantial compliance." Although the Facility indicated the nursing protocols had been implemented, the Monitoring Team found no evidence they were actually being used since the same significant problematic issues as was found during previous reviews were found for the current review regarding nursing assessments, care plans, and the overall nursing care and associated documentation. As noted in relation to nursing care plans discussed with regard to Section M.3, and the documentation of nursing care for individuals who were admitted to a community hospital detailed with regard to Section M.1, since the Monitoring Team's last review, any training provided regarding the nursing protocols had not improved the problems with nursing practices and care or brought them into alignment with the standards of care outlined in the nursing protocols. In addition, the major concerns the Monitoring Team had regarding these consistent problematic issues, especially related to individuals with high-risk health indicators and their changes in status warranting hospital admissions, was confirmed during an onsite review of Individual #65's health care prior to his death in October 2012.	

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		While the Monitoring Team was on site, a review of Individual #65's medical record was conducted with some members of the nursing staff as well as members of the Facility's Physical and Nutritional Management Team. From the documentation provided by the Facility identifying risk ratings, he was noted to be at medium risk for constipation/ bowel obstruction, dental issues, falls, fractures, polypharmacy, skin integrity, and weight issues. These medium risk ratings had been assigned in spite of the fact he had been admitted to the Infirmary during the past year on 2/2/12, 2/8/12, 2/22/12, 3/19/12, 4/16/12, 5/1/12, 7/23/12, 8/4/12, 8/6/12, 8/19/12, 9/2/12, 9/30/12, 10/13/12, and 10/15/12 for episodes of clogged and dislodged G- and/or J-tubes, urinary tract infections, tachycardia, resolving lleus, two episodes of hyperthermia, abdominal distention, status post aspiration pneumonia, status post tube replacement, dental extraction, and episodes of cellulites to his stoma site. In addition, he had been hospitalized throughout the past year on 1/28/12, 2/3/12, 2/22/12, 3/13/12, 4/1/12, 4/25/12, 7/22/12, 8/11/12, 9/7/12, 9/28/12, 10/14/12, 10/15/12, and 10/16/12, related to fever and cellulites, urinary tract infections, hyperthermia, clogged/dislodged G- and/or J-tubes, tube replacements, aspiration pneumonia, abdominal distention, and aspiration pneumonia and respiratory failure. In reviewing the documentation for Individual #65, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included: ▪ There was no quarterly Comprehensive Nursing Assessment for June 2012 found in the active record at the time of the review in November 2012. ▪ The summaries found in the Comprehensive Nursing Assessments contained in the active record did not adequately address any the health risks or changes in status that this individual frequently experienced. ▪ The HMPs found in the Active Record addressing constipation, gastrostomy/ jejunostomy tube, skin integrity, risk for aspiration, risk for fractures, seizures, and urinary tract infections were the basic template with little to no individualization for an individual with a significant number of health risks. ▪ None of the HMPs noted above were in alignment with nursing protocols. ▪ Although the risk levels were not accurately assigned, there were no HMPs found addressing his medium-risk health indicators for dental issues, falls, weight issues, and polypharmacy. ▪ The IPNs contained no consistent and regular nursing assessments to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, skin assessments, treatments provided, pain assessments, vital signs, oxygen saturations, bowel and urinary output, daily fluid input, assessments for hydration, bowel sounds, and abdominal palpation.	

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		▪ There were gaps in the nursing documentation indicating that nursing was not regularly checking and assessing an individual with several health risks and changes in status. ▪ Since there were no nursing assessments regularly conducted, changes in status could not be quickly recognized and responded to. ▪ There was no indication that the physician was consistently notified of changes in status. ▪ There was no indication that the risk levels were reviewed/revised after changes in status and hospitalizations. ▪ No IPNs were found indicating that Individual #65 was being followed, assessed, or regularly monitored by the PMNT, at the time changes in status occurred. ▪ There was no indication the PNMT was notified of changes in status, especially regarding issues related to chronic problems with the G- and/or J-tubes. ▪ There was no documentation from nursing indicating how nutrition was being provided when ongoing problematic issues with the tubes prevented their use. ▪ There was no nursing note found documenting the individual's status and transfer to the hospital on 10/16/12, prior to his death while in the hospital. Also, a review of an additional nine individuals that were admitted to the hospital since the last review (i.e., Individual #402, Individual #113, Individual #228, Individual #212, Individual #341, Individual #455, Individual #127, Individual #260, and Individual #381) found similar problematic issues throughout the nursing documentation as those found during Individual #65's onsite review (more detailed findings are provided with regard to Section M.1). These consistent problematic findings did not support that the Facility had actually implemented the use of nursing protocols. From the Monitoring Team's review, there was no indication that nursing was actually using nursing protocols as part of a structured system 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 care plans were developed that outlined specific nursing interventions for specific health issues; and ▪ Audits addressing nursing practice accurately reflected quality standards by which to measure the Facility's nursing care, and documentation. Consistent with past reviews, the problematic findings from this review indicated that	

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		AUSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility indicated that it was not in compliance with this requirement. This was consistent with the findings of the Monitoring Team.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. In response to this requirement, AUSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ The Facility's Self-Assessment indicated that regarding a review of the status of compliance with the At-Risk Individual Policy, associated procedures including the Aspiration Pneumonia/Enteral Nutrition Evaluation and the Aspiration Triggers Data Sheets, and random reviews to ensure prompt response to triggers, notification of IDT members, and follow up to resolution, training was in process addressing these areas. Thus, no data was available. ▪ However, although not related to this provision, the Self-Assessment for Section M.5 contained information related to issues regarding infection control that are discussed above with regard to Section M.1. <u>Self-Rating</u> The Facility's Self-Assessment indicated that: "based on the findings from this assessment, this provision is not in substantial compliance." Consistent with past reviews, the findings from the Monitoring Team noted below indicated the documentation reviewed did not adequately address individuals' health/mental clinical health risks in alignment with the requirements of this provision. As noted in more detail with regard to Section I, statewide revisions had been made to the At-Risk Individuals system. Some of the revisions included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, linking each risk factor with specific clinical indicators, and reformatting the Integrated Risk Rating Form to follow the same grouping sequence as the Risk Guidelines. In addition, the Risk Action Plans for the identified high and medium risk indicators were replaced with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually, supplemental forms regarding IRRF and the IHCP were developed addressing changes in status, the Aspiration Pneumonia Enteral Nutrition evaluation was revised to be used as a data collection tool rather than a format for assessment, and individual-specific Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. At the time of the review, the Facility was in the initial process of being trained regarding the revisions to the ISP and the At Risk process. Further training was to be provided after the week of the review.	Noncompliance

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		Thus, since the Facility had not yet implemented the Enhanced Risk Process at the time of the review, the Monitoring Team was not able to assess any progress made from any system revisions. However, the Facility Self-Assessment contained no information addressing the existing problematic issues found from previous reviews regarding this provision. A review of records for 20 individuals determined to be at risk (i.e., Individual #251, Individual #128, and Individual #296 for dental issues; Individual #375, Individual #253, and Individual #16 for urinary tract infections; Individual #72, Individual #353, and Individual #122 for weight issues; Individual #34, Individual #147, and Individual #456 for skin issues; Individual #337 for constipation; Individual #79, and Individual #338 for circulation issues; and Individual #369, Individual #429, Individual #179, Individual #403, and Individual #405 for falls) found that none (0%) included adequate nursing risk assessments. A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 20 individuals found that none of them (0%) contained an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. In fact, the Comprehensive Nursing Assessments the Monitoring Team reviewed were noted to have regressed from previous reviews in that some of the nursing assessments did not include any clinical information regarding the health risk indicators, while others merely listed the generic interventions from the HMPs or the IPNs from the active record. A review of these 20 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 (IRRFs). Although as noted with regard to Section I, the Monitoring Team found that there was an overall increase in the specific clinical information contained on some of the forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, cardiac, osteoporosis, and dates of injuries/fractures, there was a lack of individual-specific information noted that did not support the risk rating assigned. In addition, when reviewing some the Integrated Risk Rating forms for individuals who had changes in status, there were no revisions or updates to information found on the IRRFs. As noted from the previous reviews, nursing had no specific procedure in place to address the nursing assessment process and the analysis of the identified risk indicators. Consistent with the findings from past reviews, the nursing assessments for the At-Risk individuals were not adequate to address the health risks of the individuals reviewed.	

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		In addition, a review of the 20 records for these individuals determined to be at risk found there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage fluids or increase activity, which would have led to a preventative intervention, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 17 of the cases (85%). Individuals who had not had their Risk Action Plans integrated into their ISPs included: Individual #122, Individual #179, and Individual #369. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. At the time of the review, the Facility had not yet received all the required training regarding the revisions to the At-Risk Individuals Policy and had just begun to use the new ISP format during the review week. However, the significant existing deficits in the current At-Risk system, especially the nursing components of the system regarding the Comprehensive Nursing Assessments, the individual-specific information contained in the IRRFs from nursing, and the quality of the all the interventions contained in the Risk Action Plans and HMPs still needed to be addressed. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area.	

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		At the time of the review, the Facility indicated that they were not in compliance with this requirement of the Settlement Agreement. This 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 applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment, which provided a summary of the Facility's assessment of its progress. In response to this requirement, AUSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following: ▪ Regarding the review of the Medication Administration and Documentation monitoring tool data completed within the past six months, trend analysis, plans of correction, and validation that plans of corrective action were carried out to resolution, the Facility's Self-Assessment indicated it implemented the State Monitoring Tool for Medication Variance tracking and QA Department was in the process of analyzing these data. However, no additional information was provided in the Self-Assessment addressing the initial findings of the audits. ▪ The Facility's Self-Assessment indicated the percentages of nurses observed administering medications each quarter varied between the units. However, no specific compliance percentages were provided in order for the Facility or the Monitoring Team to determine progress in meeting this requirement. ▪ At the time of review, approval for the expansion of the medication rooms for nursing had been obtained and plans for their design were underway. ▪ Regarding the review of the quarterly Medication Administration Observations data for both oral and enteral administration, the Facility's Self-Assessment indicated that these data were reviewed quarterly and trended for issues. However, no information was provided addressing the findings of these reviews in the Self-Assessment or the Section M Presentation Book. ▪ The Facility reported that since the last review, the Facility had implemented having the nurses reading the Physical Nutritional Management Plans out loud to ensure that the PNMP instructions and positioning guidelines were being implemented. However, random reviews of the Medication Administration Records to ensure that the PNMPs were present had not yet been implemented. ▪ The Facility's Self-Assessment indicated that since the last review, the Medication Variance Committee was reinstated and met monthly. From discussions with the CNE and the Director of Pharmacy, the Facility had taken a positive step forward by beginning to critically review a number of the systems addressing medication administration and medication variances. ▪ In addition, the Facility implemented weekly Medication Room Inspections with spot checks also conducted by Pharmacy. However, no additional information	Noncompliance

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		was provided regarding any initial findings or corrective actions implemented from these inspections in the Facility's Self-Assessment. However, the Monitoring Team noted that some initial information regarding the inspections was contained in the Medication Error Committee Meeting minutes, dated 10/9/12. ▪ The Facility's Self-Assessment indicated that at the time of the review, coordination between Habilitation Therapies and Nursing was in process to develop a protocol for use of adaptive equipment during medication administration. <u>Self-Rating:</u> Regarding the Facility's compliance rating, the Self-Assessment stated: "based on the findings from this assessment, this provision is not in substantial compliance." In addition to the information that was provided in the Facility's Self-Assessment, interviews with the CNE and Director of Pharmacy, and review of the minutes of the Medication Error Committee Meetings indicated that since the last review, the Facility also had initiated the following steps regarding the Facility's overall medication administration system: ▪ In May 2012, the Facility implemented a very positive procedure that included requiring two nurses to count seven-day refills of medications sent from the pharmacy to the residences to verify all medications were present. In addition, nurses were required to count between shifts to ensure all medications were accounted for, and if there were discrepancies, the cause of the discrepancy would be timely identified, addressed, and documented on a Count Sheet. ▪ The Facility had developed specific written protocols addressing the process for physician orders and the use of Diastat in response to problematic issues that resulted in medication variances. ▪ Pharmacy and Nursing have been working together to identify discrepancies between the two disciplines regarding medication variance data. ▪ In September 2012, three new medication carts were ordered for the Facility. ▪ An interview with the Director of Pharmacy and review of the Facility's variance data indicated the Facility was now including any pharmacy and medical variances in the Facility's overall variance data. Although the Facility had taken some positive steps forward, at the time of the review, AUSSLC continued to have some significant problematic issues regarding its overall medication administration system. From review of the Medication Error Committee Meeting minutes, the Pharmacy and Therapeutics Committee meeting minutes, the Facility's medication variance data, Medication Administration Observation data, and	

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		discussions with Nursing Department staff, the following were some of the problematic issues identified: ▪ Although the Facility implemented the procedure for counting the seven-day refills of medications sent from the pharmacy to the residences, a number of emails the Facility provided indicated there were problematic issues regarding the nurses signing and returning the fill sheets back to the pharmacy to verify all the medications were received. ▪ Although Pharmacy and Nursing had been focusing significant energy on reviewing a number of the systems related to the Facility's medication administration system, the Facility continued to have problematic issues regarding the number of unexplained medications being returned to the Pharmacy each month, indicating a number of dosages potentially were not being given as ordered. ▪ A review of the percent compliance from the Medication Administration Observations conducted was found to be consistently between 83% and 100%. However, given the Facility's data showed continued unexplained shortages of medications and unexplained excesses of medications returned to the pharmacy, and medications not being sent back to the pharmacy for refill indicating the medication was not being administered as ordered, the Medication Administration Observation data was highly questionable. At the time of the review, there was no indication nursing was analyzing these obvious discrepancies in data. ▪ Medication Administration Observations were not being conducted every quarter on every nurse as the Facility's policy required. ▪ At the time of the review, no formal tracking system had been implemented addressing the type of medications being returned to the pharmacy in order to identify potential clinical issues related to trends of unexplained returned medications. For example, if seizure medications were being returned in large numbers, the Facility should have determined if a trend was occurring with increases in seizure activity. ▪ Although the Facility was spending much time and effort trying to reconcile the number of unexplained shortages or returned medications each month, the number of actual medication variances suggested that AUSSLC continued to have a significant problem regarding the under-reporting of medication variances. ▪ In addition, from discussions with the CNE, to determine a passing or failing grade for a medication administration observation, the Facility had been calculating a single compliance score from the items contained on the Medication Administration Observation monitoring tool. However, during past reviews, the Monitoring Team had indicated that since the items on the tool	

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		were not weighted according to priority and safety, single compliance percentages could reflect high compliance scores, yet the nurses observed could have inadequately performed a critical procedure. For example, a nurse could have drawn an exceedingly wrong dosage of insulin, but with the current scoring procedure, this critical error would not have been accurately reflected in the single compliance score for that particular medication observation. The Facility in conjunction with the State should consider identifying critical elements of the medication administration procedure that if not completed appropriately would result in a failed observation rather than trying to assign weight to each of the items. The weighting of such a tool would usually involve a lengthy and involved systematic process, which is not necessary to achieve the desired result. A review of the medication variances the Facility reported in response to a request by the Monitoring Team for the variance data to be separated by variances, excesses, shortages, pharmacy variances, and medical variances indicated the following: ▪ May 2012 - 64 variances and no short and/or returned medications; ▪ June 2012 - 223 variances and 28 short and/or returned medications; ▪ July 2012 - 102 variances and 12 short and/or returned medications; ▪ August 2012 - 63 variances and 11 short and/or returned medication; ▪ September 2012 - 63 variances and one short and/or returned medication; and ▪ October 2012 - 91 variances and seven short and/or returned medications. However, as noted in Section N.8, there were significant discrepancies found between Facility documents regarding the actual number of variances, excesses, and shortages for each month. Discussions with the Director of Pharmacy and the CNE indicated that they were finding discrepancies between their data reports and were in the process of trying to reconcile these inconsistencies. Based on observations of medication administration at Castner, the Monitoring Team noted considerable improvement from the previous reviews regarding telling the individuals the medications they were receiving, the provision of privacy during medication administration, and listening to lung sounds before and after medication administration, when appropriate. However, inconsistencies were noted regarding reading the PNMP to the individuals and knowing the correct position for the individual during medication administration. Although the nurses observed did review the PNMP before administering the medications, one nurse was not able to identify the correct position the individual should be in while receiving medication. Although a number of problematic issues continued to be noted regarding the	

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		medication administration systems at AUSSLC, the Facility clearly had begun to take steps to thoroughly review and implement strategies to address some of the problematic elements of the medication administration system. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system. The Monitoring Team found the Facility was not in compliance with this provision. The Facility's finding in its Self-Assessment was consistent with the Monitoring Team's finding.	

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

1. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. (Section M.1)
2. Also, as previously recommended, as AUSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions. (Section M.1)
3. The Facility should continue to implement the use of nursing protocols to guide nursing practices. In conjunction with the continuation of the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group, mentoring and supervision of nurses should focus on the use of the protocols. (Section M.1)
4. As noted in past reports, due to the number of individuals with complex medical needs at AUSSLC, acute changes in status should be considered a priority for Facility review, and the development and implementation of action plans addressing the significant deficits that exist in the nursing care. (Section M.1)
5. 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)
6. The Facility should aggregate and analyze the data from the "Real Time" Infection Control audits, along with other monitoring data addressing IC issues, and data regarding actual infection rates in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. (Section M.1)
7. Such analyses and related discussions about action plans implemented or potential solutions should be included in the minutes of the Infection Control Committee meeting minutes. (Section M.1)
8. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. (Section M.1)
9. 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 and the Settlement Agreement, as well as providing professional feedback regarding the quality and completeness of the Infection Control Program. (Section M.1)
10. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the requirement addressing checking the functioning of the emergency equipment. (Section M.1)
11. The Facility should provide appropriate competency-based training regarding the Quarterly/Annual Comprehensive Nursing Assessments from a

competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. (Section M.2)

12. It is crucial that AUSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. (Section M.2)
13. The Facility should develop and implement appropriate care plans based on priority, and risk for all the individuals at AUSSLC. (Section M.3)
14. Nursing Administration, in conjunction with Infection Control, should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)
15. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area. (Section M.5)
16. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement plans of actions aimed at long-term resolutions. (Section M.6)
17. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, and reconcile discrepancies regarding the actual variances that have occurred. (Section M.6)
18. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a thoughtful and critical review of the overall medication system. (Section M.6)
19. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. (Facility Self-Assessment)
20. The Facility should address processes regarding establishing inter-rater reliability for each of the monitoring tools. (Facility Self-Assessment)
21. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation, and analysis and provide training to the disciplines regarding how to analyze their data to identify problematic trends. (Facility Self-Assessment)

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: o **Review of Following Documents**: o Any policies, procedures, and/or other documents addressing the provision of pharmacy services, including for updated policies, highlights of the approved changes; o Any pharmacy surveys completed within the last year, plans of correction and/or internal auditing procedures and reports related to pharmacy services; o All Drug Utilization Evaluations (DUE) reports completed since last monitoring visit, including background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results; o Any follow–up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics Committee meetings and any attachments, since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance, since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments, since the Monitoring Team's last visit; o DUE calendar for next 12 months, including specifications whether fiscal year or calendar year; o For Quarterly Drug Regimen Reviews, for all individuals the Facility serves, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews are actually completed beginning 1/1/12; o For Quarterly Drug Regimen Reviews two most recent per residential home that have been completed with physician signatures and dates, including for anticholinergic justification, documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for polypharmacy justification, document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy including those for: Individual #279, dated 6/15/12, 9/11/12; Individual #6, dated 4/20/12, 8/3/12; Individual #210, dated 3/30/12, 6/26/12; Individual #369, dated 4/6/12, 7/17/12; Individual #32, dated 6/15/12, 9/6/12; Individual #184, dated 4/10/12, 7/31/12; Individual #339, dated 6/14/12, 9/6/12; Individual #445, dated 4/17/12, 7/30/12; Individual #353, dated 5/3/12, 8/10/12; Individual #248, dated 5/29/12, 8/23/12; Individual #325, dated 5/25/12, 8/22/12; Individual #94, dated 6/19/12, 9/21/12; Individual #24, dated 5/3/12, 8/10/12; Individual #246, dated 3/21/12, 6/21/12; Individual #390, dated 6/6/12, 8/30/12; Individual #179, dated 6/15/12, 9/11/12; Individual #126, dated 5/23/12, 8/17/12; Individual #261, dated 4/10/12, 7/31/12; Individual #153, dated 6/19/12, 9/21/12; Individual #421, dated 4/17/12, 7/30/12; Individual #268, dated 6/11/12, 9/5/12; Individual #23, dated 5/29/12, 8/23/12; Individual #87, dated 3/22/12, 9/18/12; Individual #399, dated

	5/22/12, 8/17/12; Individual #253, dated 3/21/12, 6/21/12; Individual #45, dated 6/14/12, 9/6/12; Individual #148, dated 3/22/12, 9/18/12; Individual #155, dated 3/30/12, 7/24/12; Individual #185, dated 4/24/12, 8/7/12; Individual #100, dated 6/7/12, 8/30/12; Individual #97, dated 3/30/12, 7/24/12; Individual #436, dated 4/6/12, 7/17/12; Individual #103, dated 6/4/12, 8/28/12; Individual #455, dated 6/4/12, 8/28/12; Individual #14, dated 5/17/12, 8/15/12; Individual #359, dated 5/24/12, 8/22/12; Individual #186, dated 6/11/12, 9/5/12; Individual #79, dated 4/27/12, 8/8/12; Individual #147, dated 4/27/12, 8/8/12; Individual #202, dated 6/14/12, 9/6/12; Individual #2, dated 4/26/12, 8/7/12; Individual #344, dated 3/30/12, 6/26/12; Individual #235, dated 5/16/12, 8/15/12; and Individual #109, dated 4/20/12, 8/3/12; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders; for four most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #32 9/6/12, Individual #248 8/23/12, Individual #94 9/21/12, Individual #206 9/21/12, Individual #23 8/23/12, Individual #43 6/26/12, Individual #455 8/28/12, Individual #323 9/5/12, Individual #346 9/6/12, Individual #458 9/18/12, Individual #232 8/10/12, Individual #186 9/5/12, Individual #202 9/6/12, and Individual #316 8/10/12; o All "single patient intervention reports" in WORx system since the Monitoring Team's last visit; o Since the last review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of all "notes extracts" associated with "single patient intervention reports;" o For the past six months, any adverse drug reaction reports (ADR) completed; o Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation, and potential errors; o Number of medication errors variances per month for prior 12 months by error type, nurse, home, shift, unit, individual, category of severity, error mode, including graphs, charts (per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc.; o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Copy of any communication between pharmacy and Nursing Department concerning medication errors/variance (e.g., emails, memos, etc.), since the Monitoring Team's last visit; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Any policies, procedures, and/or other documents addressing medication administration; o List of antibiograms per month for last six months by building; o Medication history for individuals with J or G/J tubes (not G tubes);

	o A schedule of when Quarterly Drug Regimen Reviews are conducted by home/unit; 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; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #30 8/10/12, Individual #1 7/19/12, Individual #350 5/29/12, Individual #74 6/1/12, Individual #74 7/12/12, Individual #74 9/20/12, Individual #74 9/21/12, and Individual #74 9/24/12; o Any trend analysis of chemical restraint use (graphs, etc.); o For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months, with the name/source of the database clearly identified; o For 10 orders involving drug-drug interactions, copies of physician orders, serial computer screen shots for each step, with physician order reflecting any order change based on pharmacy intervention. Documents were submitted for the following 10 individuals: Individual #321 9/26/12, Individual #72 9/26/12, Individual #398 9/27/12, Individual #196 9/24/12 (two interactions), Individual #196 9/23/12, Individual #105 6/1/12, Individual #270 9/27/12, Individual #341 9/24/12, and Individual #416 9/28/12; o For four orders involving potential allergic reactions for new physician orders, copies of serial computer screen shots for each step, with physician order reflecting any order change based on pharmacy intervention. Documents were submitted for the following individuals: Individual #321 9/27/12, Individual #224 9/27/12, Individual #22 6/20/12, and Individual #195 8/28/12; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of new physician order, computer screen shots for each step, with physician order reflecting any order change based on pharmacy intervention. Documents submitted were for the following individuals: Individual #332 10/5/12, Individual #398 9/28/12, Individual #16 9/27/12, Individual #7 10/2/12, and Individual #416 9/28/12; o For five new orders in which labs were reviewed/monitored, copy of new physician order, copies of serial computer screen shots for each step, copy of any physician order reflecting any order change based on pharmacy intervention. Documents were submitted for the following individuals: Individual #375 8/20/12, Individual #42 10/2/12, Individual #16 9/27/12, Individual #80 10/2/12, and Individual #220 9/25/12; o For five new orders for which there was potential for significant side effects, copies of new physician order, copies of serial computer screen shots for each step, copy of any physician order reflecting any order change based on pharmacy intervention, including any written documentation/information provided to the PCP and response of the PCP. Documents were submitted for the following individuals: Individual #325 6/14/12, Individual #159 8/1/12, Individual #337 7/5/12, Individual #210 9/24/12, and Individual #186 5/24/12; o Handouts from Medication Variance Committee Meeting on 11/6/12: Medication

	Reconciliation October 2012; Quarterly medication variance data - home, category; variance; Procedural Medication Errors by home – 12 month summary; Procedural Medication Errors by category – 12 month summary; Procedural Medication Errors by variance - 12 month summary; Procedural Medication Errors by Node of Variance – 12 month summary; Procedural Medication Errors by Number of Doses – 12 month summary; Doses Returned to Pharmacy - Excess Unknown and Refusals through October 2012; Calcitonin Nasal Spray returned bottles – monthly analysis May through October 2012; Internal Pharmacy Variance Trends Nov 2011 – October 2012; Med Room Audits Facility Compliance for October 2012; and Medication Room Audits October 2012; o Minutes of Pharmacy and Therapeutics (P&T) Committee on 11/7/12 and handouts: Infections by home September 2012; Polypharmacy data, updated 10/10/12; SSLC Nurse Protocol: Diastat AcuDial October 2012, revised 11/3/12; and adverse drug reaction reports; o Chemical restraint forms for September 2012; o AUSSLC Quality Assurance Monitoring for Section N, undated; o For the self-assessment process for Section N, list of monitoring/audit tools used, for each tool the number of the eligible population to be sampled, the number included in the sample (percentage of the total eligible population), the method used to determine how the same was chosen, how often the data was collected, the staff that completed the audit/monitor/survey/review, and any inter-rater reliability data analyzed for the audit/monitoring review; o For the self-assessment process for Section N, the databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, documentation of the frequency of the data collection; and o Adverse Drug Reaction training, update from Pharmacy Department, dated 11/8/12; and o Presentation Book for Section N. ▪ **Interviews with**: o Kenda Pittman, Pharm D, Director of Pharmacy; o Guy Campbell, PharmD, Clinical Pharmacist; o Bryan Davidson, PharmD, MBA; and o Brea Barner, PharmD. ▪ **Observations of**: o Medication Variance Committee meeting, on 11/6/12; and o Pharmacy and Therapeutics Committee meeting, on 11/7/12.
	Facility Self-Assessment: For Section N, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: o The monitoring activities the Facility used to conduct its self-assessment included: an internal QA review of the new order process, tracking of QDRR completion, internal audit

	to monitor accuracy and completeness of several aspects of QDRR data collection and interpretation, QDRR tracking sheet of recommendations, number of psychotropics, etc., follow-up audit to determine if recommendations from QDRRs were completed, follow-up audits to DUEs, and medication room inspections/audits. o These monitoring/audit tools included a number of good indicators to allow the Facility to determine compliance with the Settlement Agreement for Sections N.1, N2, N.4, N.5, N.6, and N.7. There appeared to be less monitoring for the many aspects of Sections N.3 and N.8. In addition, there were a number of areas the Facility did not address in its Self-Assessment, such as identifying for example per month, the rate of PCP review of QDRRs within 14 days, the length of time for psychiatry review of QDRRs, analysis of new orders step by step during the audit process, and an analysis of internal medication error rates for pharmacy services. QDRR Delivery tracking logs were submitted via the Presentation Book, but it appeared the submitted information was raw data, without monthly analysis or trend analysis. Some of the submitted documents were not interpretable, because the original had been highlighted and the wording was obliterated on the copy. However, there was no summary accompanying the log data. These differences in what the Pharmacy Department versus the Monitoring Team was reviewing likely accounted for some of the differences in compliance determinations. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews, review of QDRR forms, review of WORx information/warnings relevant to new orders, and onsite inspections. o The AUSSLC Quality Assurance Monitoring chart and the Self-Assessment Process for Section N identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Clinical Pharmacists. o The staff responsible for conducting the audits/monitoring were clinically/ programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used some other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases was noted to be complete and accurate. Examples of databases/data sources that were not considered included review of medication error categorization, and chemical restraint form tracking for timeliness of completion. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's

	Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o Of note, the Pharmacy Department was essentially monitoring itself. There was no indication the QA Department was involved in monitoring pharmacy services. ▪ The Facility rated itself as being in compliance with the following subsections of Section N: N.1, N.2, N.4, N.6, and N.7. This was not consistent with the Monitoring Team's findings. ▪ The Facility data identified some areas in need of improvement. For those areas of need, the Facility Self-Assessment did not provide an analysis of the information, and/or make reference to action plans designed to address the outstanding issues.
	Summary of Monitor's Assessment: The Pharmacy Department continued to put into place systems that monitored the quality of pharmacy services. They were able to demonstrate to the Monitoring Team a rigorous new order system to ensure safe dispensing. When requested, additional needed information was readily available, but was not inclusive of all five categories for new orders. The ADR system was efficient and effective. Training has been completed for the residential staff as well as the professional clinical staff. The next challenge will be development of a refresher course due by May 2013. The DUEs had had a positive effect on the clinical practices of the PCPs. The timely completion of QDRRs could not be verified. The Facility's Self-Assessment indicated a 96.7% compliance rate, but two separate reviews by the Monitoring Team indicated compliance at 54 to 75%, indicating need for improvement. QDRR content continued to improve. The format was user-friendly. The more recent QDRRs appeared to be more detailed and complete. The internal pharmacy monitoring of the content was an important step, but might not be sensitive enough to capture quality concerns. The Facility also needed to confirm in writing the acceptable timeline between the pharmacy completion of the QDRR and the review date of the psychiatrist. This had been done for the PCPs. As the State indicated in its comments to the draft report, a footnote on the QDRR form indicated: "28 days for residents currently going to Psychiatry Clinic." However, this did not appear to be a measurable indicator. The date of the psychiatry clinic, if it occurred, would need to be included on the QDRR, or a statement there was no psychiatry clinic visit in that quarter, which would leave the due date unclear. A clear policy consistent across the SSLC system was needed to guide all SSLCs, as well as a timeframe that was not dependent on other parameters, such as psychiatry clinic attendance. There was continued inconsistency in the chemical restraint documentation system between departments, and the review of the administration of emergency medication appeared to need improvement. It was positive that as of May 2012, nursing was printing the e-med list daily, which should continue to assist with this process. Concerns included lack of documentation of drug-drug interactions between the prescribed drug and the current drug regimen. Documentation by the psychiatrist appeared to need review to improve the content and value of that section.

	Medication variances remained a challenge. Internally to the Pharmacy, there remained need for improvement, including reduction in the rate of errors. That any errors would leave the pharmacy, and leave the pharmacy and not be captured by nursing indicates a need for a review of the current safety mechanisms in place. Focus on assisting the Nursing Department in resolving the numbers of unexplained returned medications also was needed, and the Pharmacy Department needed to demonstrate it had an effective system to track all medications to determine most importantly the cause of returned medications. The Facility was in compliance with Sections N.6 and N.7.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Pharmacy Department staffing included the following: a Pharmacy Director (i.e., part-time role at AUSSLC and part-time role as Pharmacy Services Coordinator, State Office), one PharmD as Clinical Pharmacist, two PharmDs as Staff Pharmacists, one RPh as Staff Pharmacist, and three Certified Pharmacy Technicians. "Patient intervention" entries for new orders entered into the WORx software program were submitted for review. From May 2012 through September 2012, there were a total of 52 patient intervention reports generated. The following lists the number of patient intervention entries generated per month: May 2012 - 11, June 2012 – 11, July 2012 – 13, August 2012 – five, September 2012 – 12. Interventions were broken down into four different categories. The following categories and numbers of patient interventions for each category follows for the months of May through September 2012: "interaction/compatibility intervention" – 30, "order clarification/confirmation" - eight, "drug information" – eight, and "allergy/disease state contraindication" - six. Additionally, the Pharmacy Department utilized the "Notes Extract" database of the WORx software. From 5/1/12 through 10/1/12, the following number of entries were made per month: May 2012- 34, June 2012 - 28, July 2012 – 13, August 2012 – 44, September 2012 – 107. Notes extracts appeared to focus on instructions to nurses in preparing medication to be consistent with diet (crushed medications, for example, on a modified diet). The Presentation Book for Section N also included examples of communication with the PNMP Coordinator to ensure the PNMP was consistent with pharmacy information and PCP orders and the Medication Administration section of the PNMP was current. There were also notes concerning information important to the pharmacy database, such as individuals with reduced renal function and individuals with J-tubes. A sample of 29 new prescriptions was reviewed. It is important to note that the	Noncompliance

#	Provision	Assessment of Status	Compliance
		Monitoring Team only has access to the submitted documents in making a determination of adequacy of new order processing by the pharmacy. The documents needed to verify the order was a new order (i.e., as the Monitoring Team requested onsite as "evidence of new order or change of order") and to match the entry in WORx. The Pharmacy needed to provide evidence that the software program was utilized to screen for safety, necessary information was documented as having been communicated with the PCP, and the PCP provided evidence that the order was accepted, or evidence of an order change, if indicated. In addition, if an order change was indicated, then evidence was needed that the process of filling the order was not completed until verification with a new physician order. For evidence of adequate quality for new order verifications, the following information was considered essential: a copy of the PCP order to verify that the documents the Facility submitted reviewed a new order, a copy of the computer screen shot processing this new order with the warning or red flag indicated, a copy of the patient intervention summarizing communication with the PCP or critical thinking by the pharmacist, and if a change in order was indicated, evidence of a change, such as a copy of the change in order (to verify the change in order occurred). If lab monitoring/calculations were indicated, updated lab results that were utilized and an entry reflecting the results of the calculation would be important for verification of this critical pharmacy review. Other information was also noted and documented as additional description of the pharmacy process at the SSLC, but the above represents essential components for a successful medication order review and entry. The following summarize the results of the Monitoring Team's review: ▪ Ten new orders were submitted in which the pharmacy found concerns with **drug-drug interactions** with the current drug regimen. A copy of the new PCP order was submitted in 10 of 10 orders. A computer screen shot of the order was submitted for 10 of 10. For 10 of 10, a copy of the patient intervention form was submitted. A change in the order occurred in five orders, with a copy of the order for four new orders involving a change to a new medication. For one, the medication was discontinued and the individual was sent to the ER, and no new medication order was generated. The discontinuation of the medication and transfer to the ER was reflected in communication documented in the patient intervention form. Based on this information, adequate documentation was present for drug-drug interactions in 10 out of 10 (100%). ▪ Four new orders were submitted in which **allergies** were reviewed that the Pharmacy identified as a concern. A computer screen shot of the order was submitted for four of four. A copy of the patient intervention or allergy alert was submitted in four of four. As a result of the pharmacy review, there was a documented change in order for two of four orders. There was confirmatory documentation of no change for two orders. Based on this information, adequate documentation of the new order process for allergies occurred in four of four of submitted cases (100%).	

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		▪ Five new orders were submitted in which significant **side effects** were reviewed by the Pharmacy and determined to be a concern. A copy of the PCP order was submitted for new order verification for three of five orders. A screen shot was submitted in five of five. For one order, it appeared to be old, with dates of order from 8/9/11 through 8/16/11. The submitted order and change of order were for 5/24/12. Lab results were referenced in one order. A patient intervention note was submitted for five of five. Evidence of an order change was submitted in two of two. For three, there was documentation of discussion with the PCP, but with further information, the clinical decision was that no change in medication was needed. For one of these, additional lab tests were ordered for monitoring of side effects. In summary, for these five orders submitted, three of five (60%) had adequate documentation concerning new order processing and side effect review/collaboration with the PCP. The reason for not submitting a copy of the original order in two of five orders was not clear. The reason for the date being listed as 2011 was not clarified. This suggested a lack of review of the information submitted to the Monitoring Team. ▪ Five new orders were submitted in which **current laboratory results and potential need for further testing** were identified by the Pharmacy during initial review. A copy of the original PCP order was submitted in three of five orders. A copy of the screen shot was submitted in five of five. A copy of the patient intervention was submitted in five of five. New orders were written for none of the medications based on the communication with the PCP. Lab data was submitted as evidence of review or lab was ordered with original medication order in four of five. For one order, there was no information that labs had been ordered or pharmacy had reviewed the lab flagged by WORx. Documentation was adequate in three of five (60%). It was not clear the reason for not including a copy of the original order in two of five orders to verify the new order. For one individual, the recent lab that was used in calculating a safe dosage adjustment or ensuring the dosage ordered was safe was not referenced. There appeared to be a gap in information submitted. A "note alert" indicated the need to screen for renal dosing based on decreased renal function. A follow-up snapshot did not identify the action steps taken or calculation (no lab information was included to determine if the renal function was reviewed), but there was a handwritten entry: "pharmacist performs clinical intervention based on skills," which did not appear to apply to any specific action. This was followed by a patient intervention report documenting an in-service with nurses on duty about the dosage adjustment that had been made and side effects to be monitored. There was no original order to verify if the order had been changed, the change in dosage, and/or the communication with the PCP. There were several action steps that appeared to be missing to appropriately interpret the Facility's review the new order.	

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		▪ Five new orders were submitted in which pharmacy had concerns about the potential need for **dosage adjustments**. For three of five orders, there was a copy of the new PCP order. For five of five orders, there was a copy of the screen shot. For five of five, there was documentation the PCP was contacted. A copy of the patient intervention was submitted for this in five of five orders. A change of order based on pharmacy review and PCP contact occurred in none of five. In summary, there was adequate documentation of the process in three of five (60%). The Monitoring Team could not determine the reason for not submitting a copy of the original order in two of five orders, to verify that it was a new order and to verify accurate data entry into WORx. During discussion with the Pharmacy staff, it became apparent that the gaps in the verification process for new orders represented a paper compliance deficiency. The actual process for a new order appeared to be in place. However, as part of the monitoring process, the Pharmacy Department needed to provide documentation of evidence of quality medication order processing, because this is the only way for the Monitoring Team to verify that the systems are in place and working. The description above of the documentation the Monitoring Team needs to confirm compliance should be helpful in ensuring the Facility provides the necessary evidence at future reviews. In its response to the draft report, the Facility made the following comment: "In Summary, failing to provide a copy of the original order completely negates the work and processes actually being performed. Is the assumption that we fabricated the order? Even if that were the case, the Pharmacy demonstrated that the process, safeguards, and documentation were in place. Question: Does this demonstrate that Pharmacy is in compliance with the provision, but not in compliance with the record request?" As the Monitoring Team believes was clear in the draft report, the Monitoring Team cannot assess compliance without the requested documentation. As the Facility stated in a number of comments about this section of the report, while onsite, the Monitoring Team clarified that it needed evidence of the original order or change of order, which would only reasonably be a copy of the order. In fact, at the conclusion of the week onsite, Facility staff presented the Monitoring Team with a folder containing copies of orders. However, upon review, it was determined this was only a partial set of the orders requested. It is not a matter of the Monitoring Team alleging that the Facility "fabricated" the orders, but a matter of the Monitoring Team being able to assess whether the Pharmacy accurately entered and analyzed the orders that were written. Given that the Facility submitted copies of new orders for some of the cases the Monitoring Team reviewed for the Section N.1 subsections, it appeared the Facility understood the value in submitting this information to verify new/changed orders. However, the rationale for not applying this to all cases the Monitoring Team requested remained unclear. On a positive note, the Pharmacy Department completed an internal QA review of the	

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		new order process. A weekly audit was conducted on 10 new orders and reviewed for the following quality indicators: correct patient, correct drug, correctly written order entry, correct start date, correct stop date, indication, correct prescriber, and correct route. This audit had occurred beginning the week of 1/28/12 to 2/3/12, and continued weekly since that time, except for the partial period of 8/18/12 to 8/20/12 in which five new orders instead of 10 were reviewed. The most recent data submitted was for the week of 10/1/12 to 10/7/12. According to a document (untitled) concerning Section N.1, and a designated list of medications at all facilities that require lab monitoring, when a medication on this list was ordered, the WORx software was prompted by an "Intelligent Alert." Several justification boxes would appear, and the pharmacist would select the appropriate response. A monthly or weekly database review was to be obtained with the Pharmacy Director responsible for follow-up analysis and discussion with the Medical Director, as necessary. Several lab order monitoring reports were submitted as examples of this for each month from June through September 2012. The summary report indicated the number of lab orders for the month for these medications listed, the number of orders requiring explanations in the "Patient intervention" or "Notes Extract" section of the software program, the percentage written consistent with Facility protocol, and the percentage with required explanations. Except for the initial report in June 2012, a Pharmacist reviewed them within seven days after the end of the month. Clozaril lab monitoring was recorded in a separate database. Communications with the Psychiatry Department via emails addressed the current lab findings and any need for additional orders. The AUSSLC Policy: Clozapine Monitoring Policy and Procedure, dated 1/21/11, was followed. It appeared that one of the Clinical Pharmacists was specifically assigned monitoring of Clozapine. The Facility requested that the Clinical Pharmacist have access to the government computer software program for Clozapine on 8/8/12. Due to the need for ongoing monitoring involving a number of lab values and timing variables, it was helpful to have one clinical pharmacist assigned this area of review to provide efficiency and continuity to the monitoring process.	
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 schedule for completion of QDRRs for the fiscal year 2013 was provided. For each quarter of the year, the due date, and the date after which the QDRR was considered late was provided for each residence at AUSSLC. A total of 22 residences were listed. This listing had been updated as of 9/12/12. As the parties agreed, the QDRR may be conducted up to seven days prior to the end of the review period and will be considered delinquent if completed 14 calendar days from the end date of the review period. A list of completed QDRRs was submitted for 2012. For emphasis, this guidance indicated that the compliance cut off was 13 calendar days	Noncompliance

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		from the end date of the review period, and the QDRR was "considered delinquent if completed 14 calendar days" or later. Third and fourth quarter data (fiscal year 2012) was submitted. For the third quarter, 181 of 333 QDRRs (54%) were completed within the period of time from seven days prior to the due date of the QDRR through 13 days after the 90-day due date. For the fourth quarter, 187 of 333 QDRRs (56%) were completed within the period of time from seven days prior to the due date of the QDRR through 13 days after the 90-day due date. In its response to the draft report, the State contested these findings. However, this appeared to be due to the Facility's use of a 14-day window for a compliance finding, versus 13 days, as the Monitoring Team used and was consistent with the agreed upon parameters. A sample of 44 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ A total of 33 of 44 (75%) were completed within the time period stated above. ▪ Laboratory information was submitted as part of 44 QDRRs (100%). ▪ The lab results included exact values or indication of normal range for such lab tests as Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, 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 44 QDRRs included the dates the labs were drawn (100%). ▪ Significant abnormal values were listed under the notes/comments section line for that particular lab in 35 out of 35 (100%) of applicable QDRRs. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. To reach compliance, the pharmacy must adhere to the time schedule agreed upon. The documentation and database system was in place for this. The Facility Self-Assessment indicated that the most recent 150 QDRRs were completed in a timely manner for 96.7% of the forms. The information provided to the Monitoring Team included the data for the prior two quarters, as well as the sample submitted of 44 QDRRs. There appeared to be a significant discrepancy in the Facility's findings related to the most recent 150 QDRRs, and those of the third and fourth quarters, as well as the Monitoring Team's review of recent QDRRs. The timely completion of the QDRRs from the third to the fourth fiscal quarter did not appear to change significantly based on both the Facility and Monitoring Team's reviews. During this time, there was a change in staffing of the Clinical Pharmacist position, which might have contributed to delays in completing the QDRRs. However, at the time of the Monitoring Team's review, other than an overall compliance rate for 150 QDRRs, evidence was not presented that this issue had been resolved.	

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		Without copies of the 150 QDRRs the Facility included in its sample, the Monitoring Team could not confirm the Facility's findings. The Facility remained out of compliance with this provision.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	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 eight chemical restraints used from 5/29/12 to 9/24/12. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that four individuals had one to five chemical restraints during this time. For the eight chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the eight chemical restraint forms, eight forms (100%) included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in eight out of the eight chemical restraint forms completed (100%). ▪ Side effects and adverse effects were noted in eight of the completed chemical restraint forms (100%). ▪ A discussion of drug/drug interactions was noted in four of eight (50%) completed chemical restraint forms. It appeared the Pharmacy had used different forms to complete this process. In one form, a specific question was asked: "Has pharmacy previously screened the order for drug-drug interactions?" In the other form used, this question appeared to have been omitted. It would be important to verify the administered emergency medication was reviewed for drug-drug interactions by the pharmacy prior to administration (by prior use) or prior to the administration in the emergency situation. A rapid turn-around time of this information would be important for the IDT, psychiatrist, etc. in determining whether this medication was an appropriate choice. QDRRs might record this information, but this does not substitute for a timely review of emergency use of medication in guiding the team, especially when there has been a change in the emergency medication being given since the last QDRR. ▪ There were two statements that were considered recommendations. ▪ The range of time for completion of the forms was from one to 18 days.	Noncompliance

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		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: ▪ Of the eight completed, there were seven forms (88%) on which the psychiatry comment section was completed. ▪ For none of the chemical restraints used (0%) was there a description of the behaviors and prior steps taken by the IDT/psychologist. ▪ For six of eight (75%), clinical justification was documented. ▪ For one individual who required a total of five chemical restraints, there was no comment made regarding whether maintenance medication had been changed, the BSP had been amended, or other environmental changes were completed. ▪ Side effects were mentioned in four of the reviews (50%). ▪ Effectiveness was documented in none of the cases (0%). ▪ There was one recommendation documented. It is recommended the Psychiatry Department develop a policy/protocol that provides guidance concerning expectations of the psychiatrist in completing this document. The most recent information for chemical restraints was provided in a document entitled "Stat Orders from date: 4/1/12 thru 10/5/12." This was printed from the database in WORx. The following indicates for each month, the number of chemical restraints administered: April 2012 – four, May 2012 – two, June 2012 – one, July 2012 – four, August 2012- one, September 2012 – three. The Facility provided a "Restraint Trend Report" for data available through August 2012, with trend information dating back to September 2009. During this time, the use of chemical restraints had a downward slope. Since February 2012, the chemical restraint use was flat. There averaged zero to four chemical restraints per month during this time period. An interdisciplinary meeting occurred on 3/30/12 to improve the system for administration of chemical restraints used during emergencies. The Pharmacy developed an emergency medication kit based on medications listed on the "e-med list," and the kit was to be located in the after hours medication room to improve the timely response to a behavioral emergency for which a chemical restraint was ordered. The kit was to be locked, and the Pharmacy would provide reconciliation of medications weekly and whenever a medication was used. Nursing was to print an updated "e-med list" on a daily basis. (This listed the individual, the medication dosage and route of administration for chemical restraint usage, as well as comments for indication or history).	

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		Based on some correspondence, issues were noted with regard to accurate documentation of when chemical restraints occurred. For example, from an email dated 6/7/12, there was discussion of whether or not a chemical restraint was given. For this instance, there appeared to be different sets of information. In addition, from an email dated 10/22/12, there was administration of a chemical restraint, but the after-hours cart was not used, and the nurse might have broken a tablet to provide a lesser dose. A "short" form was received indicating the need to replace the tablet, but an alternate reason was provided. It appeared there needed to be continued review of the process, and further collaboration among Pharmacy, Nursing, and Psychology Departments. <u>Polypharmacy</u> Of the 44 QDRRs reviewed, polypharmacy was noted in 30 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 30 of 30 (100%) reviews. ▪ Clinical justification for the use of polypharmacy was addressed in 27 of 30 reviews (90%). ▪ Potential interactions with other drugs or food/side effect risk was reviewed in 28 of 30 (93%) ▪ For 30 of 30 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen. The Pharmacy Department also provided a completed form entitled "Polypharmacy – Health Risk Assessment Tool" which provided guidance to the IDT and PCP in completing the IRRF and developing a risk action plan, if indicated. The polypharmacy scoring described both non-psychotropic and psychotropic polypharmacy. Definitions of polypharmacy for these two categories were included on the form. On completed forms, the medications included in the polypharmacy were listed, along with the diagnosis/indication. Recommendations for team discussion were made, with a risk rating provided. Psychotropic polypharmacy data also was reviewed at the Pharmacy and Therapeutics Committee. During the 11/7/12 meeting, the following information was presented concerning the use of psychotropic medication: ▪ For the month of September 2012, there were seven individuals receiving two or more medications from the same class regardless of the indication (Category A). This had remained stable since March 2012. ▪ There were 20 individuals on three or more medications regardless of the class or indication (Category B). This had remained stable since April 2012. ▪ There were six individuals prescribed medications consistent with both Category A and B.	

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		▪ Overall, of the campus-wide percentage of the population receiving psychotropic medication (136 individuals), 15% (21) were prescribed psychotropic polypharmacy according to the above criteria. This had remained stable since July 2012. It was further noted that there were seven individuals receiving polypharmacy considered necessary for their stability (past trials and failures had been documented). There were 14 individuals receiving polypharmacy with plans for challenge (potential reduction in medication). <u>Benzodiazepine Use</u> Benzodiazepine use was noted in 24 of the 44 QDRRs. ▪ Of these, 23 (96%) documented justification with appropriate diagnoses; and ▪ Nineteen of 24 QDRRs (79%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 44 QDRRs, all 44 (100%) were screened for medications associated with potential significant anticholinergic side effects. Of these, 34 QDRRs identified anticholinergic medications. The results of the review of these QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 34 of 34 (100%) of cases with this medication prescribed; ▪ Twenty-five of 34 (74%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect in that the clinical burden of the side effects was less than the benefit. ▪ All 34 of 34 (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 44 QDRRs reviewed, 16 listed atypical antipsychotic medication. Of these, 16 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). <u>Internal Pharmacy Monitoring</u> The Pharmacy Department created an internal audit tool for monitoring accuracy and completeness of several aspects of the QDRR form. These included whether the following were addressed in the QDRRs being audited: metabolic risk, benzodiazepine use, anticholinergic use, polypharmacy, labs, and MOSES/DISCUS. From June through September 2012, 10 forms were reviewed per month. Results indicated that there were six concerns identified with review of metabolic risk (of 40 QDRRs) and one concern for lab work (of 40 QDRRs). There were no concerns identified in the other topics reviewed. Separately, the pharmacy submitted a database entitled "Quarterly Drug Regimen Review Tracking Sheet" for all quarters of 2012 (although the footnote appeared to	

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		indicate 2011, the data was for 2012), and the first quarter of fiscal year 2013. This listed the dates of the QDRRs for each quarter, as well as the recommendations. The 2013 data included polypharmacy rating, benzodiazepine information, anticholinergic rating, and the number of psychotropic medications per individual. An additional database tracked the PCP and psychiatry follow-up to recommendations from the QDRRs. This was updated on 9/17/12, and appeared to reflect activity in the fourth quarter of fiscal year 2012, although the title indicated Q4 of 2011. These databases appeared to be up-to-date, and provided the detail required to track the quality of the QDRR recommendation and whether the recommendations were completed. In summary, the Facility remained out of compliance with this provision. At the time of the Monitoring Team's review, some processes were working well, such as some of the aspects of the Pharmacy Department's review of the use of emergency chemical restraints; the Pharmacy Department's monitoring of polypharmacy; documentation of the justification for benzodiazepine use; identification of anticholinergic medications and their side effects; and monitoring of side effects of atypical antipsychotic medications. However, other areas continued to require improvement, such as the Psychiatry Department's review of and response to chemical restraint, the Pharmacy Department's review of side effects and/or adverse risks related to benzodiazepine use, and documentation of the clinical justification of the use of each of the medications contributing to anticholinergic load/effect.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Review of 44 QDRRs showed the following: ▪ Of the 44, 44 QDRRs (100%) had the PCP signature. ▪ Of the 44, 43 (98%) had the date the PCP reviewed the document. ▪ There were 35 recommendations from the 44 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 35 out of 35 (100%). o Agreement was documented in 32 out of 35. For two out of 35, the box indicating agreement was not checked, but the recommendations were ordered, as documented by the PCP comment next to the recommendation. This indicated that there was agreement in 34 of 35 recommendations. o There was disagreement by the PCP for one QDRR. For one of one, (100%) a note of justification and plan was recorded on the QDRR. o The PCP responded within 14 days of the QDRR being completed by pharmacy in 40 of 44 QDRRs (91%). ▪ Psychiatry reviewed the QDRR whenever the Psychiatry Department was following them, including when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed 24 of 44 QDRRs, for which agreement was needed or justification for disagreement in 17 of 44.	Noncompliance

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		▪ Agreement was documented in 15 of 17 (88%). Documentation was in the recommendation response/comment section rather than in the checkbox section for one of these. No recommendation was made and no response was documented in one of 17. However, the recommendation included on this QDRR involved a non-psychotropic medication for which the psychiatrist would not need to respond. The PCP responded to the recommendation both in the checkbox and in the response/comment section next to the recommendation. ▪ Disagreement with justification and plan was documented in one of one (100%) from the 17 requiring psychiatry review. ▪ The psychiatrist responded within 14 days of the QDRR being completed by pharmacy in 14 of 17 (82%)QDRRs. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 active records in which recommendations were made on the QDRR. These are listed above in the documents reviewed section. In the sample of 10, 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility submitted four active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. In four of four cases (100%), the response (rationale and plan) was written on the QDRR. It was noted that only four QDRRs were found over the past six months in which recommendations were not followed. An additional example of the impact of the Pharmacy Department's assistance in resolving complex medication concerns was noted during review of the email communication between the Pharmacy and Nursing Departments. The Pharmacy Department had provided research results to the PCPs. This was not reflected in the QDRR process, but provided an example of an additional route through which the Pharmacy Department provided practical recommendations. In the case reviewed, an individual had repeated refusals of Exjade, due to abdominal side effects. The Pharmacy Department contacted the manufacturer for additional recommendations. The Pharmacy Department then provided a series of options/potential recommendations (four options providing details of administration and rationale for each option) to the PCPs for further review to optimize the treatment for the individual, to improve the individual's compliance, and to provide guidance to the PCPs. Additional literature from the manufacturer also was distributed to the PCPs for review. The Pharmacy provided a "QDRR Delivery Tracking" chart for the third and fourth quarters of the 2012 fiscal year, and the first quarter of the 2013 fiscal year in which the date the completed QDRR was signed by the pharmacist was recorded, followed by the dates of signature of the PCP and psychiatrist. There was no analysis of the information.	

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		There was a goal/guideline that the PCP was to review and sign the QDRR within 14 days of the pharmacy signature. It was not clear whether there was a Facility guideline by which the psychiatrist needed to review and sign applicable QDRRs. As the State indicated in its comments to the draft report, a footnote on the QDRR form indicated: "28 days for residents currently going to Psychiatry Clinic." However, this did not appear to be a measurable indicator. The date of the psychiatry clinic, if it occurred, would need to be included on the QDRR, or a statement there was no psychiatry clinic visit in that quarter, which would leave the due date unclear. A clear policy consistent across the SSLC system was needed to guide all SSLCs, as well as a timeframe that was not dependent on other parameters, such as psychiatry clinic attendance. In addition, there was no information per quarter or month that addressed PCPs compliance in reviewing and signing/dating the QDRRs within 14 days of the pharmacy signature. It was documented in the May 9, 2012 P&T Committee meeting minutes that the Clinical Pharmacist met with the Nurse Case Managers to explain the follow up process for outstanding orders such as MOSES/DISCUS, labs, and monitoring. It was identified that some of the QDRR recommendations did not result in an order being processed. This was an additional monitoring process to ensure recommendations had closure. At the August 30, 2012 P&T Committee meeting, the minutes documented that the process was in place. Although many of the components of the QDRR review process were in place, an area that required improvement was the psychiatrists' timely review of the QDRRs in which psychotropic medications were reviewed. The Facility remained out of compliance with this provision.	
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 with regard to Section J.12, this provision of the Settlement Agreement requires systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic 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 the nurse completed the exam, and subsequently, the prescribing physician reviewed the documentation. The review of the sample of the records of 21 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months for all but the following three individuals (followed by most recent MOSES completion date): Individual #417 (no second page for 6/6/12 MOSES and none in record prior to that), Individual #332 (gap between 6/29/11 and 3/30/12), and Individual #194 (only one in file dated 9/28/12). Thus, the MOSES was completed on schedule for 18 of the 21 individuals (86%).	Noncompliance

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		The records of the 21 individuals contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for all but three individuals. Those individuals whose MOSES documentation was not reviewed in a timely manner (latency between dates) were those of: Individual #158 (2/1/11 to 3/3/11), Individual #2 (8/4/12 to 10/11/12), and Individual #254 (2/22/12 to 3/24/12). Thus, the MOSES evaluations were reviewed in a timely manner for 18 of the 21 individuals (86%). 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 21 individuals indicated the following seven individuals were not prescribed an antipsychotic medication: Individual #194, Individual #376, Individual #332, Individual #84, Individual #353, Individual #154, and Individual #16. The review of the records of the remaining 14 individuals indicated that the DISCUS had been completed within the prior three months and at three-month intervals prior to that for all but the following six individuals (gap between DISCUS evaluations): Individual #56 (12/12/11 to 7/9/12), Individual #158 (most recent dated 7/6/12; gap between 11/30/11 and 5/22/12), Individual #2 (1/30/12 to 5/8/12), Individual #246 (2/2/12 to 8/20/12), Individual #33 (2/14/12 to 8/4/12, and 10/3/11 to 2/14/12), and Individual #417 (12/30/11 to 7/18/12). Thus, the DISCUS had been completed as specified for eight of the 14 individuals (57%). The DISCUS evaluation had been reviewed in a timely manner by the prescriber for 11 of the 14 individuals (79%). 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 #2 (8/8/12 to 8/24/11/12); Individual #246 (8/20/12 to 9/14/12); and Individual #417 (7/18/12 to 8/6/12). 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 MOSES and DISCUS also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties similar to those of antipsychotic agents. A list was obtained	

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		from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to create a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The following sample of four individuals (100% of those meeting this criteria) was selected, and included: Individual #454, Individual #200, Individual #169, and Individual #239. The review of the records of these individuals in relation to the MOSES indicated that the examination had been performed as required for the following three individuals (75%): Individual #454, Individual #169, and Individual #239. The record of Individual #200 did not contain any MOSES evaluation prior to 8/12/12. The review of these records for the timely review and signature of the prescriber indicated that this criterion had been met for the following three individuals (75%): Individual #200, Individual #169, and Individual #239. The only exception found in the record was that of Individual #454, for whom the signature sheet from the 3/6/12 examination contained only the month of the prescriber review, which appeared as "3." 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 for only one of the four, Individual #454 (25%). More specifically: ▪ The record of Individual #200 contained only one DISCUS in the record, dated 9/7/12, although it had been reviewed in a timely manner by the prescriber. ▪ The record of Individual #169 also contained only one DISCUS, which was date stamped 6/18/12, but did not contain the date or signature for either the nurse that completed the evaluation or the prescriber. ▪ The record of Individual #239 contained only the DISCUS dated 6/21/12, and none prior to that. This evaluation had been reviewed in a timely manner. The discrepancy was significant between the results of the completion of the MOSES and DISCUS for the individuals receiving psychotropic medications, and those prescribed Reglan and no traditional psychotropic medication. As indicated in the Monitoring Team's report for the review conducted in November 2011, the responsibility for performing the DISCUS recently had transitioned from the Psychiatric Nurses to the RN Case Managers from individuals' residences. Accordingly, during the current onsite review, a request was made for evidence supporting the training of the nurses responsible for performance of the DISCUS. The materials submitted in response to this included a number of written documents, as well as a copy of the PowerPoint presentation dated 11/6/12. The first slide indicated that the subject matter was "psychopharmacological medication side effects," which an RN, BSN	

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		presented. The Facility also produced a list of the 52 nurses that had completed this training on one of the following dates: 1/18/11, 2/22/11, 10/18/11, 10/26/11, 11/16/11, 5/25/12, or 6/21/12. During the Monitoring Team's previous 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 prescribed Reglan, but not also a psychotropic agent clearly needs to be improved, because this medication can cause significant side effects. These may include acute extrapyramidal motor side effects, which might require treatment with anticholinergic agents, as well as tardive dyskinesia, which can be irreversible, if not promptly identified and addressed. The Facility was found to be in noncompliance with this provision. This related to the deficiencies in the completion of these important side effect monitoring tools for individuals prescribed Reglan, deficiencies with regard to the timely completion of the DISCUS for individuals prescribed psychotropic medication, delays in the prescribing practitioners' reviews, as well as the lack of a method to document that any sudden significant changes in an individual's side effect status was immediately reported to the prescribing practitioner.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The Pharmacy Department was responsible for training the nursing staff concerning identification and reporting of adverse drug reactions. The policy entitled: "Adverse Drug Reaction Reporting" was effective January 10, 2012. Two training rosters were provided, printed 11/8/12. Nurses received training in May 2012 (i.e., 5/14/12, 5/15/12, 5/16/12, 5/17/12, 5/18/12, and 5/25/12). A total of 82 of 106 nurses completed this training. A second training roster was submitted for new hires in the Nursing Department. Training occurred for 26 nurses on the following dates: 5/24/12, 6/20/12, 7/6/12, 8/2/12, 9/5/12, 9/21/12, and 10/4/12. A packet of Pharmacy Department information was provided that was utilized during new employee orientation for nurses. This included the AUSSLC policy entitled: Adverse Drug Reaction Reporting. An additional in-service training for ADR recognition and reporting was held on 11/8/12 for nurses that were employed in May 2012 and had not completed the training. An additional 15 nurses completed training on 11/8/12. As of 11/8/12, a total of 123 of	Substantial Compliance

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		132 Nursing Department staff completed training in ADR recognition and reporting, for a 93% compliance rate. Training of the direct support staff was the responsibility of the Nursing Department and the Competency and Training Department. The Training Coordinator provided a summary of training direct support staff had completed through the course entitled "Observing and Reporting Clinical Indicators of Health Status." This training included a breadth of clinical presentations related to adverse drug reactions. Of 740 staff required to complete the course, the Competency and Training Department had documentation that 724 staff completed this course, resulting in a 98% compliance rate. The number of ADRs reported in the prior six months totaled eight. The following summarizes the ADRs, and follow-up: ▪ An ADR, dated 4/27/12, involved statins and liver function abnormalities. The P&T Committee reviewed the ADR with documentation dated 5/9/12. Recommendations were to add a note to the WORx pharmacy profile. A Food and Drug Administration (FDA) report was not recommended. ▪ An ADR, dated 5/18/12, involved Thorazine and hypothermia. The individual was transferred to the ER for further treatment. The P&T Committee reviewed the ADR and determined it was unclear whether the Chlorpromazine was the cause of the hypothermia, but this information was added to the allergy profile. An FDA report was not recommended. ▪ An ADR, dated 6/13/12, involved Varivax administration followed by a rash. This ADR was reviewed at the 8/30/12 P&T Committee meeting. No follow-up was necessary except adding this information to the pharmacy profile. An FDA report was not recommended. ▪ An ADR, dated 6/15/12, involved Zyprexa and a weight gain of 55 pounds over six and a half months. This ADR was reviewed at the 8/30/12 P&T Committee meeting. The summary from the Committee was that the ADR was considered mild. The CNE was to follow up on the weight at the time of the Committee meeting. An FDA report was not recommended. ▪ An ADR, dated 7/24/12, involved Topiramate and development of unsteady gait, sleepiness, shaking, and refusal of meals. On 8/30/12, the P&T Committee reviewed this ADR. The Committee noted that an unsteady gait was a common reaction. Topiramate was added to the allergy profile of the individual. An FDA report was not recommended. ▪ An ADR, dated 9/6/12, involved the administration of Golytely and development of hypokalemia. The pharmacist reviewed this and determined that the hypokalemia was not due to Golytely, but could have been due to the diuretic routinely prescribed, although the individual was on a potassium supplement. This was reviewed at the P&T Committee on 11/7/12. An FDA report was not	

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		recommended. ▪ An ADR, dated 9/27/12, involved the administration of erythromycin suspension and the development of emesis associated with signs and symptoms of pain. This ADR was reviewed at the 11/7/12 P&T Committee, and the Erythromycin was considered the likely cause of the symptomatology. However, Reglan recently had been discontinued, and this also might have contributed to the symptomatology. An FDA report was not recommended. ▪ An ADR, dated 10/12/12, involved the administration of Bactrim DS with the development of a rash and fixed drug eruption. It was reviewed at the 11/7/12 P&T Committee. The rash resolved upon discontinuation of the order. An allergy entry was made to the medication profile of the individual. An FDA report was not recommended. The Pharmacy Department tracked the ADRs in a log. From 2/14/12 through 10/12/12, there were 11 ADRs recorded on the log. The 5/18/12 chlorpromazine ADR was not listed in the ADR log, and the discrepancy might have been a database entry error. It appeared the information needed further review for accuracy. However, the number of ADRs reviewed at the P&T Committee over the past 10 months indicated that the ADR process was in place and staff were able to identify and report ADRs in a timely manner. The Facility also showed documentation of staff training on this topic. Such training should be repeated at a frequency that will ensure staff maintains the knowledge (i.e., annual refresher). The Facility was found to be in substantial compliance with this provision.	
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 tentative calendar was submitted for the fiscal year September 2012 to August 2013 that identified the medications to be included in drug utilization reviews. These included: ▪ 1st quarter (9/2012 to 11/2012) – Anticholinergics; ▪ 2nd quarter (12/2012 to 2/2013) – Multivitamins/supplements; ▪ 3rd quarter (3/2013 to 5/2013) – Valproic acid/Divalproex; and ▪ 4th quarter (6/2013 to 8/2013) - Atypical antipsychotics and metabolic syndrome. During the prior eight months, four DUE studies were completed: ▪ On 3/14/12, a drug utilization evaluation was begun that evaluated the prescribing of potassium chloride and anticholinergic medication. The objective was stated as lowering the risk of gastrointestinal irritation for those prescribed potassium chloride. The anticholinergic effect of drying secretions and slowing gastric emptying theoretically increased the likelihood of potassium tablets lodging in the esophagus or having a delayed passage. The Pharmacy reviewed the prescription of these medications. There were 22 individuals prescribed	Substantial Compliance

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		potassium. One of these received tablets, but was not receiving an anticholinergic. The Pharmacy was to implement administrative recommendations (e.g., the amount of fluid to offer with tablets, diluting liquid preparations, position of the individual, aspects of monitoring, etc.) on the instruction line of all current active potassium orders. Beginning on 3/28/12, the Pharmacy also began to print instruction sheets and attach them to all potassium orders. ▪ On 4/24/12, a drug utilization evaluation was initiated that evaluated the prescribing of calcium carbonate and proton pump inhibitor at the same time. The goal was to determine whether individuals were simultaneously prescribed these two medications. The Pharmacy indicated that calcium citrate was the preferred calcium supplement for those prescribed a proton pump inhibitor, because it did not require a low potential hydrogen (pH) for absorption. A review of active orders indicated that 26% of individuals on calcium carbonate also were taking a proton pump inhibitor. For those with enteral feeding, calcium citrate was not an option, but was considered an option for those taking medication orally. This was discussed at the May 9, 2012 P&T Committee. Pharmacy was to track for changes in ordering calcium supplementation. ▪ On 9/27/12, a follow-up to this DUE was completed. There were 15 individuals tube fed and prescribed calcium carbonate. There was no indication to change these. For those taking calcium supplements by mouth, since the original presentation, there were no order changes. After this follow-up was sent to the PCPs, it appeared there were five changes in the choice of calcium supplement prescribed. ▪ On 8/23/12, a third drug utilization evaluation was begun for evaluation of Clozapine. The purpose of the study was to review the nine individuals to ensure appropriate prescription, dosing, and monitoring. It was determined that 13% of abnormal complete blood count (CBC) results had no follow-up documentation of the finding. It also was noted that more than half of the individuals were overdue for an electrocardiogram (EKG). Recommendations were that if a CBC was not ordered to follow up on abnormalities, then the PCP and pharmacy should discuss the matter. The Pharmacy Department was to document the communication. For those CBC results that indicated low absolute neutrophil counts, completion of a repeat was expected every two weeks until normal values occurred. It was noted that the overdue EKGs needed to be resolved. On 8/30/12, this was reported to the P&T Committee. ▪ A follow-up review was reported at the 11/7/12 P&T Committee meeting for the Clozapine DUE. Findings indicated that all abnormal CBCs had follow-up documentation. There was one case of a CBC with a low absolute neutrophil count, and that case had adequate follow-up monitoring. The individuals that were overdue for EKG testing had these tests completed. It appeared the	

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		Clozapine DUE had a positive effect on the PCP clinical practices. ▪ On 10/23/12, a fourth drug utilization evaluation was begun. Ten medications with high anticholinergic activity were selected for review. The purpose of the review was to identify individuals prescribed these selected medications, assess for evidence of clinical justification of use, review the other medications prescribed with anticholinergic activity, and provide information to the PCPs on the risks of medication with high anticholinergic activity. The Pharmacy determined that 43 individuals were routinely prescribed one of these ten medications. Only one individual was prescribed more than one of these medications. There were 17 pro re nata (PRN, or as needed) orders for these ten medications, but the PRN orders were not included in the analysis. Thirty-five of the 43 individuals on one of the ten selected medications also were prescribed one to four additional medications that had moderate or low anticholinergic activity. For clinical justification, one document was found in each case that provided the justification for utilization. With heightened awareness of the anticholinergic burden of the medication regimens in these 43 individuals, the PCPs were asked to review the medication profile to minimize anticholinergic effect, when applicable. The Pharmacy was to provide a follow-up at the February 2013 P&T Committee meeting to determine if there had been medication changes based on this review. The calendar of drug utilization evaluations and follow-up studies represented a well-established system. It was having a practical impact on the clinical practices of the PCPs and psychiatrists, and followed the requirements set forth in the Health Care Guidelines. As a result, the Facility was found to be in compliance with this provision.	
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> The Facility used the document "DADS SSLC Procedure: Medication Administration Guidelines," dated February 2011. In addition, there was a revised "DADS SSLC Procedure: Medication Administration Observation Guidelines," dated January 2012. This revision provided guidance to those monitoring a medication administration. Details of the observation steps were provided in this document. The Facility also documented that there were no changes in the Facility Medication Variance Policy. The Pharmacy Department provided training to the nursing staff concerning medication variance reporting. The goal of the training was to improve the reporting of medication variances. This training occurred at the September nurse education meetings, and was referenced in an email dated 9/27/12. Explaining the purpose of the medication variance forms, defining the components of the form, illustrating steps in completion of the form with actual examples, and clarifying the staff responsible for completing the	Noncompliance

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		form were central topics of the training. A Nursing Department training roster was submitted indicating 100 out of 114 (88%) of nursing staff listed on the roster attended. Pharmacy Review of Categorization of Errors 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. Committee Monitoring of Medication Errors/Variances During the Monitoring Team's onsite review, on 11/6/12, a Medication Variance Committee Meeting was held. Tables and charts were discussed, including: "Internal Pharmacy Variance Trends;" "Medication Reconciliation" for October 2012; "Medication Room Audits Facility Compliance for October 2012;" graphs of procedural errors for October and for the prior 12 months by: home, category, variance, and node; "Replacement Doses Requested from Pharmacy: Short Unknown and Short Dose Wasted;" and "Doses Returned to Pharmacy: Excess unknown and refusals." No minutes were shared from the prior meeting, and no documentation of ongoing or planned action steps was provided in written form to address the ongoing error rate. As mentioned later in this section, the medication administration of Miacalcin remained a concern, and was tracked monthly by the Pharmacy Department. The Pharmacy and Therapeutics Committee of 11/7/12 also reviewed medication variances in the context of other pharmacy concerns. Data was provided regarding the medication variances from January through October Over the nine months, the number of medication variances peaked in June 2012. This occurred due to an increase in medication variances in Wood Hollow. This peak resolved by August 2012. The following represented the number of documented medication variances per month for the entire Facility: April 2012 – 59, May 2012 – 38 June 2012 – 195, July 2012 - 79, August 2012 – 56, September 2012 - 44, and October 2012 – 59. Most medication variances in April and May 2012 were considered Class B errors. In June through September 2012, Class C errors were the most dominant. The classification of error was reported per month: ▪ April 2012: Class B errors - 33, Class C errors – 24; ▪ May 2012: Class B errors – 32, Class C errors – six; ▪ June 2012: Class B errors – four, Class C errors – 184; ▪ July 2012: Class B errors – 20, Class C errors – 54; ▪ August 2012: Class B errors - 14, Class C errors – 39; ▪ September 2012: Class B errors – six, Class C errors – 24; and	

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		▪ October 2012: Class B errors – nine, Class C errors – 34. The reason for the change was not clarified in the documents submitted, but might have been due to a redefinition of the classification of errors, in which medication omissions changed from a Class B error to a Class C error. The medication variances were categorized by procedure. Omissions represented the most errors, totaling 308 from April through September 2012. During this time period, there were three errors/variances due to administration of medication to the wrong patient, two administration errors in which the medication was given during the wrong time, there were 27 errors of wrong dosage, seven errors of the wrong medication, two errors of the wrong technique, one error of the wrong number of medications dispensed, two errors in which the printed Medication Administration Record (MAR) did not match the order, six nursing transcription errors, 19 errors of missing documentation on the MAR, and 94 other errors not further categorized. There were a total of 471 medication errors during this time period. It was noted that there were no errors reported for the categories of wrong route, wrong dosage dispensed, medication labeled wrong, and error in PCP orders. From the Medication Variance Committee, in October 2012, there were 17 errors of omission, nine errors of wrong dosage, three errors of wrong medication, five errors of wrong medication dispensed, and one error of missing documentation on the MAR. There were 24 errors not categorized ("other"). Medication errors also were categorized according to the node of variance. Administration exceeded the number of errors compared to other categories, totaling 382 errors. Documentation errors were the next largest category, totaling 55 errors. This pattern continued into October 2012, with 34 administration errors, six documentation errors, but also six dispensing errors. When analyzing the data according to the medication errors based on number of doses, May 2012 had the largest number of errors. The following months had the number of doses documented as medication errors: ▪ April 2012 – 12; ▪ May 2012 – 392; ▪ June 2012 – 372; ▪ July 2012 – 245; ▪ August 2012 – 118; ▪ September 2012 – 145; and ▪ October 2012 – 117.	

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		The "Medication Reconciliation" reports were provided for May to September 2012. This provided information concerning unexplained returns and shortages. For the following months, these unknown excesses and shortages were reported as: ▪ May 2012: unknown shortage – 114, unknown excess: 188; ▪ June 2012: unknown shortage – none, unknown excess: none; ▪ July 2012: unknown shortage – 122, unknown excess: 196; ▪ August 2012: unknown shortage – 48, unknown excess; 93; ▪ September 2012: unknown shortage – 63, unknown excess: 75; and ▪ October 2012: unknown shortage – 56, unknown excess: 96. Pharmacy medication variances were also reported for May to September 2012. These included the following categories per month: ▪ May 2012: short pharmacy miscount - 15; ▪ June 2012: none reported; ▪ July 2012: short pharmacy miscount- 14; wrong medication pharmacy error – 34; ▪ August 2012: short pharmacy miscount – seven; ▪ September 2012: excess pharmacy miscount – one; short pharmacy miscount – three; wrong medication pharmacy error – two; no medication in unit dose package – one; and ▪ October 2012: excess pharmacy miscount – four; short pharmacy miscount-eight; wrong medication pharmacy error – three. A graph entitled "Internal Pharmacy Variance Trends" indicated the types of error from November 2011 through October 2012. From May 2012 through October 2012, the following information was obtained from this graph: ▪ May 2012: 20 medication variances, did not leave the pharmacy, filled by the technician and caught by the pharmacist; five medication variances left the pharmacy and caught by nursing; one medication variance filled incorrectly by pharmacy and reached the individual. ▪ June 2012: 23 medication variances, did not leave the pharmacy, filled by the technician and caught by the pharmacist; four medication variances left the pharmacy and caught by nursing; one medication variance filled incorrectly by pharmacy and reached the individual. ▪ July 2012: 13 medication variances, did not leave the pharmacy, filled by the technician and caught by the pharmacist; nine medication variances left the pharmacy and caught by nursing; one medication variance filled incorrectly by pharmacy and reached the individual. ▪ August 2012: three medication variances, did not leave the pharmacy, filled by the technician and caught by the pharmacist; two medication variances left the	

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		pharmacy and caught by nursing; one medication variance filled incorrectly by pharmacy and reached the individual. ▪ September 2012: 11 medication variances, did not leave the pharmacy, filled by the technician and caught by the pharmacist, seven medication variances left the pharmacy and caught by nursing; one medication variance filled incorrectly by pharmacy and reached the individual. ▪ October 2012: 12 medication variances, did not leave the pharmacy, filled by the technician and caught by the pharmacist, 19 medication variances left the pharmacy and caught by nursing; one medication variance filled incorrectly by pharmacy and reached the individual. Medication room audit results also were presented at the October 2012 Medication Variance Committee. A checklist form was completed to monitor compliance in several categories: medication room environment (17 audit indicators), medication cart (three audit indicators), refrigerator/freezer (seven audit indicators), equipment checks (four audit indicators), and reference material (two audit indicators). Percentage compliance was scored for each indicator, as well as a composite score. For October 2012, no medication room scored 100%. Four of 24 scored 80% or greater in October 2012. The QA Monthly Monitor Grid for September 2012 was submitted, and indicated that the Pharmacy Technicians were responsible for 100% of the monthly medication room inspections, including completion of the audit tool. The Compliance Nurse (not further identified as personnel from the QA, Nursing, or the Medical Departments) was to complete a 10% sample each month of the medication room inspections and completion of the audit tool. <u>Medication Error Reports</u> Copies of 10 recent medication error forms were submitted for review, with date of error identified as 9/17/12 through 9/30/12. According to the completion of these forms, there were two Class A medication errors, five Class B medication errors, and two Class C medication errors. There were no Class D medication errors. One error was not classified. From the information provided, the Monitoring Team determined that four of the Class B medication errors were actually Class C (variance that reached the individual, but did not cause harm). Additionally, the one non-classified error was a Class C medication error. In summary, there were two Class A medication errors, one Class B medication error, and seven Class C medication errors. Follow-up to the errors was documented in 10 of 10 errors. It is recommended that the Pharmacy Department review the classification of medication errors to ensure they agree with current definitions.	

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		Medication Observation Monitoring The Nursing Department submitted a schedule by which the nurses were observed for medication administration per quarter for each unit. Results were then tracked in a database. From May through September 2012, there were 62 medication administration observations, with scores ranging from 83 to 100. As discussed with regard to Section M, this is not a tool for which a composite score should be calculated. There were five problems identified. Two required verbal retraining that was followed by a follow-up medication administration observation in one week. The outcomes of the two follow-ups indicated scores of 100%. Two required re-education (completed the same day or the following day), with a repeat medication observation. It was noted for these two that the dates of the repeat that were entered into the log appeared to precede the re-education date and the initial observation date. However, it was determined the date was cut off in the log column that was copied. A follow-up medication observation score was recorded for these two nurses further in the log. One was observed five days later, and one was observed eight days later. Scores were 96% to 98%. For one problem identified, the staff was referred to "NM." It was unclear what this meant. No further medication administration observation score was identified for this nurse. Information was submitted indicating that nurses on one unit had halted temporarily the medication count process. This created the large number of medication variances for the month of June 2012. Corrective action steps were taken once identified. Increased surveillance of all nurses in that unit was to occur, including confiscation of trash and a medication count completed at that time. The Nurse Manager assigned to that unit, as well as the Nurse Educator were to complete medication administration observation spot checks. Focus was to be on correct medication administration techniques, medication counts, and to ensure no pre-pouring of medication was occurring. The Nurse Manager for that unit was also to complete daily reviews of the medication count sheets. These steps were to occur by 12/1/12. Further written information to determine progress of these action steps was not submitted. There was also a lack of oversight concerning the shortage and excess medication slips as well as the medication variance forms. The Nursing Department requested that the Pharmacy Department provide an in-service concerning completion of the medication variance forms. This was completed during the month of September 2012. Appropriate administration of Miacalcin nasal spray also required a continuing interdepartmental monitoring process. The Pharmacy requested all Miacalcin bottles be returned on a monthly basis in order to obtain a new monthly refill. The Pharmacy was able to identify approximately the number of doses that had been used or were still remaining. An ongoing monthly list of the amount remaining in each bottle was recorded	

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		for nursing review and action. This process had begun in May 2012, and continued to be an important monitoring step through September 2012. There were 32 individuals prescribed this medicine in September 2012. Pharmacy estimated that, according to the volume returned in the bottles, 10 out of 32 (31%) had the correct amount indicating appropriate medication administration of Miacalcin. The other bottles indicated potential errors. This percentage had slightly worsened from August 2012 (16 out of 32, or 50%). On 11/6/12, the most recent results for October 2012 were reviewed at the Medication Variance Committee meeting. The returned bottles indicated that 15 out of 34 (44%) had the correct amount indicating appropriate medication administration of Miacalcin. Due to the Nursing Administration's concerns related to administration of Miacalcin, the Pharmacy Department completed a nursing in-service for "Calcitonin Nasal Spray" during the month of July 2012. Training rosters were submitted. Attendance was 105 out of 120 (88%) of nursing staff. It is recommended that the Pharmacy Department review the data for the internal error rate, determine causes within the department, prioritize these causes by seriousness of error, frequency of error, and begin to provide system resolution steps. These analyses and corrective actions should be documented in a quarterly report. For medication errors due to nursing staff, the Pharmacy is challenged to continue to analyze the errors for trends, prioritize the errors by category, frequency, severity, etc., and assist the Nursing Department in developing resolution steps to prevent medication errors. It would be helpful to list the pharmacy interventions currently in place to assist the Nursing Department in medication error reduction, the type of error that has been reduced by these interventions, as well as types of errors that have not been addressed by pharmacy intervention, which would help define the remaining areas of challenge.	

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

1. The Psychiatry Department should develop and/or implement a policy/protocol that provides guidance concerning expectations of the psychiatrist in completing the psychiatry section of the chemical restraint documentation. (Section N.3).
2. Further collaboration should occur amongst the Pharmacy, Nursing, and Psychology Departments in resolving issues related to the administration and documentation of chemical restraints. (Section N.3)
3. The Facility should ensure that the MOSES and DISCUS evaluations are completed according to the schedule specified in the Settlement Agreement and reviewed by the prescriber in a timely manner. (Sections N.5 and J.12)
4. The Psychiatry Department should devise a reliable method to document that any significant changes in the MOSES and DISCUS evaluations are immediately reported to the prescribing practitioner. (Sections N.5 and J.12)
5. The Pharmacy Department should review the classification of medication errors by nursing staff to ensure they are consistent with current

definitions. (Section N.8)

6. The Pharmacy Department should review the data for the internal pharmacy error rate, determine causes within the department, prioritize these causes by seriousness of error, frequency of error, and begin to provide system resolution steps. These analyses and corrective actions should be documented in a quarterly report. (Section N.8)
7. For medication errors due to nursing staff, the pharmacy should continue to analyze the errors for trends, prioritize the errors by category, frequency, severity, etc., and assist the Nursing Department in developing resolution steps to prevent medication errors. It would be helpful to list the pharmacy interventions currently in place to assist the Nursing Department in medication error reduction, the type of error that has been reduced by these interventions, as well as types of errors that have not been addressed by pharmacy intervention, which would help define the remaining areas of challenge. (Section N.8)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section O; o The following documents for 13 individuals in Sample #1 that included individuals identified with PNM concerns; who received enteral nourishment; and/or had experienced a change of status as evidenced by admission to the Facility infirmary, community emergency room (ER), and/or hospital (i.e., Individual #6, Individual #260, Individual #389, Individual #73, Individual #212, Individual #81, Individual #363, Individual #430, Individual #306, Individual #385, Individual #171, Individual #92, and Individual #62), including: Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment/tool, Speech Language Pathology (SLP) comprehensive assessment, SLP assessment of status, SLP update, Head of Bed Elevation (HOBE) assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/Registered Dietician (RD) consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan (PNMP) and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management (PNM) foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o The following documents for five individuals in Sample #2 (i.e., Individual #381, Individual #239, Individual #90, Individual #341, and Individual #182) on the Physical and Nutritional Management Team (PNMT) caseload who were assessed or reviewed in the last six months; as well as Individual #180 and Individual #89 who had been discharged from the PNMT: PNMT action plan and supporting documentation, HOBE assessment, APEN assessment/tool, annual ISP and ISPAs for past year, IRRF prior to referral to PNMT, IRRF completed by PNMT and IDT upon referral, Integrated Progress Notes for past six months, Aspiration Trigger Sheets for past six months, PNMP and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse

	reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, Nursing Care Plan/Integrated Care Plan, documentation of staff successfully completing PNM foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress related to PNM difficulties, and PNMT Discharge and supporting documentation; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT and corresponding caseload; o List of all individuals the PNMT assessed and the date of assessment; o List of all individuals the PNMT discharged; o Physical Nutritional Management Policy and Procedure; o List of continuing education sessions participated in by PNMT members; o Agenda, curriculum, attendance rosters, and certificates of completion for PNMT staff; o Minutes and documentation of attendance for PNMT meetings; o List of changes in PNMT evaluation form; o Policy and procedures addressing identification of PNM health risk levels, including criteria for establishment of risk levels; o List of individuals with PNM needs; o List of individuals without PNM need; o Wheelchair/Mobility/Assistive Equipment Work Orders; o Completed PNMPs and Dining Plans; o List of tools PNMP Coordinators use to monitor staff compliance; o List of individuals for whom PNM monitoring tools were completed during last quarter; o Tools utilized for validation of competency of staff responsible for PNM monitoring; o Inter-Rater Reliability Scores; o Dining Plan (template) with changes; o PNM and PNMT-related database reports, and spreadsheets generated by Facility; o List of individuals on modified/thickened liquids; o List of individuals who require mealtime assistance; o List of individuals who receive nutrition through non-oral methods; o List of individuals whose diets have been downgraded or changed to a modified texture or consistency; o List of individuals with Body Mass Index (BMI) equal to or greater than 30; o List of individuals with BMI equal to or less than 20; o List of individuals who have had an unplanned weight loss of 10% or greater over a six-month period; o List of individuals who have had a choking incident during the past six months; o List of individuals who have had an aspiration and/or pneumonia incident during the past six months; o List of individuals who have had a fall during the past six months; o List of individuals who have had a decubitus/pressure ulcer during the past six months;

	o List of individuals who have experienced a fracture during the past six months; o List of individuals who have had a fecal impaction during the past six months; o List of individuals who are non-ambulatory or require assisted ambulation; o List of individuals with poor oral hygiene; o List of individuals who received a feeding tube since the last review; o List of individuals who are at risk of receiving a feeding tube; o List of individuals who have received a Modified Barium Swallow Study (MBSS) or other diagnostic swallowing evaluation during the past year; o Schedule of meals by home; o Schedule of all PNM-related meetings occurring during the week of the onsite review; o Curricula on PNM used to train new staff responsible for directly assisting individuals; o Agenda and curriculum for competency-based annual refresher training related to PNM; o List of completed PNMT Nursing Post Hospitalization Assessment/Evaluations; o The following documents for Individual #250 and Individual #2 on the PNMT caseload were submitted prior to the onsite review: PNMT Minutes, PNMT Assessments, Integrated Risk Rating forms, APEN Assessments, HOBE Assessments, PNMT Action Plans, Staff Competency-based Check-offs, PNMT Monitoring Forms, PNMPs, PNMT Nursing Post Hospitalization Assessments, and ISPA meeting documentation related to integration of PNMT assessments and Action Plans; o Quality Assurance/Quality Improvement meeting minutes related to PNM, PNMT, and the Habilitation Therapy (HT) Department; o Minutes from the HT Department meetings for the past six months; o External PNM consultant reports since last review; o Changes to Physical Nutritional Management Plan templates since last review; o Raw data for Section O monitoring; o QA/QI Quarterly Section Review for Section O for last two quarters; o List of individuals who require positioning assistance associated with swallowing activities; o List of individuals who have difficulty swallowing; o Facility policy or criteria for individuals who require a PNMP; o Facility policy for implementation of PNMPs off-campus; o Number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n), over number of staff in new employee orientation over last six months (N); o Number of current staff who have successfully completed PNM performance check-offs (n), over number of current staff (N); o Number of current staff who have completed annual refresher training (n), over number of staff required to complete annual refresher training (N); o Pneumonia tracking; o Samples of physical nutritional management competency performance check-offs for new employee orientation; o Samples of PNM competency performance check-offs for current staff;

	○ Policy for pulled/relief staff; ○ Facility PNMT Process procedures, revised 11/7/11; ○ Other Information Notebook; and ○ Performance check-offs completed for most recent PNMP Coordinator hired. ▪ **Interviews with:** ○ Kim Ingram, MEd, CCC-SLP, Director of Habilitation Therapies; ○ Karen Hardwick, State Coordinator for Specialized Services ○ Diane Hierholzer, PNMT Lead and OT; ○ Kellie Morey, PNMT PT; ○ Barbara Unger, QDDP Liaison; ○ Andy Maher, Assistant Director of Programs (ADOP); and ○ Michele Blalack, Chief Nurse Executive. ▪ **Observations of:** ○ Individuals in residences and dining rooms, including 779-F, 779-H, and 732-E; ○ PNMT meeting, on 11/7/12; ○ Morning Provider meeting, on 11/8/12; and ○ QA/QI Meeting, on 11/8/12.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 10/22/12. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section O, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. At the time of the review, the Director of HT was in the process of modifying the monitoring tool for Section O. The Director of HT had worked collaboratively with a Habilitation Therapy State Consultant and the Director of HT at LBSSLC to develop a template for self-assessment data. The template included the addition of tables to present compliance data within subsections. For example, in Section O.1, charts had been developed to report on core PNMT attendance, IDT/PNMT Attendance, and PNMT continuing education hours. Each of the eight sections for Section O included indicators to track compliance that were relevant to making compliance determinations. The development and future implementation of the template was a positive step forward in presenting relevant data to substantiate compliance. Based on a review of the Facility's current Self-Assessment: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: the Compliance Monitoring Tool. However, the Director of HT acknowledged that the current Monitoring Tool was not sufficient to assess compliance with the provisions of the Settlement Agreement. As noted above, the Director of HT was in the process of revising the Monitoring Tool and process for Section O. ○ This monitoring/audit tool (i.e., Compliance Monitoring Tool) did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. The development of the template

	for the presentation of data was a very promising step forward in aligning the items to be monitored with the elements of the Settlement provisions and the Monitoring Team's indicators. o The monitoring tool did include adequate methodologies, such as observations, record review, and staff interview. o The Self-Assessment identified the sample(s) sizes. However, the Facility template guidelines should identify how sample sizes were to be chosen for each of the subsections, including sample sizes adequate to consider them representative. o The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tool: Facility therapists (i.e., OTs, PTs, and SLPs) and a Program Compliance Monitor. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures, including, for example, the Morning Medical Meeting Attendance Summary for PNMT/Nurse Designee, PNMT Meeting Attendance Summary, PNMT Continuing Education, and PNMP Tracking Sheet, and PNMT Episode Log. However, as the Facility refines its self-assessment processes, it should identify and use other relevant sources of information. For example, the Facility should include data about competency-based training and performance check-offs for new employees and current staff. It also should develop key indicators or outcome measures in relation to the provision of physical and nutritional management supports. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section O. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: The Facility was continuing the process of rebuilding the PNMT. Since the last review, the PNMT membership from May to September 2012 consisted of a Qualified Developmental Disabilities Professional and a PNMP Coordinator. At the time of the review, the PNMT dedicated members were an OT, PT, QDDP, and PNMP Coordinator. A Facility Registered Dietician, Speech Language Pathologist, and RN were appointed as backup staff to assist the PNMT until dedicated staff was hired. Positions had been posted for a Nurse and Speech Language Pathologist.

	The PNMT Lead/OT attended the daily morning provider meetings. This provided opportunity to update clinical staff on the status of individuals on the PNMT caseload, as well as present systemic issues for discussion and resolution. In addition, the newly formed PNMT identified systemic issues during individuals' assessments and worked to resolve these concerns. Although a number of elements required further attention, the first assessment completed by the newly formed PNMT showed great promise. For this individual, the PNMT collected and analyzed relevant data to understand the cause and correlations of the individual's PNM concerns. However, a review of previous PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans. Lists the Facility presented to identify individuals having physical and nutritional management problems were not accurate (e.g., individuals who required mealtime assistance, individuals at high and medium risk for PNM concerns, individuals who had difficulty swallowing). The Director of HT acknowledged there were no Facility policies and/or procedures to maintain, update, and sustain these lists. As a result, it was not clear if all individuals with PNM needs had the supports they required. Since the last review, the therapists were completing self-audits using the PNMP Audit tool. PNMP content was improved since the last review, but additional work needed to be done to ensure all essential components were present. In addition, a review of the list of individuals without PNMPs and their risk ratings showed that some additional individuals needed a PNMP. The Monitoring Team and members of the PNMT team completed direct observations of the implementation of PNMP strategies in residences for individuals on the PNMT caseload. These observations revealed that some staff were, but others were not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, the Facility's monitoring did not identify similar problems. The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' Risk Action Plans did not generate individual-specific clinical data to substantiate an individual's progress or to assess if the individual was better or worse, monthly progress notes were not completed to report on the effectiveness of an individual's supports and services, individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis. The Facility was scheduled to receive training in the new APEN process in conjunction with the new ISP process. Consequently, the ISPs did not yet provide justification for the continued use of feeding tubes as medically necessary, or identify the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional 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,	As noted above with regard to the documents reviewed section, two samples were selected for the review of Section O. These included: ▪ **Sample #1 (IDT Caseload) -** Thirteen individuals identified with PNM concerns who received enteral nourishment, and some of whom had experienced a change of status related to PNM difficulties as evidenced by an admission to the Facility Infirmary, community emergency room and/or hospital, including: Individual #6, Individual #260, Individual #389, Individual #73, Individual #212, Individual #81, Individual #363, Individual #430, Individual #306, Individual #385, Individual #171, Individual #92, and Individual #62. ▪ **Sample #2 (PNMT Caseload) -** Five individuals on the current PNMT caseload who were assessed or reviewed in the last six months, including: Individual #381, Individual #239, Individual #90, Individual #341, and Individual #182. This sample also included two individuals who had been discharged from the PNMT in the past six months: Individual #180, and Individual #89. Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. The evaluations and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement. In addition, Section O.1 specifically requires that: "the Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ('PNMP') of care consistent with current, generally accepted professional standards of care… The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team." The status of these requirements is discussed with regard to Section O.3. **PNMT Membership** Since the last review, the PNMT membership from May to September 2012 consisted of a Qualified Developmental Disabilities Professional and a PNMP Coordinator. Existing therapists and nursing staff, as available, provided PNMT coverage. During this time period, there were significant shortages of therapists and nursing staff. A temporary PNMT was formed from 7/19/12 to 8/31/12 to review and assess an individual who was followed during Morning Provider meetings as a result of significant weight loss. A therapist from each discipline (i.e., OT, PT, and SLP) was assigned until additional therapists were hired.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
A core PNMT OT was hired, effective 8/3/12, and the PNMT PT was contracted on 8/15/12. At the time of the review, the PNMT dedicated members were an OT, PT, QDDP, and PNMP Coordinator. The Facility PNMT members were dedicated and did not have a caseload beyond the individuals supported by the PNMT. A Facility Registered Dietician, SLP, and RN were appointed as backup staff to assist the PNMT until dedicated staff were hired. Positions had been posted for a Nurse and Speech Language Pathologist. At the time of the review, there were two Registered Dieticians who provided support to 321 individuals.

The following chart provides the caseloads of core PNMT members at the time of the review:

<table>
<tr><th>Core PNMT Members</th><th>Current Caseloads</th></tr>
<tr><td>Occupational Therapist</td><td>PNMT Lead, and only supported individuals on the PNMT caseload</td></tr>
<tr><td>Registered Nurse</td><td>Vacant position</td></tr>
<tr><td>Speech Language Pathologist</td><td>Vacant position</td></tr>
<tr><td>Registered Dietician</td><td>Vacant position</td></tr>
<tr><td>Physical Therapist</td><td>Supported individuals only on the PNMT caseload</td></tr>
<tr><td>QDDP</td><td>Supported only individuals on the PNMT caseload</td></tr>
<tr><td>PNMP Coordinator</td><td>Supported only individuals on the PNMT caseload</td></tr>
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The Director of HT should continue to recruit and fill the vacant PNMT positions. In addition, the Facility had two RD positions to provide supports to 321 individuals living at AUSSLC. The RDs had extensive caseloads beyond their responsibilities for individuals on the active PNMT caseload. The Facility should initiate an analysis of the current clinician staffing and the clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs, as well as the various duties of the RDs to determine if the current staffing as well as the caseload distribution are adequate and appropriate.

<u>Ancillary PNMT Members</u>
With regard to PNMT ancillary members, the Facility's PNMT Process procedures, revised 11/7/11, did not address ancillary PNMT members. However, the Facility tracked the attendance of a Respiratory Therapist (RT) and Primary Care Physician. The Core PNMT Meeting Attendance Summary reported the RT and PCP attended none of the
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		52 meetings in August 2012, and none of the 35 meetings in September 2012. The Facility PNMT Process should define the role and responsibilities of ancillary members. **<u>Continuing Education</u>** The Facility's PNMT Process stated the PNMT was "a team of specialists with knowledge and expertise." However, the PNMT Process did not specifically address continuing education responsibilities for PNMT members. Attendance rosters, course certificates of completion, and agendas were submitted. Based on review of this documentation, two of the core PNMT members (i.e., PNMT OT and PNMT PT) attended the State HT Conference. Core PNMT members attended the following continuing education courses that provided specialized training in working with individuals with complex physical and nutritional management needs: ▪ On 6/10/12, Pharmacology for Rehab Professionals (PNMT OT); and ▪ On 9/20/12 to 9/21/12 Habilitation Therapies Conference (PNMT OT and PT). In summary, these continuing education training sessions attended by the PNMT Lead/OT and PNMT PT were relevant to providing supports to individuals at highest risk for physical and nutritional issues. **<u>PNMT Meetings</u>** The Facility PNMT Process stated: the "PNMT will meet at least weekly to review active cases to insure continued stability and avoid adverse outcomes." Designated PNMT member attendance for 64 individual-specific meetings conducted during the time frame from 8/13/12 to 9/7/12 was: ▪ SLP: 0% (vacant position); ▪ RN: 0% (vacant position); ▪ OT: 100%; ▪ PT: 100% attendance after hire date of 8/15/12; ▪ RD: 0% (vacant position); ▪ PNMT QDDP: 100%; and ▪ PNMP Coordinator: 47%. The Facility PNMT began meeting on a weekly basis in September 2012 as verified by PNMT attendance sheets. The Facility did not have a functioning PNMT prior to September 2012. However, even the current PNMT was not a fully functioning PNMT, because core positions had not been filled (i.e., Nurse, SLP, and RD). In addition, the Facility PNMT Process should address attendance by PNMT members, and/or how the PNMT would address the absence of core PNMT members.	

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		Attendance by ancillary PNMT members for PNMT meetings conducted during the time frame from 8/13/12 to 9/7/12 was as follows: ▪ The Facility PNMT medical liaison and/or PCP attended no PNMT meetings (0%). ▪ A Respiratory Therapist did not attend any PNMT meetings (0%). The PNMT meeting attendance sheets did not indicate that IDT members attended the PNMT meetings (i.e., QDDP, Nurse Case Managers and other relevant staff). The Facility PNMT Process should define the role and responsibilities of IDT members. It is important that IDT members participate in the process both to provide relevant information, but also to help develop and learn about the supports and services the individuals require. Ultimately, the PNMT should prepare teams so that when individuals are ready for discharge from the PNMT, the IDTs are prepared to resume full responsibility. **PNMT Facility Policy** The Facility PNMT Process procedures, revised 11/7/11, had not been updated. Based on interview, the Director of HT was in the process of revising these procedures. The Monitoring Team will review the revised Facility PNMT Process during the next on-site review. **PNMT Systemic Issues** The PNMT was identifying and resolving systemic issues through multiple venues. For example, in Individual #239's PNMT assessment recommendations, dated 10/29/12, the PNMT identified following systemic issues: ▪ "If not already in existence, set up protocol for chest x-rays to be taken after diagnosis of aspiration pneumonia to determine if resolved." ▪ "Implementation of a diet order form that would provide a standardized and methodical way to track changes that are made to an individual's diet throughout the year." Information was provided that showed Facility staff had used a collaborative approach to develop and finalize the Physician Order for Enteral Feedings. This form had been developed and implemented to produce data that would enable clinicians to track and trend diet order changes. However, no information was provided to indicate that a protocol had been developed for chest x-rays to be ordered after a diagnosis of aspiration pneumonia. Furthermore, the PNMT Lead provided training to Infirmary nursing staff to develop and implement a process for setting safe head of bed elevations for individuals admitted to the Infirmary. This was another example of identification and response to a systemic	

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		issue. In addition, the PNMT members attended the daily Medical Morning meetings. This provided an opportunity to present and resolve identified systemic concerns. The Facility PNMT Process should be revised to define the role and responsibilities of PNMT members in the daily Medical Morning meeting. The identification of systemic issues is an important responsibility of PNMT members. The Facility PNMT Process should define the pathways for how the PNMT will bring systemic issues to the attention of Facility Administration and work collaboratively to resolve these issues. In addition, the PNMT should consistently document the resolution of identified systemic issues. In summary, at the time of the review, the Facility's PNMT did not have the required members as outlined in the Settlement Agreement. The dedicated PNMT members were a PNMT Lead/OT, PT, QDDP, and PNMP Coordinator. The Director of HT was actively recruiting a SLP and RN to join the Facility PNMT. Progress had been made in identifying and addressing systemic issues related to the provision of PNM supports and services. However, the expectations and pathways for this process should be formalized in Facility policy and procedure. The Facility remained out of compliance with this provision.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional	**<u>Facility's Lists of Individuals with PNM Problems</u>** The Facility produced the following lists identifying individuals with PNM concerns: ▪ The Facility's list for Level of Assistance for Dining, revised 10/22/12, identified 45 individuals who were dependent on staff to eat, 16 individuals that required assistance, 51 individuals that required intermittent assistance, 40 individuals who received enteral nutrition, 62 individuals who were independent, and 106 individuals that were monitored. This list totaled to 320 individuals. ▪ During the onsite review, the Facility provided a list of 324 individuals' risk ratings. Twenty-six of 324 individuals (8%) were identified at high risk, and 136 of 324 individuals (42%) were identified at medium risk for aspiration pneumonia. Individuals in Sample #1 who had been hospitalized and received a discharge diagnosis of aspiration pneumonia should have had their risks reevaluated and have been rated at high risk for aspiration. However, these individuals who experienced a change of status (i.e., Individual #260, Individual #389, Individual #73, and Individual #212) were ranked at medium risk for aspiration. Consequently, the Monitoring Team did not have confidence these risk ratings were an accurate reflection of individuals' health status. In addition, the State recently had revised the criteria for high risk of aspiration to include all individuals who received enteral nutrition. As a result of this	Noncompliance

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	management problems to identify the causes of such problems.	change, IDTs will need to revise the risk rating for aspiration for individuals who receive enteral nutrition. • Eight of 324 individuals (2%) were identified as being at high risk, and 213 of 324 individuals (66%) at medium risk for choking. The Facility reported one serious choking incident for Individual #358 that occurred on 7/30/12. This individual was rated at medium risk for choking. This was not in alignment with the risk guidelines. Consequently, this individual's risk rating was not accurate. ▪ The Facility was unable to produce complete and accurate lists for those individuals with swallowing difficulties and individuals who required positioning assistance associated with swallowing. Based on documentation submitted, the Director of HT planned to meet with the Medical Director, Client Records staff, and the ADOP to determine the best way to produce this information and review it for accuracy. Medical diagnoses were tracked by the Facility, however, diagnoses in this area were under several different codes and the data could not be readily produced. Resolution of this problem was expected by 12/1/12. At the time of the review, the HT Director acknowledged there were no Facility policies and/or procedure(s) to define the criteria for the development of these lists and/or a formal process for maintaining, updating, and sustaining the accuracy of these lists. In addition, the Facility Assistant Director of Programs indicated the Facility had not developed a maintainable system to report risk ratings. Consequently, as noted above, the multiple lists the Facility presented to identify individuals having physical and nutritional management problems were not accurate. The Facility should develop a sustainable system to maintain and update these lists to ensure their validity. A basic component of compliance with this provision is the accurate identification of individuals with PNM concerns. Without an accurate list(s), it would be difficult for the Facility to ensure that it provides such individuals with adequate physical and nutritional interventions. **PNMT Referral Process and Initiation of Assessment** The Facility PNMT Process indicated: "the IDT, PCP and/or the PNMT may refer individuals at high risk who are not stable and for whom the team needs assistance developing a plan." In addition, the "PNMT may, following review of hospitalizations, any instance of aspiration pneumonia, or other change in status, determine need for PNMT involvement." Based on interview and documentation provided, the PNMT members implemented a PNMT Episode Log. Retroactive data from September 1, 2012 was entered in the Episode Tracking Log. The PNMT members maintained this log as a data collection system to identify individuals who the PNMT should review. Data was collected through the	

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		following methods: ▪ Participation in daily Medical Morning meetings; ▪ Participation in Infection Control Committee, although no data was available to substantiate attendance; ▪ Review of hospitalization reports; ▪ Review of weight reports; and ▪ Review of 24-hour nursing reports, as appropriate to identify relevant episodes. The PNMT was responsible for tracking the following episodes for individuals on campus: ▪ Fractures of long bones, pelvis, or spine; ▪ Choking episodes; ▪ Emesis (i.e., unresolved emesis unrelated to viral infection and/or more than three episodes in 30 days); ▪ Risk for enteral nutrition; ▪ Modified Barium Swallow Study; ▪ Feeding tube clogged; ▪ Poor oral hygiene; ▪ Urinary tract infections; ▪ Decubitus (i.e., Stage 2, Stage 3, Stage 4, unstageable, and delayed healing); ▪ Pneumonia (i.e., bacteria, aspiration, and/or unknown); ▪ Weight loss/gain (i.e., 5% in one month, 7.5% in three months, and/or 10% in six months, and/or Body Mass Index (BMI) greater than 30 and/or less than 20); ▪ Hospitalization for respiratory compromise, urinary tract infection, gastrointestinal issues, bowel obstruction, fecal impaction requiring digital removal, and dehydration; and ▪ Any other episode that might impact an individual's physical and nutritional status. Based on interview, the PNMT was in the process of learning how to track and trend this information. The plan was for the PNMT to review the Episode Tracker Log monthly and complete an analysis. This analysis should be presented to staff at Medical Morning meetings and QA/QI Council meetings. The development and implementation of the PNMT Episode Tracker Log was a significant positive development that hopefully will alert the PNMT and Facility staff of an individual's change in status. The Monitoring Team was hopeful this system would trigger intervention by the IDT and/or the PNMT to intervene with an individual before they were hospitalized. The collection and analysis of this information had been a missing link in identifying individuals who were experiencing a change of status. On 10/29/12, an in-service was provided to QDDPs and Active Treatment staff on the	

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		PNMT. The in-service covered the composition of the PNMT, who refers individuals to the PNMT, who qualifies for PNMT services, why a referral would be made to the PNMT, when and where the PNMT meets, and what services the PNMT provides. It was positive that the PNMT had provided an in-service to the QDDPs. Based on interview, the Director of HT was in the process of updating the Facility PNMT Process. The PNMT should provide additional training to IDT members when these procedures are finalized. Eight of the 13 individuals in Sample #1 had been hospitalized for PNM related concerns as evidenced by their hospital discharge diagnosis: Individual #6 (aspiration pneumonia and recurrent seizures), Individual #260 (aspiration pneumonitis), Individual #389 (aspiration pneumonitis), Individual #73 (aspiration pneumonia and gastrostomy tube placement), Individual #212 (aspiration pneumonia), Individual #363 (presumed aspiration pneumonia and gastrostomy tube replacement), Individual #306 (gastrostomy tube placement), and Individual #62 (urinary tract infection). They were reviewed to determine if a referral had been made to the PNMT, if appropriate. The Monitoring Team requested a list of individuals who had been referred to the PNMT. However, as discussed above in Section O.1, until September 2012, the Facility did not have a functioning PNMT. Individual #6 was referred to the PNMT on 10/31/12, Individual #260 was under investigation for possible referral to the PNMT, and Individual #73 received a PNMT consultation. However, the remaining five individuals (i.e., Individual #389, Individual #212, Individual #363, Individual #81, and Individual #306) had not been referred, but the PNMT should review them for possible referral. **PNMT Assessment** At the time of the Monitoring Team's onsite review, the active PNMT caseload was seven individuals (i.e., defined as full involvement) and five individuals that were in transition for discharge (i.e., defined as partial involvement). As discussed with regard to Section O.1, the Director of HT was in the process of revising the Facility PNMT Process. The Facility PNMT Process stated the PNMT was responsible for providing "a comprehensive assessment and determining appropriate interventions for persons at the highest risk of potential or actual injury and/or illness who are not stable and for whom the team needs additional assistance developing a plan." The Monitoring Team reviewed the content of PNMT assessments and action plans for five individuals in Sample #2 (i.e., Individual #381, Individual #239, Individual #90, Individual #341, and Individual #182) who were on the active PNMT caseload and found: ▪ None of five individuals' PNMT assessments (0%) provided the individual with physical and nutritional interventions and supports sufficient to meet the individual's needs. ▪ Three of the five individuals' PNMT assessments reviewed (i.e., Individual #239, Individual #381, and Individual #341) (60%) followed the Facility-established	

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		PNMT assessment template. Other PNMT assessments reviewed were missing components from the Facility PNMT assessment format. ▪ In four of five PNMT assessments reviewed (i.e., Individual #239, Individual #381, Individual #90, and Individual #341) (80%), the assessment identified the cause of the individual's physical and nutritional management problems. For the remaining individual, the PNMT assessment did not provide an adequate analysis to identify the cause of the individual's PNM concerns. ▪ In two of the five PNMT assessments (i.e., Individual #239 and Individual #341) (40%), a PNMT self-referral and/or IDT referral date was noted. ▪ In two of the five PNMT assessments (i.e., Individual #239 and Individual #341) (40%), the assessments reviewed and updated the individuals' risk rating(s), as appropriate. In assessing this indicator, the Monitoring Team specifically considered the risk ratings related to individuals' PNM needs. ▪ In two of five PNMT assessments (i.e., Individual #239 and Individual #341) (40%), there was documentation of adequate PNMT assessment of an individual's PNM related high and medium risk levels. Although, the PNMT might have reviewed an individual's risks, an IRRF was not completed or updated to provide justification and rationale for the risk rating changes. ▪ For none of the five individuals reviewed (0%), a HOBE assessment had been completed. In addition, the HOBE assessment format did not include an assessment of a recommended safe range for dental procedures. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. ▪ In none of the five individuals' PNMT assessments reviewed (0%) were individual-specific clinical baseline data established to assist teams in recognizing changes in health status. ▪ In none of the five individuals' PNMT assessments reviewed (0%) were individualized clinical criteria defined regarding when nursing staff should contact the PNMT. Given that essential components as identified above were not present, PNMT assessments were not adequate. However, the first assessment completed by the newly formed PNMT for Individual #239 was a significant positive step in the right direction. Individual #239's assessment provided hands-on assessment and a detailed, data-driven approach to understanding and providing supports to mitigate her PNM concerns. However, Individual #239's PNMT assessment was still missing essential components as noted above. The Facility was planning to develop a PNMT Assessment Audit Tool and PNMT Assessment Audit Data Spreadsheet. These tools should include the preceding essential	

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		components to substantiate the presence of these components in PNMT assessments. **<u>PNMT Action Plan</u>** A review of individuals' PNMT action plans did not show that the action plans included essential components discussed below. The Monitoring Team reviewed the five individuals' PNMT action plans and found: ▪ In none of the five individuals' PNMT action plans (0%), the plan adequately addressed the individual's identified PNM problems as presented in the PNMT assessment. The PNMT action plans were missing information and recommendations from the PNMT assessments. In addition, the PNMT action plans did not provide adequate interventions to resolve an individual's PNM problems. ▪ In none of the five individuals' PNMT action plans (0%), the HOBE recommendations were integrated into the PNMT action plan. ▪ In none of the five individuals' PNMT action plans (0%), adequate preventative interventions were included in the plan to minimize the conditions of the identified risk indicators. Although there were some preventative measures, additional preventative measures were needed to address all of the individuals' needs. ▪ In one of the five individuals' PNMT action plans reviewed (i.e., Individual #239) (20%) were there appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. ▪ In none of the five individuals' PNMT action plans (0%), the plans included the specific clinical indicators to be monitored. For example, action plans did not consistently identify clinical indicators to be monitored by nursing and/or the PNMT members that would indicate the individual's health status was stable and/or the individual was experiencing a change of status. Although some indicators were included, many were not adequate to appropriately measure individuals' health status, and many were missing. ▪ In none of the five individuals' PNMT action plans (0%), the frequency of monitoring was included. ▪ In none of the five individuals' PNMT action plans reviewed (0%), the action plan was integrated into the ISP. ▪ For one of the five individuals reviewed (i.e., Individual #239)(20%), a PNMT/IDT meeting had been conducted to discuss the Integrated Risk Rating Form, PNMT assessment, and action plan. ▪ In none of five individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of the PNMT action plan within 14 days of the plan's finalization. Given that multiple components as identified above were not present, individuals' PNMT	

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		action plans were not adequate. **PNMT Follow-up and Problem Resolution** A review of PNMT follow-up meetings for individuals on the active caseload of the PNMT in Sample #2 showed: ▪ In none of the five individuals' PNMT action plans (0%), action plan steps had established timelines. Action plans provided a timeline start date but did not provide a timeframe for completion of action steps, and/or action steps did not have an established timeline. ▪ In none of the five individuals' PNMT action plans reviewed (0%), action plan steps had been completed within established timeframes. It was difficult to discern when action plan steps had been completed. ▪ In none of the five individuals' PNMT action plans reviewed (0%), when risk to the individual warranted it, the PNMT took immediate action. For example, individuals' Aspiration Trigger Data Sheets were not completed and/or individual-specific triggers had not been integrated into the form. These forms were developed and implemented to alert staff to an individual's changes in status, and subsequently, alert PNMT members. The PNMT should have been aggressive in ensuring staff implemented these forms as well as modifying the forms to reflect individuals' triggers. ▪ In none of the five individual records reviewed (0%), documentation was present for adequate closure of PNMT action plan steps. **Individuals Discharged by the PNMT** The Facility PNMT Process did not outline the PNMT discharge process, nor define the roles and responsibilities of the PNMT and IDT members when an individual was discharged from the PNMT. The PNMT provided a list of individuals and their current status, not dated. Since the last review, the PNMT had discharged four individuals (i.e., Individual #180, Individual #81, Individual #89, and Individual #286). The Monitoring Team reviewed the records of Individual #180 and Individual #89, and findings were as follows: ▪ In one of the two individual records reviewed (i.e., Individual #180) (50%), an ISPA meeting occurred. ▪ In none of the two individual records reviewed (0%), the ISPA meeting provided objective clinical data to justify the discharge. ▪ In none of the two individual records reviewed (0%), there were adequate criteria for referral back to the PNMT. The PNMT should provide individual-specific, objective, clinical data that would indicate a change of status requiring their re-involvement.	

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		In summary, the PNMT should ensure assessments, action plans, and discharge summaries include the essential components discussed within this section. Prior to implementation of the PNMT audit tools, the Director of HT should review the PNMT audit tools to ensure these tools assess the quality of assessments and include the essential components discussed within this section. The Facility remained out of compliance with this provision.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	**Identification of Individuals Requiring a PNMP** The Facility's list of Individuals with PNM Needs, revised 10/5/12, identified 308 individuals that had PNM needs out of a census of 328 (94%). A list entitled "Individuals without PNM Needs" identified 18 of 328 (6%) individuals that did not have PNM needs. The Facility reported this information would need to be recalculated using the most current risk rating information when available to reflect the correlation between levels of risk and the need for PNM supports. The State PNM policy stated: "all individuals who require physical nutritional management services will be furnished with a PNMP or mealtime and positioning/dining plan. All individuals who cannot feed themselves are at risk for choking or aspiration, and who require positioning associated with swallowing will be identified and provided with plans and supports sufficient to meet their needs." The following concerns were noted for individuals who received a high and/or medium PNM-related risk ranking, but did not have a PNMP: ▪ Individuals at risk for choking have a need for a PNMP. Individual #146 was ranked at medium risk for choking, but did not have a PNMP. ▪ Individuals at high and/or medium risk for falls, fractures, and/or osteoporosis had a need for a PNMP. The following individuals did not have a PNMP, but were ranked at high and/or medium risk for falls, fractures and/or osteoporosis: Individual #87, Individual #292, Individual #19, and Individual #275. ▪ Individuals at high and/or medium risk for skin integrity required a PNMP. However, individuals were identified without a PNMP, but were ranked at medium risk for skin integrity, including: Individual #397, Individual #146, Individual #364, and Individual #360. ▪ Individuals at high and/or medium risk for weight indicated the need for a PNMP. However, the following individuals were ranked at high and/or medium risk for weight, but did not have a PNMP: Individual #397, Individual #87, Individual #283, Individual #364, Individual #275, Individual #7, Individual #109, and Individual #361. Based on the examples above, some individuals that had been identified as not having PNM needs might have required a PNMP. The HT Department should follow the State Office policy for individuals who require a PNMP. The State Office policy should be	Noncompliance

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		utilized to review the Facility's list of individuals with no PNM needs to determine which of these individuals meet the PNM criteria and should be provided with a PNMP sufficient to meet their needs. **PNMP Format and Content** Therapists currently were using the AUSSLC PNMP Audit Tool, revised 10/30/12, to complete a self-audit prior to the finalization of the PNMP for submission to the Individual Notebook. Audit information was not currently collected, because the self-audit process was considered part of the therapists' training process initiated in September 2012. Based on interview, the Director of HT planned to begin auditing PNMPs. These audits would be compared with therapist self-audits to establish inter-rater agreement. In addition, a PNMP Audit Spreadsheet and PNMP Audit Line Item Report had been developed. However, at the time of the review, no data entry was in place for these tools. The development of these tools was positive and should provide future data to substantiate compliance with PNMP content and implementation. On 1/2/12, the PNMP Tracking Spreadsheet, dated 10/30/12, was initiated. The spreadsheet tracked the individuals' PNMP submission date; revision date; date finalized; revision to 10/17/11 and 1/23/12 template; delivery to home, programs, and nursing for placement in Medication Administration Record (MAR); annual update; and description of changes. The Facility reported that a review of the PNMP template revision data using the PNMP Tracking Sheet indicated that 212 out of 308 PNMPs (69%) were formatted using the most current PNMP template, which was revised on 1/23/12. The Facility also should track the ISP and/or ISPA date at which the OT/PT/SLP presented the PNMP revisions to the team for review and approval. A review of 13 individuals' PNMPs who received enteral nutrition, were ranked high for PNM concerns, and/or had experienced a change in status related to PNM concerns (i.e., Individual #6, Individual #260, Individual #389, Individual #73, Individual #212, Individual #81, Individual #363, Individual #430, Individual #306, Individual #385, Individual #171, Individual #92, and Individual #62) in Sample #1 found: ▪ Thirteen of the 13 individuals (100%) had a PNMP. ▪ Thirteen of the 13 individuals' PNMPs (100%) were current within the last 12 months. ▪ None of the 13 individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. o Medical staff was present in five of 13 annual ISP meetings (38%); o Nursing staff was present in 10 of 13 annual ISP meetings (77%);	

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		o Registered dietician staff was present in five of 13 annual ISP meetings (38%); o Physical therapists were present in eight of 13 annual ISP meetings (62%); o Occupational therapists were present in eight of 13 annual ISP meetings (62%); o Speech language pathologists were present in eight of 13 meetings (62%); o Psychologists were present in six of 13 annual ISP meetings (46%); o Dental staff were present in none of 13 annual ISP meetings (0%), and o Direct support professionals were present in 12 of 13 meetings (92%). Per State Office policy, each individual's team should decide which team members should attend the annual meeting. However, teams at AUSSLC were just beginning to document their decisions with regard to team composition. For individuals with therapeutic needs, team will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. ▪ None of the 13 individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs, etc.). ▪ Thirteen of the 13 individuals' PNMPs (100%) noted individual-specific risks and related triggers. It was positive that individual-specific risks and triggers had been added to individuals' PNMPs. However, individuals' PNMPs were not consistent from individual to individual. For example, high-risk PNM issues were included for some individuals, but not others. In addition, medium risk PNM issues were noted on some PNMPs, but not on others. Clarification should be provided to therapists to provide consistency in the identification of individual-specific risks. ▪ Two individuals in Sample #1 were ambulatory (i.e., Individual #430 and Individual #6). In five of the remaining 11 individuals' PNMPs (i.e., Individual #81, Individual #363, Individual #212, Individual #62, and Individual #389) (45%), adequate positioning instructions were included for wheelchair positioning, including written and pictorial instructions and safe elevation ranges. More specifically, for the remaining individuals, the wheelchair positioning instructions did not provide adequate instructions for staff to achieve a safe elevation range. ▪ In four of 11 individuals' PNMPs (i.e., Individual #81, Individual #363, Individual #212, and Individual #260) (36%), there were adequate alternate positioning instructions, including written and pictorial instructions and safe elevation ranges. There were written and pictorial alternate positioning instructions, but instructions for how staff were to achieve a safe elevation range was missing.	

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		▪ In eight of 11 individuals' PNMPs (i.e., Individual #81, Individual #363, Individual #212, Individual #306, Individual #171, Individual #92, Individual #260, and Individual #62) (73%), bedtime positioning options were noted. Individual #430 and Individual #6 were able to re-position themselves in bed. ▪ In 13 of 13 individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ Five individuals (i.e., Individual #430, Individual #6, Individual #171, Individual #92, and Individual #260) in Sample #1 ate orally. The following related findings were made with regard to these individuals' PNMPs: o Five of five individuals' dining plans (100%) were current in the last twelve months. o Five of five individuals' dining plans (100%) included risks and triggers. o In three of five individuals' PNMPs/dining plans (i.e., Individual #430, Individual #6, and Individual #171) (60%), mealtime plans included written and/or pictorial instructions for positioning. o In five of five individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for food texture. o In five of five individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for fluid consistency. o In three of five individuals' PNMPs/dining plans (i.e., Individual #430, Individual #6, and Individual #171) (60%), mealtime plans included staff presentation techniques. ▪ Eight of 13 individuals' PNMPs (i.e., Individual #6, Individual #260, Individual #81, Individual #363, Individual #430, Individual #385, Individual #171, and Individual #92) (62%) noted safe positioning elevation ranges to be utilized during dental appointments. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. ▪ Seven of 13 individuals' PNMPs (i.e., Individual #212, Individual #306, Individual #73, Individual #92, Individual #385, Individual #260, and Individual #389) (54%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In 10 of 13 individuals' PNMPs (i.e., Individual #6, Individual #260, Individual #389, Individual #73, Individual #81, Individual #430, Individual #306, Individual #171, Individual #92, and Individual #62) (77%), medication administration strategies included positioning options with safe elevation ranges. For the remaining individuals, PNMPs were missing instructions for nursing to achieve a safe elevation range during wheelchair and/or alternate positioning options. ▪ Four individuals (i.e., Individual #6, Individual #171, Individual #92, and	

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		Individual #260) received medication orally. The following related findings were made with regard to these individuals' PNMPs: o In four of four individuals' PNMPs (100%), the medication administration strategies included instructions for diet texture and fluid consistency. o In four of four individuals' PNMPs (100%), the medication administration strategies included instructions for mealtime adaptive equipment. o In one of four individuals' PNMPs (i.e., Individual #6) (25%), medication administration strategies included instructions for presentation techniques. ▪ Twelve of 13 individuals' PNMPs (i.e., Individual #6, Individual #260, Individual #389, Individual #73, Individual #212, Individual #81, Individual #363, Individual #430, Individual #306, Individual #385, Individual #92, and Individual #62) (92%) included strategies for oral hygiene, including positioning with safe elevation ranges. The PNMP for Individual #171 instructed staff to use the "most upright position," which were not adequate instructions for staff to achieve a safe elevation range in his wheelchair. ▪ Nine of 13 individuals' PNMPs (i.e., Individual #81, Individual #363, Individual #212, Individual #306, Individual #73, Individual #92, Individual #260, Individual #62, and Individual #389) (69%) included the reasons for an individual's prescribed adaptive equipment. PNMPs for the remaining individuals did not identify the reason for prescribed adaptive equipment. ▪ Six of 13 individuals' PNMPs (i.e., Individual #430, Individual #306, Individual #73, Individual #171, Individual #385, and Individual #62) (46%) included bathing/showering positioning instructions to achieve a safe elevation range. The remaining PNMPs were missing instructions for staff to achieve a safe elevation range. ▪ Four of the 13 individuals' PNMPs (i.e., Individual #81, Individual #363, Individual #306, and Individual #73) (31%) included adequate personal care instructions, with elevation strategies during checking and changing. The remaining PNMPs were missing instructions for staff to achieve a safe elevation range. ▪ Thirteen of 13 individuals' PNMPs (100%) stated how an individual would communicate with staff. ▪ Thirteen of 13 individuals' (100%) included strategies for how staff was to communicate with an individual. A review of five individuals' PNMPs on the PNMT caseload (i.e., Individual #381, Individual #239, Individual #90, Individual #341, and Individual #182) in Sample #2 found:	

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		▪ Five of the five individuals (100%) had a PNMP. ▪ Five of the five individuals' PNMPs (100%) were current within the last 12 months. ▪ None of the five individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP into the ISP. o Medical staff were present in four of five annual ISP meetings (80%); o Nursing staff were present in five of five annual ISP meetings (100%); o Registered dietician staff were present in two of five annual ISP meetings (40%); o Physical Therapists were present in three of five annual ISP meetings (60%). A PTA attended two of the meetings; o Occupational Therapists were present in five of five annual ISP meetings (100%); o Speech Language Pathologists were present in two of five meetings (40%); o Psychologists were present in two of five annual ISP meetings (40%); o Dental staff were present in none of five annual ISP meetings (0%); and o Direct support professionals were present in five of five meetings (100%). As noted above, per State Office policy, each individual's team should decide which team members should attend the annual meeting. However, teams at AUSSLC were just beginning to document their decisions with regard to team composition. For individuals with therapeutic needs, team will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. ▪ None of the five individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs, etc.). ▪ Five of five individuals' PNMPs (100%) noted individual-specific risks and related triggers. However, a review of these individuals' PNMPs showed inconsistency from individual to individual. For example, high-risk PNM issues were included for some individuals, but not others. In addition, medium risk PNM issues were noted on some PNMPs, but not on others. Clarification should be provided to therapists to provide consistency in the identification of individual-specific risks. ▪ In three of five individuals' PNMPs (i.e., Individual #239, Individual #381, and Individual #341) (60%), adequate positioning instructions for wheelchair positioning were included, including written and pictorial instructions and safe elevation ranges. More specifically, for the remaining two individuals, although there were wheelchair positioning instructions, there were not adequate instructions for safe elevation range. For example, staff was instructed to place	

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		an individual in the "most upright" position, but there were not adequate instructions for placement of a safe elevation range of the wheelchair. ▪ In three of five individuals' PNMPs (i.e., Individual #239, Individual #381, and Individual #341) (60%), there were adequate alternate positioning instructions, including written and pictorial instructions and safe elevation ranges. Written and pictorial instructions for the correct placement of a chain were provided for staff to achieve the prescribed head of bed elevation. For the remaining individuals, the PNMP did not provide adequate instructions for a safe elevation range. ▪ In four of five individuals' PNMPs (i.e., Individual #381, Individual #239, Individual #341, and Individual #182) (80%), bedtime positioning options were noted. ▪ In five of five individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ Two individuals (i.e., Individual #90 and Individual #341) in Sample #2 ate orally. The following related findings were made with regard to these individuals' PNMPs: o Two of two individuals' dining plans (100%) were current in the last twelve months. o Two of two individuals' dining plans (100%) included risks and triggers. o In one of two individuals' PNMPs/dining plans (i.e., Individual #341) (50%), mealtime plans included written and/or pictorial instructions for positioning. Individual #90's dining plan positioning picture did not show him in an optimal position. o In two of two individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for food texture. o In two of two individuals' PNMPs/dining plans (100%), mealtime plans included written and/or pictorial instructions for fluid consistency. o In two of two individuals' PNMPs/dining plans (100%), mealtime plans included staff presentation techniques. ▪ Two of five individuals' PNMPs (i.e., Individual #341 and Individual #182) (40%) noted safe positioning elevation ranges to be utilized during dental appointments. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. ▪ Five of five individuals' PNMPs (100%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In five of five individuals' PNMPs (100%), medication administration strategies included positioning options with safe elevation ranges. ▪ Two individuals (i.e., Individual #90 and Individual #341) received medication	

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		by mouth. The following related findings were made with regard to these individuals' PNMPs: o In two of two individuals' PNMPs (100%), the medication administration strategies included instructions for diet texture and fluid consistency. o In two of two individuals' PNMPs (100%), the medication administration strategies included instructions for mealtime adaptive equipment. o In none of two individuals' PNMPs (0%) did medication administration strategies include instructions for presentation techniques. ▪ Four of the five individuals' PNMPs (i.e., Individual #239, Individual #90, Individual #341, and Individual #182) (80%) included strategies for oral hygiene, including positioning with safe elevation ranges. For the remaining PNMP, instructions were missing on how to achieve a safe elevation range. ▪ Five of five individuals' PNMPs (100%) included the reasons for an individual's prescribed adaptive equipment. ▪ Three of five individuals' PNMPs (i.e., Individual #239, Individual #381, and Individual #90) (60%) included bathing/showering positioning instructions to achieve a safe elevation range. For the remaining PNMPs, bathing instructions did not indicate how to achieve a safe elevation range. ▪ Four of five individuals' PNMPs (i.e., Individual #239, Individual #90, Individual #341, and Individual #182) (80%) included adequate personal care instructions, with elevation strategies during checking and changing. Individual #381's personal care instructions did not provide strategies for staff to achieve a safe elevation range in bed when her briefs were changed. ▪ Five of five individuals' PNMPs (100%) included strategies for how staff was to communicate with an individual. ▪ Five of five individuals' PNMPs (100%) stated how an individual would communicate with staff. Areas of noncompliance in PNMP strategies were not significantly different between individuals in Sample #1 or Sample #2. The following concerns were noted: ▪ PNMPs were not adequate, because essential components were missing. ▪ Although individuals' PNMPs had been updated to include individual-specific risks and triggers, multiple individuals' PNMPs did not include high and/or medium risks related to PNM and related triggers to alert staff to a potential change in status. ▪ Written and pictorial instructions were provided for an individual's head of bed elevation, which demonstrated the placement of the red/green chain to achieve a safe elevation range. However, written and pictorial instructions for alternate positions (i.e., right and left sidelying) instructed staff to place an individual on	

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		their side "with elevation." Consideration should be given to expanding these instructions to include elevation per chain. ▪ HOBE assessments had not been consistently completed to establish safe elevation ranges in wheelchair and alternate positions, bathing/showering, personal care, oral care, dental appointments, or other activities that were likely to provoke swallowing difficulties. Individuals' PNMPs should have HOBE assessment data integrated to provide staff instructions for safe elevation ranges in daily activities. ▪ The absence of clinicians (i.e., OT, PT, SLP, and RD) during the annual ISP meetings negatively impacted the discussion related to the integration of PNMP and dining plans into the ISP, risk assessment, and multiple support plans. These clinicians were the authors of the PNMPs and their contribution was critical to the team understanding the purpose of the individual's PNMP. Per State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. A general rule of having a single clinician to represent the HT Department will not suffice. This process will have to be individualized, and be driven by teams' decisions. The content of PNMPs had improved since the Monitoring Team's last compliance review in November 2011. However, individuals' PNMPs were missing essential components. The Facility should ensure the Facility PNMP Audit tool encompasses these components to validate PNMPs contain these necessary components. A blank copy of an Assistive Equipment Checklist, revised 9/30/12, was provided in the Presentation Book for Section O. Home staff were to complete the form on a monthly basis by initialing that individual-specific PNMP equipment was present and in good repair. If equipment was missing and/or broken, home staff were to report immediately to the HT Department. At the end of the month, the completed checklist was provided to the QDDP. However, there were no Facility procedures provided to formalize this process. **Implementation of Individuals' PNMP Off-Campus (i.e., community outing, hospitalization)** The State Office policy 012.2 stated that PNMPs were to "span a 24-hour day, 7 days a week." The Facility's policy entitled: "Role and Responsibilities of Direct Contact Staff in Providing Care for Our Clients During Their Hospitalization," dated July 2006, stated: "ensure the client's safety and welfare at all times… following the client's PNMP,	

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		reposition schedule and check and change schedule." However, there was no specific Facility policy to address the implementation of an individual's PNMP off-campus. Since the last review, 11 individuals in Sample #1 and five individuals in Sample #2 been hospitalized. The Monitoring Team reviewed Hospital Liaison Reports and progress notes for 11 individuals in Sample #1 (i.e., Individual #430, Individual 306, Individual #212, Individual #363, Individual #73, Individual #6, Individual #171, Individual #62, Individual #389, Individual #260, Individual #81) and five individuals in Sample #2 (i.e., Individual #381, Individual #239, Individual #90, Individual #341, and Individual #182). A review of Hospital Liaison reports for 11 individuals in Sample #1 noted the following: ▪ None of the Hospital Liaison Reports and/or progress notes for these individuals (0%) addressed the presence and/or implementation of the individuals' PNMPs. A review of Hospital Liaison Reports for the five individuals in Sample #2 found: ▪ None of the five Hospital Liaison Reports and/or notes (0%) addressed the presence and/or implementation of the individuals' PNMPs. These were examples of individuals' PNMPs not being monitored for implementation while off-campus. The implementation of PNMPs in the hospital should be of highest priority. The Facility should ensure the implementation of PNMPs off-campus, including community outings, transportation to the emergency room, etc. **Change in Status Update for Individuals' PNMPs Conducted by the IDT and/or Individuals on the PNMT Caseload** Individuals' revised PNMPs were reviewed to determine if an ISPA meeting had been conducted to address the proposed revisions. For the individuals in Sample #1, 11 of the 13 individuals' PNMPs had been revised after their annual ISP meeting (i.e., Individual #6, Individual #260, Individual #389, Individual #212, Individual #81, Individual #430, Individual #306, Individual #385, Individual #171, Individual #92, and Individual #62). ▪ None of the 11 individuals (0%) had an ISPA meeting conducted to discuss and approve PNMP revisions. ▪ None of the 11 individuals' records (0%) had supporting documentation to show that the individuals' revised PNMPs had been implemented (i.e., individual-specific monitoring occurred after the PNMP revision date). When revisions occur to a PNMP, an ISPA meeting should be convened to provide IDT members the opportunity to discuss the revisions, make adjustments, if necessary, and agree on the final revisions. For the individuals in Sample #2, none of the five individuals' PNMPs (i.e., Individual #381, Individual #239, Individual #90, Individual #341, and Individual #182) had been	

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		revised after their annual ISP meeting. In summary, the content of individuals' PNMPs showed progress. However, PNMPs were missing essential components as discussed within this section. The Facility should review the PNMT Audit tool to ensure the essential components for this section are included. The PNMT Audit tool should be implemented to assess the status of PNMP compliance with these essential components. An ISPA meeting should be convened to present, discuss, and approve PNMP revisions. In addition, the Facility should formalize procedures for implementation of PNMPs off-campus. The Facility remained out of compliance with this provision.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** The Monitoring Team and members of the PNMT (i.e., PNMT OT, PNMT PT, and Director of HT) completed direct observations in residences for six individuals on the PNMT caseload, including: Individual #239, Individual #381, Individual #90, Individual #341, Individual #402, and Individual #182. These observations found: ▪ In one of the two observations (i.e., Individual #239) (50%), individuals' staff were following PNMP instructions for alternate positioning. Individual #381 was not positioned correctly in her bed. ▪ In none of one observation (i.e., Individual #182) (0%) was staff following the PNMP wheelchair positioning instructions. ▪ In none of the two observations (0%) was staff following the PNMP positioning schedule for alternate positioning (i.e., Individual #341 and Individual #402). ▪ In one of the one observation (i.e., Individual #341) (100%) was staff following the PNMP transfer strategies. ▪ In none of the one mealtime observation (i.e., Individual #90) (0%) was staff following the dining plan. ▪ In none of the one observation of an individual during medication administration (0%) (i.e., Individual #402) was the nurse following the PNMP instructions. The PNMP provides the foundation for health and safety. These observations substantiated that some staff were not competent and/or compliant in implementing foundational and/or individual-specific PNMP strategies. The PNMT and IDT members should provide additional support to staff to enhance their competency in the implementation of PNMPs, most importantly, for those individuals at highest risk. The Facility's efforts to train staff and monitor their compliance with PNMPs are discussed below with regard to Sections O.5 and O.6. The full implementation of adequate training and monitoring activities is key to ensuring "staff engage in mealtime practices that do not pose an undue risk of harm to any individual."	Noncompliance

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		In summary, the Facility should place a high priority on staff compliance with individuals' PNMPs. The Facility remained out of compliance with this provision.	
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.	**NEO Orientation** The Facility Certified Occupational Therapy Assistant (COTA) and Physical Therapy Assistant (PTA) provided training for new employees. At the time of the review, there were no train-the-trainer competencies that had been developed and implemented for the therapy assistants to substantiate their competencies as trainers for PNM foundational classes. Based on information the Facility provided, 581 of 632 staff (92%) had completed the lifting/transfer course. The Preventing Aspiration class was completed for 718 of 836 staff (86%). The data seemed to be incorrect, because the same number of staff would be responsible for taking these two courses. The Facility did not divide new staff from current staff that completed annual refresher classes. This training data was not adequate to substantiate how many new employees had successfully completed PNM foundational training, because the new employees were responsible for completing PNM foundational classes beyond lifting/transfers and preventing aspiration. In fact, new employees were responsible for completing 22 performance check-offs within the PNM content areas. **PNM Core Competencies for Current Staff** Based on interview with the Director of HT, a final plan had not been developed to provide training in foundational PNM competencies to current staff. This was problematic. **Annual Refresher Training** Based on interview, the Facility's annual refresher training included two courses: Lifting People, and Preventing Aspiration. The Facility reported that 581 of 632 staff (92%) had completed lifting/transfers. The Preventing Aspiration course was completed by 718 of 836 staff (86%). This training data included new employees and current staff. Overall, the training compliance rates were high. However, as noted above, it was unclear why these numbers varied to widely, because the same numbers of staff should have been responsible for completing this training. The Facility should produce reliable data identifying the number of current staff completing annual refresher training minus new employees. The Facility should consider expanding Annual Refresher training to include testing of core competencies for mealtimes.	Noncompliance

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		Individual Specific Training The Facility reported the Competency Based Training Spreadsheet data had been entered through 8/13/12, and had not been collected and entered past this date. Based on interview and documentation submitted, a further review of training sheets and the spreadsheet was occurring to determine possible causes for why data had not been entered, and to determine whether changes were needed to the training and data collection process. The Facility also indicated a policy was needed to further define the individual-specific training beyond NEO. Based on record review, individuals' staff in Sample #1 had received PNMP individual-specific training. However, training data had not been consistently entered into the Facility Competency-Based Training Spreadsheet. Consequently, it was not possible to determine how many staff had successfully completed individual-specific performance check-offs (n) versus the total number of staff (N) needing to complete PNMP individual-specific training and performance check-offs. All of the individuals in Sample #1 had PNMP revisions. Four of the 13 individuals' records (i.e., Individual #363, Individual #73, Individual #269, and Individual #81) (31%) indicated training had been completed on the revisions. However, some of the training did not require staff demonstration, which did not meet the standard of competency-based training for the required skills or competencies for PNMP implementation. The following examples provide additional information: ▪ The Notification/Information Training Roster for Individual #363's dressing guidelines, dated 7/6/12, provided five steps required to dress/undress Individual #363 while he was lying in bed. Staff on first, second, and third shift signed the training roster that acknowledged their competency through "verbalized back." There was no requirement for staff to demonstrate their skills for the implementation of these five steps. A second Notification/Information Training Roster, dated 5/24/12, was submitted for changes to his PNMP after his hospitalization. There was no requirement for staff demonstration, nor had monitoring been completed to assess implementation of these changes post hospitalization. ▪ On 5/18/12, Individual #73 received a feeding tube. There were multiple Notification/Information Training Rosters related to PNMP revisions and his transition to another home. However, staff was not required to demonstrate their skills in the implementation of his PNMP revisions. The Facility should review individual-specific check-offs to ensure these check-offs require staff demonstration of PNMP strategies. In addition, these examples reinforce	

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		the importance of finalizing and implementing the PNM foundational training plan and completion of performance check-offs for veteran staff to test their competency for PNMP implementation. **Training of Relief/Pulled Staff** There was no Facility policy for the training of pulled/relief staff. At the time of the onsite review, current staff had not completed training and performance check-offs in core PNM competencies. Observations completed by the Monitoring Team substantiated that current and/or relief/pulled staff that provided supports to individuals required additional support to implement PNMPs correctly. **Trainer Competencies** PNMP Coordinators were responsible for training staff on PNMP individual-specific competency-based training and performance check-offs. The Facility had 15 PNMP Coordinator positions allocated. Eleven of these positions were filled. A spreadsheet was submitted, revision date of 10/8/12, which indicated 11 PNMP Coordinators had completed competency check-offs for 23 PNM competencies (i.e., Ankle Foot Orthoses, bath transfer bench, bath trolley, bed positioning, booties, dining equipment, elbow pad, elbow splint, gait belt, helmet, hosiery, lemon ices, mealtime, mechanical lifting, palm protectors, positioner and wheelchair positioner, rolling shower and toilet chair, shower chair, Simply Thick, stand pivot transfer, two-person manual lift, walking, and wrist-hand splint). Based on documentation submitted, on 11/9/12, the Director of HT discussed a plan with the HT Department staff to perform PNM competency performance check-offs for all PNMP Coordinators on a quarterly basis, beginning on 12/1/12. However, the Facility had not formalized a train-the-trainer process for the PNMP Coordinators to substantiate their competency as trainers. Therapists should have PNMP Coordinators demonstrate their competencies as trainers, including, but not limited to their understanding of the role and function of competency-based training and performance check-offs, demonstration of competency in the proper sequence of training steps for a specific content area (e.g., mechanical lift), ability to provide coaching/mentoring to staff receiving training, accurately scoring competency performance check-offs, and following procedures for documentation of competency-based training and performance check-offs. The Facility should develop and implement a policy to define the train-the-trainer process for PNMP Coordinators to substantiate their competency as trainers. **Facility Initiatives** Based on interview with the Director of HT, the meal management program had been put on hold since the Monitoring Team's last compliance review in 11/11. However, there were plans to re-implement the program. The AUSSLC Meal Management Protocol, dated	

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		11/4/11, was to be revised and re-implemented. The Monitoring Team agrees with this decision, because observations in dining rooms revealed the need for more oversight due to the fact that staff were not compliant with individuals' dining plans. Meal management issues were reported regularly at daily unit meetings. Morning Meeting Minutes for the Castner Estates Unit had a section for Review of Meal Management /Supervision. The section noted the date/time of the meal, home visited, issues noted, corrective action taken, follow-up person responsible, and due date. However, these minutes did not document resolution of the mealtime issues raised. The Facility should provide PNM foundational competency-based training and performance check-offs to veteran staff. The Facility should ensure that individual-specific training is competency-based. A policy should be developed and implemented to define the training process for pulled/relief staff. The HT Department should develop and implement train-the-trainer competencies. The Facility remained out of compliance with this provision.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Facility Monitoring of Staff Competency with PNMPs** The primary monitoring form the HT Department staff used was the Compliance Monitoring form. The Compliance Monitoring form had been revised to provide more discrete indicators for positioning, mealtime, medication administration, lifting/transfer, communication, and bathing. These revisions were positive and should provide more data to substantiate staff compliance with specific PNMP instructions. Based on interview with the Director of HT, the revised monitoring form was to be utilized beginning in December 2012. The therapists and PNMP Coordinators were responsible for monitoring. The Facility reported the validation process for monitors to achieve inter-rater agreement had not been implemented. At the time of the review, no Facility policies or protocols had been developed for the implementation of the monitoring process. The Compliance Monitoring Summary results for July, August, and September 2012 indicated the results of staff compliance were likely invalid, because overall compliance with all monitoring was currently at 97%. The Director of HT indicated this percentage was too high and was not congruent with informal observations during meals and other PNMP activities. The Monitoring Team would agree with the Director of HT that the monitoring results were not reflective of observations of staff the Monitoring Team made during the review. As discussed above, many of these observations showed staff breaching PNMP instructions. The Director of HT developed a corrective action plan that entailed re-training of PNMP Coordinators. The Monitoring Team agreed with the Facility's plan to re-train of PNMP Coordinators. In addition, the therapists and PNMP Coordinators should establish an agreed upon threshold for inter-rater agreement. The	Noncompliance

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		achievement of inter-rater agreement between monitors will be required for the Facility to have confidence in monitoring data. The Facility submitted a spreadsheet including the following sections: general information, individual, observer/monitor, staff information, observation, staff drill, calculations, and noncompliance. There were multiple data requirements within each section. For some individuals, individual-specific monitoring had been completed for positioning, bathing, communication, lifting/transfer, snacks, and meals. However, as noted above, there was no established monitoring schedule and/or an established frequency to monitor individuals at high risk. On a positive note, the HT Department staff had developed a monitoring database. It included adequate indicators to provide data to track and trend monitoring data. However, no reports had been generated yet. The Monitoring Team reviewed the monitoring results for five individuals (i.e., Individual #381, Individual #239, Individual #90, Individual #341, and Individual #182) in Sample #2, who the Monitoring Team and members of the PNMT observed. The Monitoring Team requested individual-specific monitoring results for the past six months. The monitoring results were reviewed and the following concerns were noted: ▪ No Compliance Monitoring forms were presented for Individual #239, and Individual #182; ▪ Compliance Monitoring forms were submitted for Individual #381, Individual #90, and Individual #341. However, the frequency of monitoring completed was not adequate as discussed below: o Individual #381's positioning was monitored one time in both June and August. Staff performing a lift and transfer were monitored one time in August. No compliance monitoring was conducted for mealtime, medication administration, oral care, bathing, and/or communication. o Individual #90's meal was monitored two times in July and once in September. No compliance monitoring was conducted for positioning, medication administration, oral care, bathing, lifting/transfer, and/or communication. o Individual 341's positioning was monitored one time in August. No compliance monitoring was conducted for mealtime, medication administration, oral care, bathing, lifting/transfer, and/or communication. The monitoring data for these individuals reflected 100% staff compliance with PNMPs. The Facility's monitoring results were not in alignment with the Monitoring Team's observations. Consequently, the Monitoring Team did not have confidence in the individual-specific monitoring data presented. These monitoring results would lead the Facility to the conclusion that there were no problems with staff compliance with PNMPs.	

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		However, the Monitoring Team and members of the PNMT observed breaches in the implementation of individuals' PNMPs for the five individuals observed. These monitoring results would not be useful in identifying problematic trends that needed to be addressed. The Facility should be able to have confidence in monitoring data to allow it to substantiate problematic trends, and develop corrective action plans to address the trends. As stated in previous reports, the HT Department staff should develop a monitoring policy to define the monitoring system to test staff compliance with PNMPs and dining plans. At a minimum, such a policy should include: ▪ Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.); ▪ Training and validation process by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement; ▪ Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that require individual-specific enhanced PNMP and mealtime monitoring; ▪ Formal schedule for monitoring to occur; ▪ Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement; ▪ Auditing process of completed monitoring forms to ensure compliance with Facility policy; ▪ Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and ▪ Establishment of a threshold for staff re-training for monitoring results that illustrate repeated staff non-compliance with PNMPs and therapy programs. In summary, the Facility was monitoring staff compliance with PNMPs, but additional work needed to be done to formalize the process. The Facility should formalize the monitoring process by establishing procedures. Based on interview with the HT Director, there was no confidence in the accuracy of the monitoring data and the Monitoring Team agreed with this assessment. The Facility should validate monitors' competence with the monitoring process. The Facility remained out of compliance with this provision.	
O7	Commencing within six months of the Effective Date hereof and with	**<u>Effectiveness of Monitoring to Assess the Progress of Individuals with Physical or Nutritional Management Difficulties</u>**	Noncompliance

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	full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	This provision requires members of the IDT and/or PNMT to conduct effectiveness monitoring. Effectiveness monitoring should not be confused with compliance monitoring. A compliance monitoring system, as required by Section O.6, provides information on the status of staff compliance with PNMPs. The purpose of effectiveness monitoring is to report on the efficacy of the interventions developed to minimize and/or reduce high and/or medium PNM risk indicators. Effectiveness monitoring should answer the question of whether the individual is better or worse. The State At-Risk Individuals policy in the Risk Review section accurately described such a process when it stated: "each discipline or program staff identified as responsible in the plan must review the support plans that address identified risk to assess the effectiveness of the support for which they are responsible. This review must be completed as indicated by an individual's risk severity or status change, in order to assess effectiveness. Documentation of the review will be recorded in the Integrated Progress Notes." A review of individuals' Risk Action Plans and IPNs in Sample #1 found: ▪ None of the 13 individuals' records (0%) contained evidence of effectiveness monitoring by therapists to assess the efficacy of risk action plan interventions for individuals with PNM difficulties. ▪ None of the 13 individuals' records (0%) contained evidence that interventions were changed due to a lack of an individual's progress. The following concerns were noted: ▪ IDT members had not conducted effectiveness monitoring to assess the progress of an individual's risk action plan interventions. ▪ Individuals' Risk Action Plans did not generate individual-specific clinical data, which should be used to substantiate an individual progress and to assess if the individual was better or worse. ▪ Individuals' IPNs did not include assessment of an individual's clinical indicators to provide an update on health stability and/or instability. ▪ Monthly progress reports were not completed to report on the effectiveness of an individual's supports and services as identified in the risk action plans. **PNMT Monitoring to Assess Individuals' Progress** Based on the Monitoring Team's review of the records for individuals in Sample #2: ▪ Five of the five individuals' records (100%) contained evidence that the progress of individuals with PNM difficulties was monitored to assess the efficacy of the risk plan interventions. However, the newly formed PNMT had just initiated individual-specific monitoring to track the progress of their interventions.	

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		The following concerns were noted: ▪ Individual-specific triggers had not been integrated into Aspiration Trigger Data Sheet(s) to alert staff to a change in status. Aspiration Trigger Data sheets were not consistently completed. ▪ Individuals' PNMT action plans did not consistently specify individual-specific clinical indicators to define an individual's stable and/or unstable health status. Individuals' PNMT Follow-up and IPNs consistently stated that the PNMT was conducting monitoring of IPNs and trigger sheets. However, these monitoring results did not definitively report whether the data obtained during an assessment showed the individual's health status was stable and/or unstable. As a result, the monitoring results did not yet consistently address the efficacy of the recommended interventions to minimize the individual's PNM risks. ▪ IPNs did not include a report on the effectiveness of an individual's supports and services as identified in a risk action plan. In summary, the Facility should implement an effectiveness monitoring system to evaluate and report on the progress of individuals' risk action plans supports and services, and revise interventions, as appropriate. The Facility remained out of compliance with this provision.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Individuals Who Receive Enteral Nourishment** Three lists were submitted that identified individuals who received enteral nutrition: ▪ The first list, not dated, identified 47 individuals who were fed by tube. The list reported the individual's name; home; gastrostomy, jejunostomy or nasogastric tube; date of tube placement; primary or supplementary tube enteral feeding; nutrition delivered by pump, gravity or bolus; prescribed formula; date of prescription; additives; diet order for pleasure feeding; and comments. ▪ The second list "G-Tube to Oral Intake Review," not dated, identified 47 individuals that tracked the completion of an individual's annual APEN assessment/data collection tool and subsequent recommendations. ▪ The third list "Level of Assistance for Dining," revised 10/22/12, identified 40 individuals fed by a gastrostomy tube. Of note, there was a difference in the individuals listed from list to list. Consequently, there was a discrepancy in how the Facility calculated the number of individuals who received enteral nutrition. There was no Facility policy and/or procedure(s) to formalize a system to maintain and update this list. The Facility should develop and implement procedures to maintain and update an accurate list of individuals who receive enteral nutrition. **Individual(s) Who Received a Feeding Tube**	Noncompliance

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		The Facility PNMT Process did not speak specifically of referral to the PNMT for individuals at risk of receiving enteral nutrition. Since the last review, Individual #73 (i.e., tube placement on 5/18/12) received a gastrostomy tube. However, the Facility did not have a functioning PNMT during this time period to support a referral to the PNMT. On a positive note, the PNMT began tracking individuals who were at risk of receiving enteral nutrition. The Facility should revise the Facility PNMT Process to define the clinical nutritional indicators that place an individual at risk of receiving a feeding tube. When an individual experiences an ongoing nutritional decline, the IDT should refer the individual at risk of receiving a tube to the PNMT prior to placement of a feeding tube and/or after an emergency tube placement. **<u>APEN Data Sheet and Integrated Risk Rating Form</u>** Since the Monitoring Team's last review, the draft State At-Risk Individuals policy and procedures, dated 5/24/12, presented a revised process for completing an APEN data sheet, as opposed to the previous assessment. The Aspiration Pneumonia/Enteral Nutrition template was identified as a data collection tool that should be completed at least annually if the individual: ▪ Had aspiration pneumonia during the past year; and/or ▪ Received enteral nutrition or medication. In addition, the Change of Status IRRF noted: "for individuals who receive enteral nutrition, the APEN should be used to help identify potential for return to oral eating and establish medical necessity of continuing enteral nutrition. The analysis and related rational must be documented in the IRRF." The APEN Data Sheet instructions also indicated: "for individuals who receive enteral nutrition, the APEN should be used to help identify potential for return to oral eating and establish medical necessity of continuing enteral nutrition." The analysis and related rationale was to be documented in the individual's Integrated Risk Rating Form. The purpose of the APEN was to "provide a vehicle for recording the data needed to guide the team in determining appropriate risk assignment." Multiple disciplines were to contribute APEN data. The Nurse Case Manager was responsible for bringing the completed form to the ISP meeting. The IDT would utilize the APEN data for a "comprehensive discussion of enteral nutrition, aspiration and other related risk factors." The IDT was to "formulate plans based on the discussion and analysis to determine the best course of treatment or action for individuals who have had aspiration pneumonia and to assess individuals for possible return to oral eating." However, the Facility had not received training on these revisions. Consequently, these revisions had not been formally implemented. One of the Facility's lists for individuals who received enteral nutrition identified the date	

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		of the annual APEN assessment and/or identified if an assessment had not been completed. The Facility list(s) should include the date of the APEN data sheet, IRRF, and ISP, including confirmation of the required discussion and team decision, to track whether or not data is collected and team assessments are conducted at least annually to determine whether or not the continued use of the feeding tube is medically necessary. Eight individuals in Sample #1 received enteral nourishment, including: Individual #389, Individual #73, Individual #212, Individual #81, Individual #363, Individual #430, Individual #306, and Individual #62. Two of these individuals had feeding tubes placed within the previous year (i.e., Individual #306 on 3/2/12, and Individual #73 on 5/18/12). Three of the eight individuals (38%) had an APEN assessment and/or data collection tool completed (due to the timing of the review, the old APEN assessment as well as the APEN data collection tools were requested). Those that did not included: Individual #73, Individual #306, Individual #212, Individual #430 (not current), and Individual #363 (not current). A review of the remaining three individuals' (i.e., Individual #62, Individual #389, and Individual #81) APEN assessments (i.e., for these individuals, the new APEN data sheet was not in use yet), action plans, and ISPs found: ▪ None of the three individuals' APEN assessments and IRRFs (0%) followed the State-established APEN template. ▪ Three of the three individuals' APEN assessments and IRRFs was completed within a 12-month period. As noted above, within the full sample, five individuals did not have them or they were out-of-date, resulting in a compliance rate of 38%. ▪ None of the three individuals' APEN assessment and IRRFs (0%) indicated that there was input from appropriate IDT members as outlined in the State-established APEN format. ▪ One of the three individuals' APEN assessments and IRRFs (i.e., Individual #81) (33%) provided justification that the continued use of the tube was medically necessary. The assessment, or moving forward, the IRRF or ISP, should provide clinical justification and an analysis of why the tube remains a medical necessity. The assessments for the remaining two individuals did not assess the medical necessity of a tube, or assess the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate. ▪ None of the three individuals' APEN assessment and IRRF recommendations or action plans (0%) was implemented. ▪ None of the three individuals' APEN assessments and IRRFs (0%) recommended the implementation of a plan to return the individual to oral feeding, if appropriate. Three individuals in Sample #2 received enteral nourishment, including: Individual #239, Individual #381, and Individual #182. Individual #239 did not have an APEN	

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		assessment and Individual #182's APEN was outdated. A review of Individual #381's APEN assessment (i.e., for this individual, the new APEN Data Sheet was not in use yet), action plans, and ISP found: ▪ None of the one individual's APEN assessments and IRRFs (0%) followed the State-established APEN data sheet template. ▪ As noted above, one of the three individuals' APEN assessments and IRRFs (33%) were completed within a 12-month period. ▪ None of the one individual's APEN assessment and IRRF (0%) indicated that there was input from appropriate IDT members as outlined in the State-established APEN template. ▪ None of the one individual's APEN assessment and IRRF (0%) provided justification that the continued use of the tube was medically necessary. ▪ None of the one individual's APEN recommendations and action plans (0%) was implemented. ▪ None of the one individual's APEN assessment and IRRF (0%) recommended the implementation of a plan to return the individual to oral feeding, if appropriate. These assessments and action plans for individuals in Sample #1 and one individual in Sample #2 did not meet the requirements of the Settlement Agreement to: "evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary" and "where appropriate, the Facility shall implement a plan to return the individual to oral feeding." **Pathway to Return to Oral Eating and/or Receipt of a Less Restrictive Approach to Enteral Nutrition** Based on interview with the Director of HT, the Facility did not have written procedures for returning an individual to a less restrictive approach to receiving enteral nutrition, or if appropriate, a return to oral eating. None of the individuals in Sample #2 participated in a formal therapeutic/pleasure feeding program. According to the Facility's list for individuals who received enteral nutrition, one individual in Sample #1 participated in oral eating (i.e., Individual #363). A review of this individual's records found: ▪ None of the one individual who had returned to oral eating (0%) had a plan to return to oral feeding. ▪ Because no plan had been developed, its implementation could not be assessed. ▪ None of the one individual who returned to oral eating (0%) had received a mealtime assessment. ▪ Because no plan existed, none of the one individual's plans (0%) identified individual-specific triggers for when the plan should be stopped. ▪ Because no plan existed, none of the one individual's plan (0%) identified	

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		monitoring oversight for staff compliance with the plan. ▪ Because no plan existed, none of the one individual's plans (0%) were monitored as outlined in the plan. ▪ Because no plan existed, none of the one individual's plans (0%) were modified, if appropriate. In summary, the Facility remained out of compliance with this provision. In addition to fully implementing the new APEN data collection tool and IRRF/ISP process in relation to individuals that are enterally fed, the Facility should establish procedures for IDTs and/or PNMT members to follow individuals who are recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake.	

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

1. The Director of HT should continue to recruit for the vacant dedicated PNMT positions (i.e., SLP and RN). (Section O.1)
2. The HT Director should initiate an analysis of the current clinician staffing and the clinicians' caseloads. This analysis should take into account the scope and severity of individuals' needs (e.g., individuals' high and medium PNM risk indicators), as well as the various duties of clinicians to determine if the current staffing as well as the caseload distribution is adequate and appropriate, particularly with regard to Registered Dieticians. (Section O.1)
3. The Facility PNMT Process should define the role and responsibilities of IDT members. It is important that IDT members participate in the process both to provide relevant information, but also to help develop and learn about the supports and services the individuals require. Ultimately, the PNMT should prepare teams so that when individuals are ready for discharge from the PNMT, the IDTs are prepared to resume full responsibility. (Section O.1)
4. The Facility PNMT Process should define the pathways for how the PNMT will bring systemic issues to the attention of Facility Administration and work collaboratively to resolve these issues. In addition, the PNMT should consistently document the resolution of identified systemic issues. (Section O.1)
5. Lists the Facility maintains to identify individuals having physical and nutritional management problems should be accurate. The Facility should develop and implement a sustainable system to maintain and update these lists to ensure their validity. (Section O.2)
6. PNMT assessments should be sufficient to identify physical and nutritional interventions and supports to meet the individuals' needs. They should follow the Facility-established PNMT assessment template; provide an adequate analysis to identify the cause of the individual's PNM concerns; include a PNMT self-referral and/or IDT referral date; update the individual's risk rating(s), as appropriate; address HOBE assessment data; establish individual-specific clinical baseline data to assist teams in recognizing changes in health status; and identify individual-specific clinical criteria to alert nursing staff to contact the PNMT. (Section O.2)
7. PNMT action plans should include: the individual's identified PNM problems as presented in the PNMT assessment; integration of HOBE assessment data; preventative interventions to minimize the conditions of identified risk indicators; appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan; and specific clinical indicators to be monitored. (Section O.2)
8. The Facility PNMT Process should define the PNMT Discharge process. (Section O.2)
9. The HT Department should follow the State Office policy for individuals who require a PNMP. The State Office policy should be utilized to review the Facility's list of individuals who have do not have PNMPs to determine which of these individuals meet the PNM criteria, and

provide them with a PNMP sufficient to meet their needs. (Section O.3)

10. The Facility should ensure the implementation of PNMPs off-campus. (Section O.3)
11. The Facility should review the PNMP audit tool to ensure the tool includes the essential components of PNMPs. (Section O.3)
12. The Facility should implement the PNMP audit tool to ensure individuals' PNMPs contain essential components. (Section O.3)
13. When revisions to PNMPs occur, an ISPA meeting should be convened to provide IDT members the opportunity to discuss the revisions, make adjustments, if necessary, and agree on the final revisions. (Section O.3)
14. Per State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. (Section O.3)
15. A timeline should be developed and implemented for the completion of HOBE assessments for the identified universe of individuals who meet the criteria for a HOBE assessment. (Section O.3)
16. The PNMT and IDT members should provide additional training and/or support to staff to enhance their competency in the implementation of PNMPs, particularly for those individuals at highest risk. (Section O.4)
17. The provision of competency-based training and staff performance check-offs for PNM core competencies for veteran staff should be implemented. (Section O.5)
18. The Facility should review competency-based individual-specific training and performance check-offs for PNMP strategies to ensure the performance check-offs require a demonstration component. (Section O.5)
19. As one measure of staff competency-based training compliance, data should include the total number of staff who will require training (N) and the number of staff who have completed PNM training (n) to yield a compliance percentage. This should be calculated for foundational training, annual refresher training, and individual-specific training. (Section O.5)
20. The Facility should provide additional training and/or support to relief/pulled staff to ensure PNMPs are implemented as prescribed. (Section O.5)
21. The Facility should develop and implement train-the-trainer competency check-offs for PNMP Coordinators to substantiate their competency as trainers. More specifically, therapists should have PNMP Coordinators demonstrate their competencies as trainers, including, but not limited to their understanding of the role and function of competency-based training and performance check-offs, demonstration of competency in the proper sequence of training steps for a specific content area (e.g., mechanical lift), ability to provide coaching/mentoring to staff receiving training, accurately scoring competency performance check-offs, and following procedures for documentation of competency-based training and performance check-offs. (Section O.5)
22. As recommended in previous reports, the HT Department staff should develop a monitoring policy to define the monitoring system to test staff compliance with PNMPs and dining plans. At a minimum, such a policy should include:
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.);
    b. Training and validation process by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement;
    c. Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that require individual-specific enhanced PNMP and mealtime monitoring;
    d. Formal schedule for monitoring to occur;
    e. Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement;
    f. Auditing process of completed monitoring forms to ensure compliance with Facility policy;
    g. Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and

h. Establishment of a threshold for staff re-training for monitoring results that illustrate repeated staff non-compliance with PNMPs and therapy programs. (Section O.6)

23. The Facility should continue with their revision of the Compliance Monitoring process. Part of this analysis should assess if the monitoring activities produce adequate data to determine staff competence and compliance in safely and appropriately implementing PNMPs and dining plans. If not, revisions should be made to the form(s) and/or instructions, and/or additional training should be provided to those implementing the forms. (Section O.6)
24. The Facility should implement an effectiveness monitoring system to evaluate and report on the progress of individuals' risk action plans supports and services, and revise interventions as appropriate. (Section O.7)
25. The Facility should develop a sustainable system to maintain and update an accurate list(s) of individuals who receive enteral nutrition. (Section O.8)
26. The Facility list(s) identifying individuals who receive enteral nutrition should include the date of the APEN data sheet, IRFF, and ISP, including confirmation of the required discussion and team decision, to track whether or not data is collected and team assessments are conducted at least annually in order to determine whether or not the continued use of the feeding tube is medically necessary, as required by the Settlement Agreement. (Section O.8)
27. The Facility should establish procedures for IDTs and/or PNMT members to follow individuals recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake. (Section O.8)

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 For the following 14 individuals, including individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the emergency room, and/or hospital, and/or received direct therapy intervention(s): Individual #358, Individual #93, Individual #89, Individual #74, Individual #340, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, Individual #223, Individual #312, Individual #376, and Individual #175, the following documents: Occupational Therapy/Physical Therapy comprehensive assessment, assessment of status, update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition assessment, Speech Language Pathology comprehensive assessment, assessment of status, update in individual record, Head of Bed Elevation assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan, dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o Facility policies and procedures related to the provision of OT/PT supports and services; o Organizational chart of Habilitation Therapy Department; o Current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff, corresponding caseloads, and CVs for new hires; o Continuing education completed by OTs and PTs, since the Monitoring Team's last onsite visit; o List of individuals who use wheelchair as primary mobility; o List of individuals with transport wheelchairs; o List of individuals with other ambulation assistive devices; o List of individuals with orthotics and/or braces;

	○ Physical Nutritional Management Maintenance Log; ○ OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; ○ Tracking Log of completed individual assessments; ○ Wheelchair seating and PNM clinic assessment (templates); ○ Compliance Monitoring form template; ○ Competency-based performance check-off sheets for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; ○ Summary reports and monitoring results related to OT/PT; and ○ List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interviews with**: ○ Kim Ingram, MEd, CCC-SLP, Director of Habilitation Therapies; and ○ Karen Hardwick, State Coordinator for Specialized Services. ▪ **Observations of**: ○ Individuals in Residences 782, 779-F and 732-P, and Workshops 503 and 544.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 10/22/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section P, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/ guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: the Compliance Monitoring tool. The HT Department and/or QA Department staff were not using the Monitoring Tool for Section P. Based on interview, the Director of HT was in the process of revising the Monitoring Tool for Section P. ○ This monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Compliance Monitoring tool was designed to monitor staff compliance with PNMPs, including positioning, mealtime, snacks, medication administration, oral care, bathing, and lifting/transfers. This tool was not adequate to provide sufficient data to address the provisions of all of the subsections of Section P. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ The Compliance Monitoring tool did not have adequate methodologies to substantiate compliance for the subsections of Section P. ○ The Self-Assessment did identify the sample(s) sizes. The Facility will need to clearly identify the total population (N) used to define the sample selected (n). ○ The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The Facility's revision to the monitoring tool for Section P should provide adequate written procedures for the

	implementation of the monitoring tool. o The following staff/positions were responsible for completing the audit tools: Therapists and the Program Compliance Monitor. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. When the revised monitoring tool is implemented, the therapists should monitor with the Program Compliance Monitor for a period of time to ensure inter-rater agreement is established. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures. For example, the Facility had reviewed staff training rosters, a competency-based training spreadsheet, and a monitoring database. However, additional indicators should be developed, particularly in relation to outcomes for individuals. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section P. This was consistent with the Monitoring Team's findings ▪ The Facility data did identify areas in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connect the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: Individuals' OT/PT assessments were significantly improved from the last review. However, the assessments were still missing some essential components. A positive practice was the development of an OT/PT assessment audit tool, but the tool had not been implemented. OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of effectiveness review of the individual's progress with direct and/or indirect OT/PT supports. Individuals with PNMPs and dining plans were not monitored at an established frequency with an emphasis on enhanced monitoring for individuals at high risk for PNM concerns. The monitoring also did not address the status of their identified occupational and physical therapy needs, and the effectiveness of their OT and PT therapy programs. Furthermore, all prescribed adaptive equipment was not assessed for its condition, availability, and effectiveness.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>P1</td><td>By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.</td><td><u>Current Staffing</u>
The Facility had five OT and five PT positions allocated. At the time of the review, there were no therapy vacancies.

At the time of the Monitoring Team's onsite review, the following chart represented the caseloads of the Facility OTs and PTs:

<table>
<tr><th>Occupational Therapists</th><th>Current Caseload</th></tr>
<tr><td>OT #1</td><td>Lead OT and supported 55 individuals in Castner Estates</td></tr>
<tr><td>OT #2 Contractor</td><td>Supported 55 individuals in Castner Estates</td></tr>
<tr><td>OT #3 Contractor</td><td>Supported 111 individuals in Wood Hollow Estates</td></tr>
<tr><td>OT #4 Contractor</td><td>Supported 105 individuals in Sunrise Estates</td></tr>
<tr><td>OT #5 Contractor</td><td>PNMT OT and Lead, and supported individuals on PNMT caseload</td></tr>
<tr><th>Physical Therapists</th><th>Current Caseload</th></tr>
<tr><td>PT #1</td><td>Supported 55 individuals in Castner Estates</td></tr>
<tr><td>PT #2</td><td>Supported 55 individuals in Castner Estates</td></tr>
<tr><td>PT #3</td><td>Supported 111 individuals in Wood Hollow Estates</td></tr>
<tr><td>PT #4</td><td>Supported 105 individuals in Sunrise Estates</td></tr>
<tr><td>PT #5</td><td>PNMT PT and supported individuals on PNMT caseload</td></tr>
</table>

The Facility did not indicate what an adequate caseload for OTs and PTs at Austin SSLC would be. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to OT and PT needs.

Each of these therapists held a license to practice in the state of Texas.

<u>Continuing Education</u>
Documentation of continuing education courses the OTs and PTs completed was submitted. Clinicians attended the following continuing education courses over the past six months:
▪ On 4/26/12, Sports Nutrition for Therapists;
▪ On 4/22/12, Ethics and Professional Responsibility Part I: PT;
▪ On 6/10/12, Pharmacology for Rehab Professionals;
▪ On 7/13/12, Sensory and Motor Control in Individuals with Autism Spectrum</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Disorder (ASD); ▪ On 7/13/12, ASD Biomarker; ▪ On 7/13/12, Autism: What Have We Learned?; ▪ On 7/14/12, Intellectually Able Adults with ASD: Challenges and Opportunities; ▪ On 9/20/12 to 9/21/12, Habilitation Therapies Conference. Attendance sheets, course curriculum, and continuing education certificates of completion were submitted for these courses. The OTs, and PTs, attended appropriate continuing education courses that included information that was relevant to and transferrable to the individuals they supported. **New Admissions** Since the Monitoring Team's last review, no individuals had been admitted to AUSSLC. **OT/PT Assessments** An OT/PT assessment should include the following essential components: ▪ Signature and date by the clinician upon completion of the written report; ▪ Date showing it was completed at least 10 days prior to the annual ISP meeting; ▪ Diagnoses and relevance to functional status; ▪ Individual preferences, strengths, and needs; ▪ Medical history and relevance to functional status; ▪ Health status over the last year; ▪ Medications and potential side effects relevant to functional status; ▪ Documentation of how the individual's risk levels impact his/her performance of functional skills; ▪ Functional description of motor skills and activities of daily living with examples of how these skills are utilized throughout the day; ▪ Evidence of observations by OTs and PTs in the individual's natural environments (e.g., day program, home, work); ▪ Discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings; ▪ Discussion of the expansion of the individual's current abilities; ▪ Discussion of the individual's potential to develop new functional skills; ▪ Comparative analysis of health and impact on functional status over the last year; ▪ Comparative analysis of current functional motor and activities of daily living skills with previous assessments; ▪ Identification of need for direct or indirect OT and/or PT services, as appropriate; ▪ Reassessment schedule; ▪ Monitoring schedule;	

#	Provision	Assessment of Status	Compliance
		▪ Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs; ▪ A recommendation regarding the individual's appropriateness for community placement; and ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Fourteen individuals' OT/PT comprehensive assessments (i.e., Individual #358, Individual #93, Individual #89, Individual #74, Individual #340, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, Individual #223, Individual #312, Individual #376, and Individual #175) were reviewed for the presence of the essential components of an assessment. This review found: ▪ Two of 14 individuals' OT/PT assessments (i.e., Individual #393 and Individual #175 (14%) were signed and dated by the clinician upon completion of the written report. ▪ One of 14 individuals' OT/PT assessments (i.e., Individual #175) (7%) were dated as having been completed at least 10 days prior to the annual ISP. Individual #393's OT/PT assessment was not completed at least 10 days prior to the annual ISP. The therapist had not dated the remaining 12 individuals' OT/PT assessments. Consequently, the Monitoring Team could not determine if the OT/PT assessment had been completed at least 10 days prior to the annual ISP. ▪ Ten of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #93, Individual #89, Individual #74, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, and Individual #175) (71%) included diagnoses and relevance to functional status. ▪ Nine of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #89, Individual #74, Individual #27, Individual #280, Individual #393, Individual #63, Individual #376, and Individual #175) (64%) included individual preferences, strengths, and needs. ▪ Seven of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #89, Individual #27, Individual #280, Individual #243, Individual #393, and Individual #175) (50%) included medical history and relevance to functional status. ▪ Eight of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #89, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, and Individual #175) (57%) addressed health status over the last year. ▪ Six of 14 individuals' OT/PT assessments (i.e., Individual #89, Individual #27, Individual #280, Individual #393, Individual #63, and Individual #376) (43%) listed medications and discussed the potential side effects relevant to	

#	Provision	Assessment of Status	Compliance
		functional status. ▪ Fourteen of 14 individuals' OT/PT assessments (100%) provided documentation of how the individuals' risk levels impacted their performance of functional skills. ▪ Eleven of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #93, Individual #89, Individual #74, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, Individual #223, and Individual #175) (79%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. ▪ One of 14 individuals' OT/PT assessments (i.e., Individual #280) (7%) provided evidence of observations by OTs and PTs in the individuals' natural environments (e.g., day program, home, work). ▪ None of 14 individuals' OT/PT assessments (0%) reviewed the current supports and services provided throughout the last year and their effectiveness, including monitoring findings. ▪ Five of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #280, Individual #243, Individual #63, and Individual #175) (36%) discussed the expansion of the individual's current abilities. ▪ Five of 14 individuals' OT/PT assessments (i.e., i.e., Individual #358, Individual #280, Individual #243, Individual #63, and Individual #175) (36%) presented the individual's potential to develop new functional skills. ▪ Nine of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #89, Individual #74, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, and Individual #175) (64%) gave a comparative analysis of health and impact on functional status over the last year. ▪ None of 14 individuals' OT/PT assessments (0%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. ▪ Fourteen of 14 individuals' OT/PT assessments (100%) identified the need for direct or indirect OT and/or PT services, as appropriate, or justified the rationale for not providing it. ▪ Nine of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #89, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, Individual #376, and Individual #175) (64%) had a reassessment schedule. ▪ None of 14 individuals' OT/PT assessments (0%) supplied a monitoring schedule. ▪ Six of 13 individuals' OT/PT assessments (i.e., Individual #358, Individual #280, Individual #243, Individual #393, Individual #63, and Individual #175) (46%) had recommendations for direct interventions and/or skill acquisition	

#	Provision	Assessment of Status	Compliance
		programs. However, the remaining seven individuals' assessments indicated deficits that could have been addressed by direct and/or indirect therapy interventions. Individual #27 was under hospice care, so was not included in this calculation. ▪ Twelve of 14 individuals' OT/PT assessments (i.e., Individual #358, Individual #93, Individual #89, Individual #74, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, Individual #223, Individual #376, and Individual #175) (86%) made a recommendation about the appropriateness for community transition. ▪ Fourteen of 14 individuals' OT/PT assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. Individuals' OT/PT assessments were significantly improved from the last review. However, the assessments still were missing some essential components as noted above. Consequently, these assessments were not yet adequate. The OTs and PTs should consider the essential components that were not present when completing assessments to ensure future assessments are comprehensive as required by the Settlement Agreement. The Facility had developed an OT/PT audit tool but the tool had not been implemented at the time of the review. Consequently, there was no data available. The audit tool should be reviewed to ensure the essential components of assessments discussed in this section are included. In summary, progress had been made in hiring OTs and PTs to fill the Facility's budgeted allocation for these positions. Individuals' OT/PT assessments were improved, but additional work needed to be done. The OT/PT assessment template and audit tool should be reviewed to ensure the essential components for OT/PT assessments are incorporated. The Facility remained out of compliance with this provision.	
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	**Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** The primary OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. PNMP content and format are discussed with regard to Section O.3, and staff compliance with PNMPs is reviewed with regard to Section O.6. All of the 14 individuals in the sample had a PNMP, dining plan, and prescribed adaptive equipment. A review of the 13 individuals' ISPs found (Note: Individual #93 did not have an ISP):	Noncompliance

#	Provision	Assessment of Status	Compliance
	as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	▪ For 11 of the 13 ISPs reviewed (i.e., Individual #358, Individual #89, Individual #27, Individual #280, Individual #243, Individual #393, Individual #63, Individual #223, Individual #312, Individual #376, and Individual #175), (85%), a PT attended the annual meeting. ▪ For five of the 13 ISPs reviewed (i.e., Individual #280, Individual #393, Individual #223, Individual #312, and Individual #175) (38%), an OT attended the annual meeting. For individuals with OT/PT needs, the OT and PT should attend unless the team provides adequate justification. ▪ In none of the 13 ISPs reviewed (0%), the PNMP was integrated in the ISP. ▪ In one of the ISPs reviewed out of seven applicable ISPs (i.e., Individual #63) (14%), skill acquisition programs that had been recommended in the OT/PT assessment were present. However, six individuals' assessments (i.e., Individual #358, Individual #280, Individual #243, Individual #393, Individual #63, and Individual #175) indicated potential for skill development, but no skill acquisition programs related to these programs were present in the ISPs. ▪ Two individuals in the sample (i.e., Individual #93 and Individual #280) received direct OT intervention. In one of the two individuals' ISPs and ISPAs reviewed (i.e., Individual #280) (50%) skills learned in therapy were integrated into the individual's daily routine. Individual #93 did not have an ISP. A review of Individual 93's ISPAs did not address the integration of transfer training in her daily routines. ▪ Seven individuals in the sample (i.e., Individual #243, Individual #393, Individual #63, Individual #223, Individual #312, Individual #376, and Individual #175) received direct PT intervention. In none of the seven individuals' ISPs and ISPAs reviewed (0%) skills learned in therapy were integrated into the individual's daily routine. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT unless the team provides justification; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. **<u>Direct OT/PT Interventions</u>** Two individuals in the sample (i.e., Individual #280 and Individual #93) received direct OT intervention, and seven individuals (i.e., Individual #243, Individual #393, Individual #63, Individual #223, Individual #312, Individual #376, and Individual #175) received direct PT intervention. The direct OT and PT intervention plans were requested. However, no therapy intervention plans were submitted for review. Consequently, there was no established goal for the direct therapy interventions.	

#	Provision	Assessment of Status	Compliance
		Moreover, the Monitoring Team could not assess whether or not such programs included: "individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression." Comprehensive progress notes related to OT and/or PT interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal; ▪ Description of the benefit of the goal to the individual; ▪ A report on the consistency of implementation; and ▪ Recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. Therapists documented interventions in individuals' IPNs. For none of the nine individuals' records reviewed (0%) was documentation of OT and PT progress notes comprehensive. The progress notes did not incorporate the essential components outlined above. **Indirect OT/PT Programs** At the time of the review, the primary indirect OT/PT support was the PNMP. For individuals who received indirect OT and/or PT programs (i.e., PNMPs), monthly documentation from the OT and PT should include: ▪ Information regarding whether the individual showed progress with the stated goal(s); ▪ A description of the benefit of device and/or goal(s); ▪ Identification of the consistency of implementation; and ▪ Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. For none of these 14 individuals in the sample who received indirect OT and PT supports (0%) was documentation of the OT and PTs' review comprehensive. There were no progress notes. However, such notes should have incorporated the essential components outlined above. The completion of monthly progress notes should provide effectiveness review/monitoring of the individual's progress with direct and/or indirect OT and PT supports. In summary, the Director of Habilitation Therapies should collaborate with Facility staff on strategies to support integration of OT/PT services and supports in an individual's	

#	Provision	Assessment of Status	Compliance
		ISP and daily routines. Procedures should be developed and implemented for direct therapy intervention plans and progress notes. These procedures should include how therapists will provide monthly updates on indirect supports (i.e., PNMPs).	
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.	**Competency-Based Training** The Facility noted that refresher training records had been entered through 8/31/12. It had been determined that other competency training data had not been collected and entered into the Competency Training Spreadsheet. Based on interview with the Director of Habilitation Therapies, further review of training sheets and the spreadsheet was occurring to determine possible causes and revision to the training and data collection process. The status of the Facility's compliance with competency-based training and monitoring for continued staff competency and compliance of direct support professionals was addressed with regard to Sections O.5 and O.6. **Individual-Specific Training** One of the 14 individuals' staff (i.e., Individual #340) (7%) had received training on individual-specific PNMP strategies. The status of individual-specific training was addressed in further detail with regard to Section O.5.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and 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.	**Monitoring System** The Facility reported that a review of the compliance monitoring results for July, August, and September 2012 indicated the results of staff compliance were likely invalid, because the overall compliance with all monitoring was currently at 97%. This percentage appeared to be too high and did not match informal observations completed by the Director of Habilitation Therapies during meals and other activities. On 9/27/12, a Corrective Action Plan was written. It indicated additional training for the PNMP Coordinators would be conducted on 10/3/12 to improve accuracy of monitoring results. However, additional work needed to be done. Therapists and PNMP Coordinators should establish inter-rater agreement with the Compliance Monitoring form to have confidence in monitoring data. At the time of the review, the Facility did not have a policy and/or procedures to define the monitoring process for 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. All of the 14 individuals within this sample had identified PNM needs as evidenced by	Noncompliance

#	Provision	Assessment of Status	Compliance
		their PNMPs, dining plans and prescribed adaptive equipment. A review was conducted of the individuals' Compliance Monitoring and OT/PT assessments resulting in the following findings: ▪ None of the 14 individuals (0%) were monitored on an established schedule to assess the effectiveness of their physical and nutritional and therapy supports. ▪ The assistive and supportive devices section of the OT/PT assessment template required therapists to list each piece of equipment, purpose, and state the risk or functional ability that the equipment addressed. However, there was no requirement to address the condition, availability, and effectiveness of all prescribed equipment. None of 14 individuals' prescribed adaptive equipment (0%) was assessed. ▪ None of the 14 individuals (0%) were monitored for the status of their identified occupational and physical therapy needs. ▪ None of the 14 individuals (0%) were monitored for the effectiveness of their direct and/or indirect therapy OT/PT programs. With regard to the implementation of the Compliance Monitoring Form: ▪ Seven of the 14 individuals (i.e., Individual #312, Individual #243, Individual #223, Individual #63, Individual #376, Individual #393, and Individual #280) (50%) had not received any PNM monitoring during the past six months. ▪ Five of the 14 individuals' [i.e., Individual #175 (one time), Individual #358 (one time), Individual #93 (two times), Individual #89 (two times), and Individual #340 (one time)] (36%) were monitored during mealtime over the past six months utilizing the Compliance Monitoring Form. The following concerns were noted: o Individual #358 experienced a choking incident on 7/30/12. One meal was monitored on 8/12/12. This was not adequate, because he was at high risk for choking. o All fourteen individuals in the sample had dining plans that should have been monitored during the past six months. ▪ None of the 14 individuals' positioning (0%) was monitored during the past six months. ▪ None of the 14 individuals' (0%) bathing/showering was monitored during the past six months. ▪ None of the 14 individuals' (0%) oral care was monitored during the past six months. ▪ Two individuals' staff (i.e., Individual #93 and Individual #27) (14%) were monitored one time for lifting and transfers during the past six months. As discussed with regard to Section O.2, the Monitoring Team did not have confidence in the accuracy of individuals' risk ratings. Consequently, neither the Facility nor the	

#	Provision	Assessment of Status	Compliance
		Monitoring Team was able to identify individuals who should have received enhanced monitoring for their high-risk status. In summary, the Facility should develop and implement a monitoring system that encompasses the elements presented with regard to Section P.4.	

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

1. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals to determine appropriate OT and PT caseloads. (Section P.1)
2. The Facility should review the revised OT/PT assessment template and content guidelines to ensure essential components are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the OT/PT assessment audit form should include these components. (Section P.1)
3. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT unless the team provides justification; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. (Section P.2)
4. The Facility should ensure the development and implementation of a direct therapy intervention plan for individuals receiving direct therapy. (Section P.2)
5. The Facility should ensure the completion of comprehensive progress notes related to OT/PT direct interventions and indirect programs, including:
    a. Information regarding whether the individual showed progress with the stated goal;
    b. A description of the benefit of the goal to the individual;
    c. A report on the consistency of implementation; and
    d. Recommendations/revisions to the direct intervention or OT/PT program as indicated related to the individual's progress or lack of progress. (Section P.2)
6. Individuals who receive OT/PT direct interventions and/or programs should be monitored for the following:
    a. The condition, availability, and effectiveness of their prescribed adaptive equipment;
    b. The status of their identified occupational and physical therapy needs; and
    c. The effectiveness of their OT and PT therapy programs. (Section P.4)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures, and/or other documents addressing the provision of dental care, including for updated policies/procedures/protocols, highlighted areas of approved change; o For the past six months, minutes from the statewide Dental Committee; o Lists of individuals who within the past six months: ▪ For newly admitted individuals, were seen for dental services, including date of admission, and date of initial evaluation; ▪ Were seen for dental services during the past six months other than for the annual exam, date of visit, and reason or type of visit; ▪ Have refused dental services; ▪ Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; ▪ Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain (yes or no), dentist documents confirmed pain (yes or no), and treatment documented; ▪ Have had preventative dental care; ▪ Have had restorative dental care, including name, date of completed restorative work, and for each appointment completed, type of restorative work; and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam; o Most recent comprehensive exams for one individual from each residence – copy from dental office's record of visit and copy from active record of same visit, including source of documentation for each record provided, including information for following individuals: Individual #282, Individual #151, Individual #261, Individual #301, Individual #93, Individual #303, Individual #181, Individual #41, Individual #127, Individual #103, Individual #378, Individual #60, Individual #4, Individual #405, Individual #389, Individual #190, Individual #74, Individual #7, Individual #336, Individual #416, Individual #98, and Individual #188; o Five most recent off site oral surgery consults and progress notes in past six months; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental services, and/or quality assurance/enhancement reports, including subsequent corrective action plans;

	o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal, including reason for appointment (e.g., prophylaxis, annual, etc.), name, reason for appointment dates of refusals, and date of completion; o List of those who have not seen 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, including date of last full mouth x-rays; o List of those who were edentulous at time of the last onsite visit, and those who have become edentulous since that time; 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 appointment 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 (i.e., 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 last in the six months, including any ISPAs that documented discussion/action plans concerning dental refusals; o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment for: Individual #210; o Appointment schedule for those undergoing general anesthesia/conscious sedation, including individuals for whom general anesthesia was scheduled but the appointment was not completed, and the reason; o For six individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation, and post-operative checklist or monitoring forms, etc., for: Individual #151 9/17/12, Individual #34 9/12/12, Individual #303 9/12/12, Individual #181 9/17/12, Individual #35 9/12/12, and Individual #98 9/17/12; o For the past six months, copies of any correspondence concerning restraint and sedation use at office visit (to QDDP, team, psychologist, etc.); o Copy of complete dental records for prior three years at AUSSLC (including progress notes (prophylactic, annual, emergency, restorative, etc./forms) completed, x-ray consult reports, restraint checklist, oral surgeon consults, etc., for one individual most recently seen from each residential unit, as well as table format with name, dates of annual exams, prophylactic exams, and dates of other treatment, for: Individual #34, Individual #93, and Individual #327; o In response to request for 10 individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring

	(including pre-treatment sedation sheets), information for the following individuals: Individual #324 7/5/12, Individual #324 7/31/12, Individual #432 5/16/12, Individual #358 5/16/12, Individual #374 3/22/12, Individual #328 5/14/12, Individual #42 7/19/12, Individual #448 3/5/12, Individual #220 5/29/12, and Individual #142 5/30/12; o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV, or general anesthesia; o Copy of any restraint and sedation tracking list/system used by the Dental Department [i.e.. type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach (lower dosage, less mechanical restraint duration, etc.)]; o In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure, for: Individual #333 6/7/12, Individual #144 9/6/12, Individual #380 7/12/12, Individual #4 6/14/12, and Individual #393 9/10/12; o For those completing annual exams in past six months, oral hygiene rating in each exam listed per individual and date of exam; o List of those who receive suction tooth-brushing treatment; o List of those who have been identified as benefiting from suction tooth-brushing treatment, but who are not receiving suction tooth-brushing at time of the Monitoring Team's visit (waiting for equipment, training, care plan revision, etc.); o Copy of 10 annual dental assessments completed in last 30 days and for the prior year for these same individuals: Individual #151 10/16/11, 9/17/12; Individual #34 9/29/11, 9/12/12; Individual #368 10/6/11, 9/13/12, Individual #440 9/19/11, 9/13/12; Individual #303 10/18/11, 9/12/12; Individual #181 9/26/11, 9/17/11; Individual #101 10/28/11, 9/13/12; Individual #98 9/20/11, 9/17/12; Individual #393 10/4/11, 9/10/12; and Individual #327 9/29/11, 9/28/12; o List of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record for all individuals, including copies of these annual exams (including odontogram); o Copy of 10 most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #151 9/17/12, Individual #34 9/12/12, Individual #368 9/13/12, Individual #440 9/13/12, Individual #303 9/12/12, Individual #181 9/17/12, Individual #101 9/13/12, Individual #98 9/17/12, Individual #393 9/10/12, Individual #327 9/10/12;

	○ Most recent/current Facility oral hygiene data, including numbers and percentages of good, fair, poor ratings, with date of data; ○ For those individuals for which care plans/ISPs indicate they brush their own teeth, the most recent two oral hygiene scores, with dates of the scores; ○ List of those individuals that floss their own teeth; ○ List of individuals provided instructions on flossing, with dates of training; ○ For those individuals that brush their own teeth but do not floss, indicate reason for not flossing their own teeth, indicate whether skill acquisition plan has been created or implemented for flossing; ○ For those that are edentulous, list of those with dentures; ○ For those edentulous without dentures, list of reasons with documentation as indicated; ○ Summary information on desensitization plans, since Monitoring Team's last visit; ○ For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24 hours following TIVA administration in prior six months; ○ For those with documented pneumonia in past six months, for each individual, date pneumonia documented, date of last dental visit, type of procedure/visit completed, and type of anesthesia (TIVA, oral, local, none, etc.); ○ List of staff in Dental Department and their CPR certification status; ○ Presentation Book for Section Q; ○ AUSSLC Quality Assurance Monitoring for Section Q, undated; ○ For the self-assessment process for Section Q, list of monitoring/audit tools used, for each tool, the number of the eligible population to be sampled, the number included in the sample (the percentage of the eligible population sampled), the method used to determine how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor/survey/review, and any inter-rater reliability data analyzed for the audit/monitoring review; and ○ For the self-assessment process for Section Q, the databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, documentation of the frequency of the data collection. ▪ **Interviews with**: ○ Rhonda Stokley, DDS, Dental Director. ▪ **Observations of**: ○ Pre-treatment Sedation/Desensitization Committee, on 11/7/12.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Dental Department QA monitoring tool. ○ These monitoring/audit tools included adequate indicators to allow the Facility to

	determine compliance with some aspects of the Settlement Agreement. However, other areas did not have sufficient monitoring oversight. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools included adequate methodologies, such as record reviews, and reviews of dental logs. o The Self-Assessment identified the sample(s) sizes. However, it did not consistently include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). As a result, it could not be determined if the sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: dental staff. o The staff responsible for conducting the audits/monitoring were clinically/ programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tool The Dental Department QA Monitoring Tool had been re-initiated in September 2012. ▪ The Facility used some relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. The quality of the data maintained in the databases generally was noted to be complete, accurate, and up-to-date. However, as the Facility noted in its Self-Assessment, it did not have a process in place to ensure the validity of the data in the database. Examples of databases/data sources that were not included were the tracking of consent completion, oral hygiene rating tracking for those who brush their own teeth, desensitization results tracking, post-TIVA injury tracking, and post dental visit pneumonia retrospective review data. ▪ Generally, the Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Sometimes measured the quality as well as presence of items. However, it often appeared that timeliness and the presence of items were the focus of the self-assessment, as opposed to the quality of the dental supports provided. ▪ The Facility rated itself as being in noncompliance with Section Q. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas of need/improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying, for example, the need for improvement in the oral hygiene ratings. However, the Facility Self-Assessment did not then point to action plans that had been developed or other plans to correct deficiencies noted.
	Summary of Monitor's Assessment: The Dental Department continued to make progress in providing quality and comprehensive care. The timely completion rate of the annual dental exams was 97%. Suction

	tooth brushing was beginning to be offered to additional individuals that would benefit from this procedure. A pilot project for improving oral hygiene in one residence was being developed. A new process for desensitization that was interdisciplinary had developed individual-specific plans that had potential for positive impact. Concerns remained in that 53% of the campus had poor oral hygiene ratings. Although there were two Dental Assistants and two Dental Hygienists, limited time appeared to have been assigned for training and teaching in all residences in which individuals had poor dental hygiene. Considerable efforts had been made to train individuals and staff during in-home exams or at the dental clinic, but no information was available regarding whether the training was competency-based, or whether follow-up occurred to determine if this training was effective. The Dentist did not appear to consistently document follow-up to procedures completed using oral sedation and total intravenous anesthesia (TIVA) to verify a recovery without complications. Given the number of injuries within 24 hours of TIVA, follow-up with documentation might be necessary after 24 hours to ensure no injuries occurred to the oral cavity and/or to determine if release from the Infirmary was premature. The State Office should review the definition of a dental emergency for documentation purposes. At AUSSLC, acute care visits were not entered into the emergency log, making it difficult to track the timeliness of notification of the Dental Office and treatment. In its response to the draft report, the Facility stated: "All dental visits are recorded in the tracking log but did not necessarily warrant the term 'emergency' in our opinion… At the Monitor's request we will now keep an Emergency/Acute Care Log." State Office review of the definition of a missed appointment was also needed. AUSSLC had narrowed down the definition, and in the process, removed data from reports provided to the QA/QI Council that should have been included and reviewed. It is important to record all reasons for missed appointments in order to track the percentage of appointments affected by delay in evaluation and treatment, as well as ensure follow-up care is provided. Desensitization efforts continued at a slow pace. At the time of the review, 10 desensitization plans using a revised format had been created. Although they held potential for success, they had not yet been piloted. Much progress had been made in the Dental Department. However, there were many challenges that remained. The Facility remained out of compliance with this section.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30	<u>Staffing</u> The Dental Department was staffed by one Dentist, two Registered Dental Assistants, two Registered Dental Hygienists, and had one vacancy for a Dentist position. This vacant	Noncompliance

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	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.	position had been filled for approximately two months in the prior six months, but was vacant at the time of the Monitoring Team's visit. CPR certification was submitted for the Dental Department staff. For the five staff, each was current in CPR. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from April through September 2012. A list of 148 individuals was included. Six of these had database errors/typographical errors, and were removed. Of the 142 individuals remaining, all 142 were listed with a prior annual examination date. Of these, 138 of 142 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 97%. For the four that were overdue, three were noted to have delays in obtaining consent. The Dental Department documented that two individuals residing at AUSSLC had not seen a dentist in more than 365 days. These two individuals needed TIVA for a successful appointment. There were "consent issues" for both individuals. Both individuals did complete an appointment after the 365 days. For one individual, the due date was 8/30/12, and the appointment was completed 9/26/12. For one individual, the due date was 9/20/12, and the appointment was completed 10/1/12. Separately, copies of 10 annual dental assessments completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessment were submitted. These were completed in September 2012. For 10 out of 10 (100%) of these individuals, an annual dental assessment had been completed within 365 days. The Dental Department tracked completion of annual exams on a monthly basis, and provided monthly reports with success rates listed. Copies of the completed annual dental summaries for the IDTs' review for ISP preparation were submitted. The annual dental assessment was used as the annual dental summary, according to the submitted information. The content included the following: ▪ Ten of the 10 assessments (100%) had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 assessments (100%) had entries for oral hygiene rating. ▪ Seven of the seven assessments (100%) in those with teeth had entries for teeth restorations, and periodontal condition. Three were edentulous. ▪ A soft tissue exam was documented in 10 out of 10 (100%). ▪ A summary of findings/treatment during the visit/ future treatment plans was	

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		documented in nine of 10 (90%) of the cases. ▪ Oral hygiene recommendations were documented in 10 of 10 assessments (100%). ▪ Risk rating was documented in 10 out of 10 (100%) assessments. ▪ Community transition preparedness was documented in 10 out of 10 (100%) assessments. Additionally, during the time period from April 2012 through September 2012, there were no new admissions. The Facility submitted the complete dental records for the prior three years for one individual from each residential unit, as a separate measure of completeness and timeliness in dental documentation. Three records were submitted, and the following findings were based on the review of this material: ▪ For three out of three (100%), the most recent annual dental assessment was within 365 days of the prior assessment. ▪ None of three were edentulous. ▪ For those with teeth, a periodontal chart was submitted in none of three records. In its response, the Facility indicated: "In lieu of a full periodontal charting we perform a PSR (periodontal screening record) which is done in many military dental exams. A PSR is performed at every exam. If the PSR is not performed the reason is documented." During future reviews, the Monitoring Team will assess these screenings. ▪ Three of three had a TIVA anesthesia record submitted. ▪ Three of three (100%) had information submitted concerning the completion of dental x-rays. ▪ The level of cooperation and need for sedation/restraint was documented in three of three records (100%). ▪ The oral hygiene rating was recorded in three of three records (100%). ▪ In the prior year, restorations occurred in two of three. ▪ The level of risk for dental needs was recorded in three of three (100%) annual dental assessments. ▪ The recommendations for oral hygiene (tooth-brushing recommendations/ flossing, etc.) were recorded in three of three (100%) records. ▪ A statement of preparedness for community transition was recorded in three out of three records (100%). <u>Oral Hygiene</u> An oral hygiene index was completed on each individual at the time of the annual exam. The most recent oral hygiene scores were submitted. According to this document, for the 148 dental exams completed from April through September 2012, 39 (26.4%) had a good	

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		oral hygiene score, 30 (20.3%) had a fair oral hygiene score, and 79 (53.4%) had a poor oral hygiene score. A pilot project was initiated in which one residence was selected for the "Oral Hygiene Improvement Project." On 7/20/12, an inventory was completed to determine whether the appropriate supplies were available in each individual's oral hygiene box. As of 8/10/12 (or 8/17/12 – different documents appeared to include different dates), an updated oral hygiene rating was obtained on each individual in the selected residence. This provided a baseline, following which dental clinic personnel were to observe individuals and staff completing the daily oral hygiene techniques. This was to be followed by training to the individuals and staff in correct oral hygiene techniques. A follow-up oral hygiene rating was to be completed once the pilot project was fully implemented to determine impact. On 10/19/12, a follow-up inventory of the oral hygiene boxes was to occur. The Dental Department submitted the numbers of individuals and/or staff trained in oral hygiene instruction while the individual was in the dental clinic or when an in-home exam was conducted. The number of trainings per month was provided, including: April 2012 – 31, May 2012 – 36, June 2012 – 37, July 2012 - 49, August 2012 – 22, and September 2012 - 32. This was a total of 207 instructions. There was no information as to the effectiveness of these many trainings in the clinic and in the home, and/or whether they were competency based. The Dental Department also provided new employee orientation training concerning dental care. This occurred during new employee orientation, which varied from once or twice monthly. *Suction 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 26 individuals received suction tooth brushing, which was 26 out of 321 (8%) of the population. On 9/12/12, the PNMPs for those who received suction tooth brushing were reviewed to determine if this procedure had been incorporated into that document. Of the 24 individuals that received suction tooth brushing at that time, only 10 had a PNMP that reflected this information. This was communicated to the Habilitation Therapies Department. Based on a draft policy for suction tooth brushing that provided guidance concerning selection criteria, an additional 22 individuals were identified as qualifying for suction	

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		tooth brushing. Of these, orders were written for one of the 22 individuals. However, the Dentist and/or PCP had not finalized approval for the other 21 individuals. The draft policy AUSSLC – Dental Services: Suction Tooth Brushing was dated 9/14/12. The Facility submitted a list of those with a diagnosis of pneumonia from 3/2/12 through 8/27/12, along with the date of the prior dental appointment and the procedure completed during that appointment. Of a list of 31 individuals that had pneumonia, three individuals had dental appointments from four to eight days prior to the date of the pneumonia diagnosis. One of these had an extraction and prophylactic treatment under TIVA eight days prior to the diagnosis of pneumonia. For the other two, sedation was not recorded. One was for a postoperative visit from an earlier extraction (which occurred 15 days prior to the diagnosis of pneumonia), and one was a prophylactic treatment that occurred four days prior to the diagnosis of pneumonia. From other documentation provided ("Risk Level Rating of HIGH"), the three individuals that developed pneumonia all had been designated as being at high risk for aspiration, and were at risk for developing pneumonia whether or not dental care was completed. It is recommended that the Dental Department monitor procedures on an ongoing basis to ensure that those at highest risk of aspiration have maximum attention in prevention of aspiration of secretions, with appropriate documentation of preventive steps taken during any dental procedure. It also is recommended that the Dental Department develop a monitoring system and complete a dental record review when an individual subsequently develops pneumonia within two weeks of a dental appointment to determine adequacy of clinical, administrative, or documentation steps. This might lead to systemic changes such as: including serial or continuous pulse oximetry readings during non-TIVA visits for those at highest risk of aspiration, a focused medical clearance completed within 24 hours prior to the dental appointment that might provide guidance to the Dental Department in whether to complete or reschedule the appointment, and/or a follow-up note within 24 to 72 hours for those at highest risk of aspiration through a telephone call to the nurse in the residence or brief record review of that time period to gather additional information concerning the outcome of the dental visit. Determining the most recent oral hygiene rating prior to the pneumonia might indicate the need for further tooth-brushing instruction to the individual and staff assisting that individual. *Tooth Brushing* The Dental Department provided documentation of tooth-brushing instruction for the individual and/or staff. The Dental Department was not able to obtain a list of those individuals who brush their own teeth, according to their ISPs. However, they were able to determine these individuals through the Dental Department records. The list included 58 names of	

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		individuals who brushed their own teeth. Of these, nine needed assistance to complete this task. The oral hygiene scores of these 58 individuals were submitted for the prior two ratings completed at the time of the annual exams. For one individual, there was an error and this individual was not included in further analysis. For one individual, there was only one rating submitted, because the dates and rating were identical for the "previous OH rating" and the "latest OH rating." For the 56 individuals for whom information was submitted for two prior dates: ▪ Thirty-one remained in the same category of oral hygiene rating. There were three that maintained a good oral hygiene rating. For 11, the individuals maintained a fair oral hygiene rating. For 17, the individuals continued to have poor oral hygiene ratings. For the 28 individuals with fair and poor hygiene, it was not determined whether the IDT and/or the Dental Department had identified the need for additional assistance/steps or review of the plan for brushing one's own teeth. ▪ For 15 individuals that brushed their own teeth there was improvement in the oral hygiene ratings. For nine individuals, the ratings improved from poor to fair, for four individuals the ratings improved from fair to good, and for two, the ratings had improved from poor to fair. ▪ For 10 individuals, the oral hygiene ratings worsened. For one individual, the rating changed from good to poor. For three individuals, the ratings changed from good to fair. For six individuals, the ratings changed from fair to poor. It was not determined whether the IDT and/or Dental Department had identified this worsening in oral hygiene rating and whether steps had been taken to address this decline. *Flossing* The Dental Department listed one individual that flossed their own teeth. However, this was documented as not occurring on a regular basis. A list of those individuals with independent tooth-brushing skills was provided, along with the reasons for not being able to floss independently or with assistance. Except for the one mentioned here, the reason provided was that both cooperation and dexterity were inadequate. The Dental Department provided a historical perspective on attempts to teach individuals the skill of flossing at AUSSLC. In the past (dates not identified), individuals with potential for successful flossing were provided appointments at which training was offered through demonstrations on models, demonstrations on the individual, and then assistance with self-flossing. The use of floss picks was considered to have a better outcome than string floss. However, challenges remained, including inability to comprehend the task, inability to systematically floss from tooth to tooth, poor manual dexterity in attempting to use the floss to complete the task, and the concern for tissue destruction from aggressive flossing. It was decided that: "independent flossing is not advisable in this population." Consequently, in the prior six months, there was no training of individuals	

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		in flossing their own teeth. <u>Preventive, Restorative, Emergency Dental Services</u> *X-Rays* The Dental Department referred to the AUSSLC Dental Clinic: Annual Dental Assessment Policy in guiding the determination for ordering x-rays. This was left to the judgment of the Dentist, and was based on risk/benefit. For those utilizing TIVA, x-rays were up-to-date. Obtaining x-rays without TIVA was dependent on the cooperation of the individual. An attempt was made to obtain x-rays for known dental pathology, but the need was individualized, depending on the comorbid conditions of the individual. A list of those with x-rays completed, with type of x-ray completed, and date, was not submitted. It is recommended that the risk-benefit ratio of obtaining x-rays be documented in an IDT meeting, as well as the ISP, with demonstration of family/guardian understanding and written agreement/consent to forego one or more types of x-rays based. *Edentulous Individuals* Information submitted indicated 55 individuals residing at AUSSLC were edentulous, for a rate of 55 out of 321 (17%). Since May 2012, no individual had become edentulous. Two of 55 individuals that were edentulous had dentures. One of these individuals was not considered edentulous, because there were teeth in the lower gum/ridge, but not in the upper ridge. This individual received an upper denture. A total of 53 individuals that were edentulous did not have dentures. Reasons given were: inadequate cooperation for denture fabrication to be completed, and complex oral anatomy, or refused dentures when offered. For each individual that was edentulous, the annual dental assessment indicated whether the individual was a candidate for dentures and whether the level of cooperation was inadequate. The annual dental assessment also included oral hygiene recommendations for those that were edentulous. *Breadth of Services* The Dental Department provided the breadth of services required to care for the individuals at AUSSLC. From April 2012 through September 2012, 257 appointments were completed for prophylactic care. A total of 148 appointments were completed for annual dental exams, and 56 appointments were completed for restorative care. One individual was seen and treated for a dental emergency. Eleven individuals underwent dental extractions. The number of teeth extracted ranged from one to eight per visit. *Oral Sedation* Monitoring and evaluation of use of oral sedation was reviewed. Ten active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review: ▪ One out of the eight (13%) confirmed nothing by mouth (NPO) status or nothing	

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		per G-tube at the time of the dental visit. Two individuals of the ten (20%) were documented to not have NPO status. ▪ Ten of 10 (100%) listed the medication administered, the dose, and the route. ▪ Five of 10 (50%) listed pre-procedure vital signs in the home. ▪ Ten of 10 (100%) had an examination note on the date of the visit. One entry was written greater than 60 days after the dental visit. ▪ Documentation of intra-procedure vital signs often could not be identified based on the data submitted. This was due to a lack of documentation regarding when the procedure precisely started and stopped to allow determination of which set of vital signs was completed during the visit. Vitals signs were listed at times in the narrative Dental Progress Note, and at times, on the post anesthesia care vital sign flow sheet. It is recommended that the Dental Department develop a tracking system that clearly defines the beginning and ending times of procedures, as well as clearly marking when vital signs were taken before, during, and after the procedure. This would reduce the uncertainty in measuring compliance in this area. ▪ Ten of 10 (100%) documented post- procedure vital signs. ▪ Adequate documentation regarding effectiveness of sedation was found in 10 of the 10 (100%) of the active records. ▪ None of 10 (0%) documented Dental Department follow-up the next business day. ▪ Two of 10 (20%) documented a post dental procedure IPN note. ▪ Because the Monitoring Team did not specifically request documentation of current sedation consent, the Facility did not provide it as part of the dental records for these individuals. During upcoming reviews, the Monitoring Team will ensure this is included in its requests. ▪ Two of 10 (20%) documented use of mechanical restraint. The other records did not include evidence of the use of mechanical restraint. ▪ None of 10 included a restraint checklist. *General Anesthesia/TIVA* The Dental Department submitted the TIVA appointment schedule for the time period April 2012 to September 2012. For April 2012, 12 TIVA appointments were completed. For May 2012, 13 TIVA appointments were completed. For June 2012, 10 TIVA appointments were completed. There was one appointment not completed due to time constraints and was rescheduled for September 2012. The reschedule date was not completed due to the individual not being kept NPO, and was rescheduled a second time in October 2012. No information was submitted to verify if the appointment was completed. For July 2012, nine TIVA appointments were completed. For August 2012, four TIVA appointments were completed. Six appointments were rescheduled due to "consent issues," and all were subsequently completed in September 2012. For	

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		September 2012, there were 19 TIVA appointments. One was rescheduled due to time constraints, but the individual was still seen during the month of September 2012. The other individual has missed an appointment in June 2012, and was rescheduled for October 2012. The active record was submitted for six individuals who had undergone general anesthesia in 2012. The date range of these procedures was from 9/12/12 through 9/17/12. The procedures under general anesthesia included one or more aspects of dental care. The list varied from case to case, and included the following: restorative care, prophylactic treatment, x-rays, and annual assessment. Review of these records revealed the following: ▪ A current consent (defined as completed and dated within 365 days of the procedure) for the dental procedures/anesthesia was submitted in none of six (0%). ▪ Consistent with standard practice, a pre-operative medical (i.e., completed by the PCP) and/or anesthesia (i.e., completed by an anesthesiologist) clearance was completed and submitted in none of six cases (0%). ▪ An operative note by the dentist was recorded in six of six cases (100%). ▪ The operative anesthesia record was completed in six of six (100%). ▪ For those with teeth, a periodontal chart was submitted for none of six (0%). ▪ The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score was submitted in four of six (67%) of the active records. ▪ A Dental Department recovery note was submitted for none of six (0%). ▪ An Infirmary nursing discharge report/form was completed/submitted in two of six (33%). ▪ A post-operative vital sign flow sheet was submitted in six of six (100%). For one of six, the vital sign log could not be located, but the dental office had a copy of vital signs logged while in the Dental Department. ▪ Pain medication was prescribed in six of six cases (100%). ▪ As appropriate, an annual dental assessment was completed while under TIVA/ general anesthesia in five of five cases. The Facility provided information concerning injuries reported within 24 hours of TIVA administration. For the time period from 4/5/12 through 9/17/12, there were 62 appointments for individuals listed as having been scheduled for TIVA, involving 55 individuals. Of the 62 appointments involving 55 individuals, there were eight incidents of injuries in the 24-hour time period following, involving eight individuals. These were described as one of the following: superficial scratches, abrasion, tripped and fell, and slapped by a peer. This was a rate of eight out of 62 (13%) TIVA visits. No information was submitted describing the follow-up review and decisions made by the IDTs.	

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		However, this suggested the need for increased supervision and monitoring for those completing TIVA. In its response to the draft report, the Facility stated: "Every incident of injury is reviewed by Incident Management and steps are taken as they deem necessary. Of the 8 out of 62 injuries most were considered superficial scratches or abrasions. One was an incident caused by a completely different individual. Only two were of a serious nature (involving falls or trips, both of which occurred the following day, long after the anesthesia medications have left the system) and 2 of 62 is 3%. While we are not implying that superficial scratches or abrasions are unimportant we would like to point out that there is no control data in this analysis. There is no data provided in this instance to compare the occurrence of superficial scratches and abrasions across the rest of the campus during the same time period. Please note that there are nursing protocols to ensure monitoring of individuals before release from the infirmary and also upon their return to the home. It is also important to note further that when an individual is most at risk of an adverse event, immediately post-TIVA, they are in the dental clinic under the direct supervision of both dental staff and the anesthesiologist. The individual is not released to the infirmary without the anesthesiologist's approval. Note, as well, that a superficial scratch of the nose, for example, may also occur while in the infirmary." Of note, the Facility provided no evidence in its response that until this was raised in the Monitoring Team's report, it was looking at this data, or analyzing it in a way that would be meaningful. This was the Monitoring Team's point. Of concern, the Facility's response did not recognize the potential individual responses to general anesthesia that certainly can last more than a day. *Extractions* For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ From the submitted documentation, current consent was submitted in none of five (0%). In its response to the draft report, the Facility indicated that the Monitoring Team did not request this documentation. However, Document Request #XIV.29 read: "For most recent five extractions in past six months, copy of initial evaluation for this, second opinion, and subsequent documentation until closure." Consent documentation clearly should have been included, and should be for future reviews. ▪ A prior dental IPN/DPN indicating the need for extractions was documented in two of five (40%). All five individuals had extractions under TIVA. It is noted that the Dental Department is at times not able to assess need for extraction until sedation is administered, at which time the procedure is completed. ▪ For five of five cases, IV sedation was used. For none of the five cases, oral sedation was used. None only utilized a local anesthetic. ▪ From one to four teeth were extracted at a visit. ▪ Pain medication was provided in five of five cases (100%).	

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		▪ A follow up dental note the following morning in the Infirmary or a phone call to the residence (for one individual not admitted overnight to the Infirmary) was documented in one of five cases (20%). ▪ A follow-up visit was documented in five of five cases to determine healing or complications. Oral surgery consultation was utilized in reviewing radiographs to discuss treatment for selected individuals. However, the Dental Department indicated there was no oral surgery consultation in the prior six months. *Emergency Treatment* The Dental Department documented only one emergency in the prior six months. On 8/1/12, the one individual was hit in the mouth by a peer, and developed dental pain. A late entry, dated 8/13/12, in the IPN and DPN indicated a dental staff home visit on 8/2/12, because the individual refused to go to the dental clinic. A brief exam was completed, and the dental staff recommended a dental clinic visit. A late entry, dated 8/21/12, documented follow-up on 8/9/12, in which the Dental Department called the residence, to determine whether the individual would come to the dental office, but the individual did not subsequently come to the dental office. There was no further follow-up of this dental emergency. With the census at AUSSLC over 330 during the previous six months, it would be anticipated that there would be several acute care/emergency visits. The Dental Department indicated that when the Dental Clinic knew of an acute need, they scheduled the individual to be seen the same day. It is recommended that a dental emergency log be developed that records the time the acute illness (e.g., dental pain, trauma, etc.) occurs, and the time the individual is seen in the Dental Office. This should include the reason for the visit, a tracking system for closure of the concern, and whether there was pain management. It is probable that there were several acute visits seen efficiently, but there was no current system in place to document the ability of the Dental Department to examine and treat individuals with acute dental needs in a timely manner, and to document the cause, the administration of pain medication, and whether there is closure to the case. This would provide evidence of timely evaluation and adequate treatment of acute care visits. As noted above, emergency treatment was reviewed for one individual. The following findings are made based on this one review: ▪ Zero of one dental entry (0%) documented the presence or not of pain. The PCP treated pain at the time of the incident. Pain was not further treated. A nursing note on 8/2/12 indicated there was no further pain. The Dental Department note did not comment on the presence or degree of pain. It was documented	

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		that the injury did not interfere with the ability to eat. ▪ Successful follow-up occurred for zero of one individual (0%). The individual's was unable to cooperate with visiting the dental clinic. As the Dental Department strives toward substantial compliance with this sub-section, the following are areas on which focus should be placed: ▪ It will be important to maintain the progress that has occurred in the Dental Department. ▪ Efforts to improve oral hygiene ratings are essential, given that individuals with poor hygiene represented 53% of the population, those with fair oral hygiene represented 20% of the population, and the remaining 26% had good oral hygiene. ▪ Suction tooth brushing should be provided to those that need it. ▪ For individuals at high risk for aspiration pneumonia, the Dental Department should ensure that reasonable steps are taken to monitor their status before, during, and after dental procedures. ▪ For individuals experiencing pneumonia within two weeks of a dental visit, thorough review should occur to determine if changes in practice/documentation are needed. ▪ For individuals that brush their own teeth, when declines occur in their oral hygiene, or their oral hygiene ratings are in the fair or poor categories, the IDT and/or Dental Department should identify these issues, and discuss and implement, as appropriate, steps to address these concerns. ▪ For those undergoing oral sedation, attention is needed in relation to a number of the indicators outlined above. ▪ Similarly, for those undergoing general anesthesia/TIVA, attention is needed in relation to a number of the indicators outlined above. ▪ Further analysis is needed of injuries occurring within 24 hours of the administration of TIVA, with action taken as appropriate. ▪ For extractions, the following were in need of improvement: ensuring documentation of consent is available for review, documentation in lay terms in a standardized location (such as the brief IPN that is written at the time of the procedure, and the annual dental assessment if it occurs at the time of the extraction, rather than only in a DPN narrative using dental terms and abbreviations) of the reasons for the extractions, and follow-up the following day. ▪ As discussed above, the Dental Department should maintain a log of dental emergencies and/or acute dental needs, which should allow tracking of the various requirements discussed above.	

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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 subsections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Provision of Dental Records to IDTs</u> Copies of the most recent comprehensive exams from the active record were requested for one individual from each residence, along with the copy from the Dental Office records. This was used to assist in determining whether the IDTs received adequate/complete dental information for the individuals. The Dental Department used a carbon copy to ensure identical information was available. For the 22 submitted copies, identical information was available in the active record and Dental Office record in 21 out of 22 (95%). <u>Refusals/Missed Appointments</u> A review of information from a document entitled: "Dental Clinic: Refused Appointments - April 2012 – September 2012" indicated that nine appointments were refused. Six individuals refused these nine appointments. Five follow-ups were completed. Two follow-ups for these individuals were still pending/remained incomplete (the document scan date was 10/9/12). One appointment was refused and not rescheduled, because the reason for the acute care problem no longer existed. Two individuals refused more than one appointment. Reasons for the scheduled appointments that were refused included: prophylaxis (three appointments), extractions (zero appointments), exam (not further defined) (one appointment), exam and prophylaxis (two appointments), limited evaluation (acute care visit) (one appointment), and restoration (two appointments). The refused appointments occurred from three residences. One residence (Residence #797) was responsible for seven of nine refused appointments. In this residence, four individuals refused these seven appointments. The Facility submitted copies of ISPs and ISPAs in response to refusal(s) for three of the individuals. For three other individuals, the IDT did not meet to discuss refusals, because there was no prior history of refusal. The following summarizes the actions teams took: ▪ For one individual, the ISP of 8/30/12 included the IRRF information that indicated the individuals' lack of cooperation, and also documented some discussion between the individual and the IDT regarding refusals of dental care. There was reference that refusals were addressed in a BSP, but this was not provided. It would appear that the individual's refusals for dental care were not resolved despite following a BSP. ▪ For a second individual, the ISP of 8/22/12 indicated the challenge was getting	Noncompliance

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		the individual to the appointment. Once in the office, cooperation was considered adequate. The most recent successful visit occurred because a parent assisted in the process. There did not appear to be documented discussion of other options in ensuring cooperation in attending appointments. In its response to the draft report, the Facility indicated: "There was discussion within the dental clinic about ways to achieve success with this endeavor and the home supervisor and QDDP were also notified of the refusals via email, per part of our dental clinic policy on missed/refused appointments. We knew that in the past the individual had had a successful appointment with his father present. While we knew his father would be unable to attend this time, we enlisted his father's help in motivating him to attend his appointment. He attended and the appointment was a success. We do not feel that time is always best spent gathering multiple solutions that may or may not work. We only needed one successful strategy and we had it (if it was unsuccessful we would have requested an IDT meeting). We feel that parental involvement in their children's oral care is a positive support for the individual and respectfully stand behind the decision." Given that this individual will need to have dental care his entire life, relying on one family member without exploring other options to assist in the process did not represent good team planning. ▪ For a third individual, an ISPA, dated 4/27/12, indicated that the next dental appointment would be scheduled in the afternoon, rather than the morning. Overall, one of three ISPs (33%) appeared to address the ongoing concern for refusals. When refusals are not resolved and an action plan for refusals is part of a BSP, then the team needs to review the plan, as part of the follow-up ISPA, to determine if it was followed, further training was indicated, or a new or revised plan for refusals was needed. For one individual, although there was a positive response when a parent was in attendance, there was minimal discussion of other options to be considered in improving cooperation and motivation to attend. For the time period from April 2012 through September 2012, there were 10 missed/no show appointments that were not categorized as refusals. Reasons for the scheduled appointments that were missed included prophylaxis (six appointments), exam not further defined (one appointment), exam and prophylaxis (one appointment), prophylaxis and x-rays (one appointment), extractions (no appointments), and restorations (one appointment). The major reasons identified for missed appointments included: not being kept NPO (three), schedule conflict (one), staffing (two), and lack of communication in the home (four). The missed/no show appointments occurred across several homes. One home had two missed appointments for the time period for April through September 2012. However, eight homes each had one missed appointment, indicating no trend.	

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		For the 10 appointments that were missed, a follow-up completed appointment was documented in nine cases. For one appointment, TIVA was scheduled in October 2012 (the date of the scanned document was 10/9/12), and no further information was available. For nine individuals, the completed appointment occurred from six to 15 days after the missed appointment. The Dental Department noted that missed appointments for reasons beyond the Dental Department's control were tracked in the database. It is valuable to separate out missed appointments for which the Dental Department could assist in preventing a recurrence. However, the total number of missed appointments provides value in determining overall percentages of visits for which there was a delay in care, as well as to determine the length of time between missed appointments and completed appointments. It is recommended that all missed appointments be tracked (e.g., weather, illness of individual or dental staff, broken equipment in the dental office, etc.). In its response to the Monitoring Team's draft report, the Facility stated: "The dental clinic tracks every reason an appointment is missed including weather, the dentist being out sick, etc. The report that is sent out to the campus does not include these things as they are not pertinent to the dental clinic's goal of making sure the campus is aware of the missed appointments that they can have control over and hopefully prevent in the future. For future records requests, we will include all data for the Monitor." The issue is not what is available to the Monitoring Team. Rather, the Monitoring Team's point was that the Dental Department and QA/QI Council should review this data as well, and analyze it to determine if actions are necessary to address some of the issues identified, as well as to ensure that no matter the reason, missed appointments are rescheduled within a reasonable period of time, and are completed with minimal delay in dental care. A total of 441 appointments were kept, nine appointments were refused, and 10 appointments were not refused, but missed for other reasons. For a total of 460 scheduled appointments, there was a 441 out of 460 (96%) show rate. It was not clear whether the numbers the Dental Department provided included appointments scheduled, but not kept due to inclement weather, medical illness of the individual, and other factors beyond control of the Dental Department. Adding these additional appointments to the missed appointments also might have impacted the final percentage for show rate. These numbers were not available. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. For the prior six months (April to September 2012), there were 441 completed appointments. The Dental Office did use mechanical restraints. For 19 of 441 appointments completed (4.3%), mechanical restraints were utilized. For 10 of 441 appointments (2.2%), oral	

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		sedation was utilized. For 67 of 441 appointments (15.2%), TIVA was utilized. Two different documents were submitted to provide this information, and both agreed on the numbers of mechanical restraint use during this time period. There were small differences in recorded numbers of oral sedation and TIVA administration. The "Dental Clinic Restraint and Sedation Section of Tracking List April 2012 – September 2012" listed 70 cases of TIVA, versus the 67 recorded in a document entitled "Dental Clinic: Percent of individuals utilizing TIVA April 2012 - September 2012." The difference in numbers occurred in documentation of TIVA for July 2012. Similarly, the "Dental Clinic Restraint and Sedation Section of Tracking List April 2012 - September 2012" listed nine cases of oral sedation, and the document entitled "Dental Clinic: Percent of Individuals utilizing oral sedation April 2012- September 2012" listed 10 cases. The differences in numbers occurred in documentation of oral sedation for May 2012. The Dental Department is encouraged to review various databases and data collections to ensure accuracy, completeness, and agreement of information. A list of HRC-approved dental and medical restraints/sedation was requested. According to the Dental Department, this was not available. The current process was that the need for sedation or restraint was documented in the annual dental assessment, which was forwarded to the QDDP for entry into the ISP. However, as this was a rights restriction, a desensitization plan was then required before the Human Rights Committee granted approval for the rights restriction. *Desensitization* A list of names was submitted for which desensitization plans had been developed, including the dates of development. This totaled seven individuals with medical desensitization plans, 141 with dental desensitization plans, and 45 with both medical and dental desensitization plans, for a total of 193 individuals. From the table submitted, an additional entry was noted that there were 86 individuals without plans. The reason for listing the additional 86 names was not clear, but suggested that these 86 individuals were identified as needing review to determine potential benefit from a plan. A sample of implementation data was supplied for two residences. Information was from September and October 2012. It was not identified how these reports were reviewed to determine progress or need for changing the content of a plan, and whether the forms were completed, and completed accurately. There was no information to determine if there had been success with any of the plans. While implementation and tracking of these dental desensitization plans were ongoing, an interdisciplinary committee was formed to provide an individualized approach to the need for desensitization, using data collection to determine current oral hygiene ratings,	

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		current level of oral hygiene participation of each individual, and steps needed to achieve a successful oral hygiene program for the individual. This was in the pilot stage for selected individuals in one home. Specifically, this Pre-Treatment Sedation/ Desensitization Committee was initiated to review the needs of the individuals in preparing for procedures, both medical and dental. The purpose was to "create more individualized, thoughtful desensitization plans." An additional goal was to develop a system of storage of data and monitoring of the plans. Meeting dates provided included: 7/21/12, 8/10/12, 9/7/12, 10/22/12, and 11/7/12. The attendance was multidisciplinary and for most/all meetings participation included representatives from psychiatry, dentistry, medicine, psychology, pharmacy, nursing, and QDDP services. Progress had been made in selecting individuals from one residence as a pilot. According to the minutes of the 10/22/12 meeting, and the Dental Department Provision Action Information, steps the Dental Department reported had been completed included completion of the oral hygiene audits assessments by the hygienist (baseline assessments by 8/31/12), completion of the dental task analysis (five measurement indicators), the dental clinic task analysis (12 measurement indicators), and the development of the dental report for ISPA desensitization plan development (entitled "Dental Task Analysis" of all analyses by 9/14/12, final report of all analyses to committee chair by 9/25/12). For the 10 individuals selected, the IDT was to develop individual-specific desensitization plans. Documentation was to include an information cover sheet, documented skill acquisition goals, and the individual's specific plan for skill development. Additionally, a policy was submitted entitled "Related to use of Sedation for Routine Recurring Medical Exams and Procedures" and was undated, and appeared to be a non-formalized policy. The quality of the revised plans is discussed in further detail with regard to Section C.4 of the Settlement Agreement. <u>Quality Assurance/Improvement Initiatives</u> The QA Monthly Monitoring Grid indicated that an assigned dental hygienist was to complete a 10% sample monthly using the Section Q monitoring tool. This included reviewing 33 individuals each month. The Dental Director was to audit a 5% sample size, and the Compliance Nurse was to review a 10% sample size. Utilization of this monitoring tool resumed in September 2012. No report was provided by the QA Department. Quarterly reports were generated by the Dental Department. Submitted were copies of the "Quarterly Missed Appointment Report" for the 2nd Quarter of 2012 and 3rd Quarter of 2012. The second quarter data indicated that there were 154 scheduled appointments, and 145 completed appointments, for a completion rate of 94%. Reasons for the missed appointments were identified, and corrective action steps were listed on the quarterly report, including sending a copy of the report to the home supervisors,	

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		QDDPs, and Unit Directors. The third quarter data indicated that there were 212 scheduled appointments, and 202 completed appointments, for a completion rate of 95%. Several corrective action steps were identified. For instance, an additional step with NPO orders included faxing them to the Dietary Department. Annual exams also were tracked on a monthly basis. For each month, a determination of exams to be completed within 365 days of the prior exam was determined, and a review was made verifying timely completion of these exams. For those exams that were completed after the 365-day time period, the reasons for the overdue exam were determined and corrective actions were implemented. For April, June, and July 2012, there were no annual exams completed that were overdue. In May 2012, August 2012, and September 2012, identified issues included delays in consent, furlough, and refusals. An attendance tracking sheet was completed and included the following information for each appointment: dental procedure, scheduled date, date of completion, reason appointment missed, date rescheduled, sedation used, restraint used, type of restraint used, and whether the record was brought with the individual, if applicable. However, as discussed in more detail in the section that discussed the Facility's Self-Assessment, more work was needed to improve the quality assurance efforts related to dental services. Although the Facility was reviewing a number of relevant areas, other areas did not have sufficient monitoring oversight, and the quality of supports needed review, as well as their timely provision. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations.	

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

1. The Dental Department should implement and monitor procedures on an ongoing basis to ensure that those at highest risk of aspiration have maximum attention in prevention of aspiration of secretions, with appropriate documentation of preventive steps taken during any dental procedure. (Section Q.1)
2. The Dental Department should develop a monitoring system and complete a dental record review when an individual subsequently develops pneumonia within two weeks of a dental appointment to determine adequacy of clinical, administrative, or documentation steps. This might lead to systemic changes such as: including serial or continuous pulse oximetry readings during non-TIVA visits for those at highest risk of aspiration, a focused medical clearance completed within 24 hours prior to the dental appointment that might provide guidance to the Dental Department in whether to complete or reschedule the appointment, and/or a follow-up note within 24 to 72 hours for those at highest risk of aspiration through a telephone call to the nurse in the residence or brief record review of that time period to gather additional information concerning the outcome of the dental visit. Determining the most recent oral hygiene rating prior to the pneumonia might indicate the need for further tooth-brushing instruction to the individual and staff assisting that individual. (Section Q.1)
3. The Dental Department should expand its efforts to provide programs focused on oral hygiene across the campus. The Dental Department staff

should take a more active role in teaching and demonstrating quality oral health care in all residences of individuals with poor oral hygiene. (Section Q.1).

4. For individuals that brush their own teeth, when declines occur in their oral hygiene, or their oral hygiene ratings are in the fair or poor categories, the IDT and/or Dental Department should identify these issues, and discuss and implement, as appropriate, steps to address these concerns. (Section Q.1)
5. The Facility should review injuries following TIVA procedures to determine whether there is a need for a policy to provide guidance to teams in determining the need for increased supervision and monitoring for 24 hours post TIVA procedures. (Section Q.1)
6. A dental emergency log should be developed that records the time the acute illness (e.g., dental pain, trauma, etc.) occurs, and the time the individual is seen in the Dental Office. This should include the reason for the visit, a tracking system for closure of the concern, and whether there is pain management. (Section Q.1)
7. To ensure consistency, the definition of an emergency/acute care visit should be defined across the SSLC system. (Section Q.1)
8. When the dentist is recommending modifications to the standard x-rays, team discussion regarding the risk/benefit ratio of obtaining x-rays should be documented in an ISPA and/or the ISP, with demonstration of family/guardian understanding and written agreement to forego one or more types of x-rays. (Section Q.1).
9. All missed appointments should be tracked, trended, and analyzed, including ones outside of the direct control of the Dental Department (e.g., weather, illness of individual or dental staff, broken equipment in the dental office, mandatory training, etc.), and action should be taken as appropriate to address identified problematic trends. (Section Q.2)
10. The Dental Department should review various databases and data collections to ensure accuracy, completeness, and agreement of information. (Section Q.2)
11. Given the length of time taken to develop a pilot program for dental desensitization for 10 individuals, the Facility should assist and provide support to the Dental Department in developing desensitization plans at a faster pace for those that would benefit from such a program. (Section Q.2)

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section R; o AUSSLC Self-Assessment, Action Plans, and Provision Action Information for Section R; o For the following 20 individuals who had communication deficits, alternative and augmentative communication (AAC) system(s), and/or received direct and/or indirect communication supports: Individual #406, Individual #426, Individual #195, Individual #393, Individual #385, Individual #179, Individual #284, Individual #457, Individual #355, Individual #270, Individual #344, Individual #374, Individual #333, Individual #210, Individual #73, Individual #11, Individual #409, Individual # 16, Individual #14, and Individual #183, the following documents: Communication Comprehensive assessment, Update and Assessment of Current Status, ISP and ISPAs for past year, Positive Behavior Support Plan, skill acquisition programs related to communication and supporting documentation for implementation (indirect supports), direct SLP therapy intervention plans and supporting documentation such as IPNs, monthly reviews by SLP, AAC programs and supporting documentation for implementation of indirect supports, individual-specific communication monitoring for past six months, and evidence of effectiveness monitoring for SLP interventions (direct) and programs (indirect); o Policy and procedures addressing the provision of speech and/or communication services and supports, including changes since the Monitoring Team's last visit; o Continuing education and other training completed by SLPs with certificates of completion, since the Monitoring Team's last visit; o List of current SLP and audiology staff along with corresponding caseloads, and CVs for newly hired SLPs; o List of individuals with AAC devices; o Communication Master Plan List; o AAC Screening forms; o Speech language (SL) comprehensive assessments and updates (templates) used by SLPs along with any changes; o Tracking Log of SLP assessments completed since Monitoring Team's last review; o Monitoring forms used by SLPs, Speech Language Pathology Assistants (SLPAs), and PNMP Coordinators; o Copies of blank communication competency-based performance check-off sheets for new employees; o Inter-rater reliability compliance scores and corresponding audits; o List of individuals receiving direct speech services and focus of intervention; o List of individuals with behavioral issues and coexisting severe language deficits, and risk level/status for challenging behavior; o List of individuals with PBSPs and replacement behaviors related to communication; o Minutes for Communication committee meetings held since the Monitoring Team's last

	review; o Minutes for Speech Department meetings held since the Monitoring Team's last review; o List of all general common area communication devices; o OT/PT Assessments, ISPs, and PNMPs for four individuals (i.e., Individual #193, Individual #184, Individual #440, and Individual #344) most recently assessed by an SLP for whom AAC device was recommended; o Blank communication competency-based performance check-off for individual-specific communication programs; o External consultant reports since last review; o Completed audits of SLP documentation; o Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review; and o American Speech Hearing Association (ASHA) certification for SLPs. ▪ **Interviews with:** o Kim Ingram, MEd, CCC-SLP, Director of Habilitation Therapies; and o Janice Taylor, MS, CCC-SLP. ▪ **Observations of:** o Individuals in Residences 782, 779-F and 732-P, and Workshops 503 and 544.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, updated 10/22/12. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section R, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Compliance Monitoring Tool. The HT Department and/or QA/QI staff were not using the Monitoring Tool for Section R from State Office. Based on interview, the Director of HT was in the process of revising the Monitoring Tool for Section R. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Compliance Monitoring tool was designed to monitor staff compliance with communication programs. This tool was not adequate to provide sufficient data to address all of the subsections of Section R. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The Compliance Monitoring tool did not have adequate methodologies to substantiate compliance for the subsections of Section R. o The Self-Assessment identified the sample(s) sizes. The focus of the sample was individuals that received direct therapy. For Section R, the Facility will need to review additional sample(s). The Facility will need to clearly identify the total population (N)

	used to define the sample selected (n). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The Facility's revision of the monitoring tool for Section R should provide adequate written procedures for the implementation of the monitoring tool. o The following staff/positions were responsible for completing the audit tools: Therapists and Program Compliance Monitor. When the revised monitoring tool is implemented, the therapists initially should monitor with the Program Compliance Monitor and inter-rater reliability should be established. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. There was no data presented to substantiate inter-rater reliability between therapists and the Program Compliance Monitor. ▪ The Facility did use other relevant data sources and/or key indicators/outcome measures. For example, the Facility had audited multiple spreadsheets, logs, and databases (i.e., SLP position/tracking log, continuing education spreadsheet, SL assessment log, AAC device spreadsheet, therapy log, review of ISP/ISPAs, and monitoring spreadsheet). However, as the Facility refines its self-assessment processes, it should identify and use other relevant sources of information. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators; o Did not consistently measure the quality as well as presence of items; and o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section R. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: The Facility was allocated five SLP positions. At the time of the review, the Facility had two full-time SLPs. Since the last review, two SLPs had resigned. There were three vacancies. The Director of Habilitation Therapies continued to actively recruit to fill these vacant positions. Individuals' Speech and Language assessments were significantly improved from the last review. However, the assessments were missing some essential components. Fifteen competency performance check-offs had been developed for new employees. The communication performance check-offs were adequate to assess new employees' competencies for providing communication supports to individuals. A plan was being developed to provide communication

	competency-based training and performance check-offs for current staff. Some staff had been provided with individual-specific competency-based training and performance check-offs to demonstrate their competency in supporting individuals in the use of their AAC systems. However, the Monitoring Team was not able to discern if the total number of staff providing supports to these individuals had been trained. In addition, the competency performance check-offs provided did not include staff training for all of an individual's AAC devices. The monitoring of AAC devices was occurring for some individuals. However, based on documentation provided the monitoring was not adequate. The Facility did not have a policy defining the process for monitoring individuals' AAC equipment or its use.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Samples for Section R:** ▪ **Sample R.1:** Ten individuals with a SLP Comprehensive Assessment completed in the last 12 months including: Individual #374, Individual #333, Individual #195, Individual #393, Individual #385, Individual #457, Individual #284, Individual #355, Individual #426, and Individual #409; ▪ **Sample R.2:** Four individuals receiving direct speech services including: Individual #406, Individual #426, Individual #195, and Individual #393; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits including: Individual #179, Individual #344, Individual #210, Individual #73, Individual #11, Individual #16, Individual #14, and Individual #183; and ▪ **Sample R.4:** Ten individuals with AAC systems including: Individual #426, Individual #179, Individual #284, Individual #355, Individual #270, Individual #344, Individual #374, Individual #333, Individual #409, and Individual #406; This paragraph of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R. This section of the report will address compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed with regard to Section R.2. Staff training is addressed with regard to Section R.3, and the Facility's monitoring system is discussed with regard to Section R.4. **<u>Staffing</u>** The Facility was allocated five SLP positions. At the time of the review, the Facility had two full-time SLPs. Since the last review, one SLP resigned in July and another SLP resigned in October. There were three vacancies.	Noncompliance

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The current census of the Facility was 321 individuals. Based on SLP caseload documentation the Facility provided, the following chart represents the caseloads of the Facility SLPs:
<table>
<tr><th>Speech Language Pathologists</th><th>Current Caseload</th></tr>
<tr><td>SLP #1</td><td>Supported 166 individuals in residences 781, 782, 783, 784, 785, 786, 787, 796, 797, 732-E, 732-P, and 779-R</td></tr>
<tr><td>SLP #2</td><td>Supported 157 individuals in residences 729, 788, 789, 791, 792, 793, 794, 795, 732-D, 779-H, and 779-F</td></tr>
<tr><td>SLP #3</td><td>Vacant position as of 3/1/12</td></tr>
<tr><td>SLP #4</td><td>Vacant position as of 7/16/12</td></tr>
<tr><td>SLP #5</td><td>Vacant position as of 10/2/12</td></tr>
</table>
The Facility did not indicate what an appropriate caseload would be for SLPs at AUSSLC. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. However, based on the large caseloads the two SLPs carried at the time of the onsite review and the number of open positions, the Facility did not provide an adequate number of SLPs to meet the needs of the individuals the Facility supported.

<u>Qualifications</u>
The Facility had documentation to show appropriate qualifications for licensed SLPs.
▪ Two of two full-time SLP staff (100%) were licensed to practice in the state of Texas.
▪ Two of two full-time SLP staff (100%) had evidence of American Speech and Hearing Association certification.

<u>Continuing Education</u>
Documentation of continuing education courses the SLPs completed during the past six months was submitted. Based on documentation submitted, no State-sponsored webinars were offered in the past six months. The continuing education attended by the clinicians included the following courses:
▪ On 9/20/12 to 9/21/12, Annual Habilitation Therapists Conference; and
▪ On 8/1/12 to 8/2/12, Evidence-Based Practices for AAC Evaluation.

Based on a review of continuing education completed since the last review:
▪ Two of two full-time SLP staff (100%) had completed continuing education relevant to communication and transferrable to the population served.
</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		<u>Facility Policy</u> A local policy did not exist that provided clear operationalized guidelines for the delivery of communication supports and services. Upon development, the Facility SLP policy and/or procedures should incorporate these essential components: ▪ Roles and responsibilities of the SLPs (e.g., meeting attendance, staff training etc.); ▪ An outline of the assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of new admission assessments (i.e., within 30 days of admission or readmission); ▪ Timelines for completion of comprehensive assessments (i.e., within 30 days of identification via screening); ▪ Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (i.e., within five days of identification as indicated by the IDT); ▪ A process for effectiveness monitoring by the SLP; ▪ Criteria for providing an update (i.e., Assessment of Current Status) versus a Comprehensive Assessment; ▪ Methods of tracking progress and documentation standards related to intervention plans; and ▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. In summary, the Facility did not have an adequate number of SLPs and should continue to recruit SLPs. In addition, the Facility should develop and implement a local policy to define the provision of communication services and supports, including the essential components as presented within this section.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems	**<u>Assessment Plan</u>** At the time of the Monitoring Team's most recent review, the following criteria for Priority Assignment was used to schedule Augmentative Communication Assessments: • Priority 1 - individuals newly admitted to the Facility, and individuals with a PBSP and/or autism that did not speak; • Priority 2 – individuals without a PBSP and/or autism that did not speak; • Priority 3 – individuals with a PBSP and/or autism who speak; and • Priority 4 – individuals without a PBSP and/or autism who speak.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>involving behavioral supports or interventions.</td><td>The priorities had been re-ordered since the last review. Priority 1 had been expanded to include individuals with a PBSP and/or autism that did not speak. Priority 2 individuals had previously been identified as Priority 3. The Facility presented the following data for the completion of individuals' SL/communication assessments within the current priority levels:

<table>
<tr><th>Priority Level</th><th>Number of Completed Assessments</th><th>Number of Individuals</th><th>Percentage Complete</th></tr>
<tr><td>1</td><td>122</td><td>122</td><td>100%</td></tr>
<tr><td>2</td><td>91</td><td>94</td><td>97%</td></tr>
<tr><td>3</td><td>30</td><td>66</td><td>45%</td></tr>
<tr><td>4</td><td>7</td><td>41</td><td>17%</td></tr>
<tr><td>TOTAL</td><td>250</td><td>323</td><td>77%</td></tr>
</table>

<u>New Admissions</u>
Since the Monitoring Team's last review, no individuals had been admitted to AUSSLC.

<u>Communication Assessment</u>
A Speech Language comprehensive assessment should include the following essential components:
▪ Signature and date by the clinician upon completion of the written report;
▪ Date showing it was completed at least 10 working days prior to the annual ISP;
▪ Diagnoses and relevance of impact on communication;
▪ Individual preferences, strengths, and needs;
▪ Medical history and relevance to communication;
▪ Medications and side effects relevant to communication;
▪ Documentation of how the individual's communication abilities impact his/her risk levels;
▪ Description of verbal and nonverbal skills with examples of how the individual utilizes these skills in a functional manner throughout the day;
▪ Evidence of observations by SLPs in the individual's natural environments (e.g., day program, home, work);
▪ Evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who do not communicate verbally;
▪ Discussion of the expansion of the individual's current abilities;
▪ Discussion of the individual's potential to develop new communication skills;
▪ Effectiveness of current supports, including monitoring findings;
▪ A description of the individual's AAC needs, including clear clinical justification and rationale as to whether the individual would benefit from an AAC</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		device/system; ▪ Comparative analysis of health and functional status from the previous year; ▪ Comparative analysis of current communication function with previous assessments; ▪ Identification of the need for direct or indirect speech language services, as appropriate; ▪ Specific and individualized strategies to ensure consistency of implementation among various staff; ▪ Reassessment schedule; ▪ Monitoring schedule; ▪ Recommendations for direct interventions and/or skill acquisition programs, as appropriate, including the use of AAC as indicated for individuals with identified communication deficits; ▪ A recommendation regarding the individual's appropriateness for community placement; and ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Ten individuals' Speech Language comprehensive assessments (i.e., Individual #374, Individual #333, Individual #195, Individual #393, Individual #385, Individual #457, Individual #284, Individual #355, Individual #426, and Individual #409) in Sample R.1 were evaluated for the presence of these essential components: ▪ Ten of 10 individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ Eight of 10 individuals' SL assessments (i.e., Individual #374, Individual #333, Individual #195, Individual #393, Individual #284, Individual #355, Individual #409, and Individual #426) (80%) were dated as completed at least 10 working days prior to the annual ISP. Individual #457 did not have an ISP submitted. Consequently, it could not be determined if his SL assessment was completed at least 10 working days prior to the annual ISP. Individual #385's SL assessment was not completed at least 10 working days prior to the ISP. ▪ Ten of 10 individuals' SL assessments (100%) included diagnoses and relevance of impact on communication; ▪ Ten of 10 individuals' SL assessments (100%) included individual preferences, strengths, and needs; ▪ Five of 10 individuals' SL assessments (i.e., Individual #374, Individual #333, Individual #195, Individual #393, and Individual #284) (50%) included medical history and relevance to communication; ▪ None of 10 individuals' SL assessments (0%) listed medications and discussed side effects relevant to communication; ▪ Ten of 10 individuals' SL assessments (100%) provided documentation of how	

#	Provision	Assessment of Status	Compliance
		the individual's communication abilities impacted his/her risk levels; ▪ Ten of 10 individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Two of 10 individuals' SL assessments (i.e., Individual #195 and Individual #426) (20%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ None of 10 individuals' SL assessments (0%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; ▪ Ten of 10 individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities; ▪ Ten of 10 individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills; ▪ Nine of 10 individuals' SL assessments (i.e., Individual #374, Individual #333, Individual #195, Individual #393, Individual #385, Individual #457, Individual #284, Individual #355, and Individual #426) (90%) included the effectiveness of current supports, including monitoring findings; ▪ Ten of the 10 individuals' SL assessments (100%) assessed AAC needs, including clear clinical justification and rationale as to whether the individual would benefit from AAC; ▪ None of 10 individuals' SL assessments (0%) offered a comparative analysis of health and functional status from the previous year; ▪ Seven of 10 individuals' SL assessments (i.e., Individual #374, Individual #333, Individual #195, Individual #393, Individual #385, Individual #457, and Individual #284) (70%) gave a comparative analysis of current communication function with previous assessments; ▪ Ten of 10 individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ Ten of 10 individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Ten of 10 individuals' SL assessments (100%) had a reassessment schedule; ▪ One of the 10 individuals' SL assessments (i.e., Individual #195) (10%) supplied a monitoring schedule; ▪ Ten of 10 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC devices/systems, as indicated for individuals with identified communication deficits; ▪ Ten of 10 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition; and	

#	Provision	Assessment of Status	Compliance
		▪ Ten of the 10 individuals' SL assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. Individuals' SL assessments were significantly improved from the last review. However, the assessments were missing some essential components as noted above. Consequently, these assessments were not yet adequate. The SLPs should consider the essential components that were not present in these assessments when completing assessments to ensure assessments are comprehensive as required by the Settlement Agreement. The Facility had developed an assessment audit tool, but the tool had not been implemented. The Facility should expand the assessment audit tool to incorporate the essential components. **SLP and Psychology Collaboration** Based on review of eight individuals' records in Sample #R.3 with Positive Behavior Support Plans (i.e., Individual #179, Individual #344, Individual #210, Individual #73, Individual #11, Individual #16, Individual #14, and Individual #183), the following was noted: ▪ Four of eight communication assessments and PBSPs reviewed (i.e., Individual #183, Individual #210, Individual #179, and Individual #344) (50%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Four of eight communication assessments reviewed (50%) contained evidence of review of the PBSP by the SLP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 5/8/12 to 9/17/12, participation by a SLP was noted in 14 of the 15 meetings (93%). In summary, progress had been made with individuals' SL assessments. Additional work needed to be done to ensure the assessments included essential components. Although some individuals' SL assessments and PBSPs indicated collaboration between the SLP and psychologist, this was not consistent in the records reviewed.	
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	**Integration of Communication in the ISP** Based on review of the ISPs for 10 individuals in Sample R.4 who had AAC devices (i.e., Individual #426, Individual #179, Individual #284, Individual #355, Individual #270, Individual #344, Individual #374, Individual #333, Individual #409, and Individual #406), the following was noted: ▪ In six of 10 ISPs reviewed for individuals with communication needs (i.e., Individual #374, Individual #333, Individual #355, Individual #426, Individual #409, and Individual #270) (60%), an SLP attended the annual meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
	communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	▪ In none of 10 ISPs reviewed (0%), the type of AAC device/system and/or communication supports (i.e., might include, but not be limited to, the Communication Dictionary and strategies for staff use) was identified. ▪ Communication Dictionaries for none of the 10 individuals (0%) were reviewed at least annually by the IDT as evidenced in the ISP. ▪ None of 10 ISPs reviewed (0%) included a description of how the individual communicated, including the AAC system. ▪ None of 10 ISPs reviewed (0%) included how communication interventions were to be integrated into the individuals' daily routines. ▪ None of 10 ISPs reviewed (0%) contained skill acquisition programs to promote functional communication in the use of their AAC systems. The integration of communication supports and services in an individual's ISP should be a major focus. The SLPs for individuals within this sample had developed and included documentation in individuals' records of communication dictionaries, communication strategies, as well as staff instructions for individual's AAC devices. Unfortunately, the individuals' ISPs reviewed did not adequately describe how these devices would be integrated in the individuals' daily routines. To ensure adequate implementation of such devices and strategies, the individuals' ISPs should include: attendance by a SLP for individuals with communication needs unless the team provides adequate justification; the type of AAC device/system and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of the communication dictionary and description of necessary changes, as appropriate; a description of how the individual communicates including the AAC system, if they have one; how communication interventions will be integrated into the individual's daily routine; and development and implementation of skill acquisition programs to promote functional communication in the use of AAC systems. **<u>Individual-Specific AAC Systems</u>** A member of the Monitoring Team and the Director of Habilitation Therapies conducted observations in residences (i.e., 782, 779-F, and 732-P) and workshops (i.e., 503 and 544) for five individuals with AAC systems (i.e., i.e., Individual #406, Individual #457, Individual #393, Individual #426, and Individual #385). Findings included the following: ▪ AAC systems for three of the five individuals (i.e., Individual #406, Individual #426, and Individual #393) (60%) were present. ▪ AAC systems for none of five individuals (0%) were noted to be in use. ▪ For five of five individuals with AAC systems (100%), staff instructions/skill acquisition plans related to the AAC system were available. ▪ Five of five individuals' AAC systems (100%) were portable and functional. **<u>General-Use AAC Devices</u>**	

#	Provision	Assessment of Status	Compliance
		The Facility indicated the intent of all common area devices was to promote communication skills and encourage incidental learning in the context of daily living activities. The Facility provided a communication equipment list that identified shared AAC devices that included the location and type of device. The Monitoring Team observed the presence of general-use AAC devices during observations of the five individuals in their residences and workshops. These devices included staff instructions. However, the Monitoring Team did not observe staff and/or individuals utilizing these generic devices. **Direct Communication Interventions** At the time of the review, four individuals received direct speech interventions. Direct communication-related intervention plans and supporting documentation (i.e., progress notes) for four individuals in Sample R.2 who received direct speech services (i.e., Individual #406, Individual #426, Individual #195, and Individual #393) were reviewed. Individual #393 was discharged from direct therapy on 9/28/12. The direct therapy plans included functional and measureable long and short-term goals and included methodologies. Comprehensive progress notes related to communication interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal; ▪ A description of the benefit of the device and/or goal to the individual; ▪ A report regarding the consistency of implementation; and ▪ Recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. For four of four individuals (100%), documentation of the SLP's review of communication interventions was comprehensive. The progress notes reviewed for the past six months did incorporate the essential components outlined above. **Indirect Communication Supports** Individuals with AAC devices in Sample R.4 had indirect communication supports/programs designed to assist the individuals and/or staff in using the AAC device or to enhance their skills in utilizing the AAC system. Staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. For such indirect supports, the SLPs monthly documentation should: ▪ Provide information regarding whether the individual showed progress with the stated goal(s); ▪ Describe the benefit of device and/or program for the individual(s); ▪ Identify whether or not implementation is consistent; and ▪ Identify recommendations/revisions to the program as indicated in reference to	

#	Provision	Assessment of Status	Compliance
		the individual's progress or lack of progress. However, no monthly progress notes were provided to report on the effectiveness review/monitoring of the individuals' progress with indirect SL supports. **Competency-Based Training and Performance Check-offs:** Since the last review, the SLPs had developed 15 additional competency performance check-offs. The communication performance check offs were adequate to assess new employees' competencies for providing communication supports to individuals the Facility supported. Based on interview with the Director of HT, a plan was being developed to provide communication competency-based training and performance check-offs to current staff. The Self-Assessment for Section R.3 indicated that 100% of new employees from April 2012 through September 2012 achieved compliance with the following performance check-offs: basic sign language, picture communication boards, hearing aid care and use, and dry ear precautions. However, the Facility was not able to provide data for the number of new employees over the past six months and the number that had successfully completed communication competency performance check-offs. New employees were included in the number of staff that were required to complete the Lifting and Transfer and Preventing Aspiration courses. In the future, the Facility should provide the total number of new employees (N) over the number that have successfully completed communication performance check-offs (n) that would provide a compliance percentage. **Individual Specific Competency-Based Training** Based on interview with the Director of HT, individual specific competency-based training was provided for individuals at high risk as a result of changes to the PNMP or as a result of failed Compliance Monitoring checks. However, this directive was not formalized in Facility policy and/or procedure. The SLPs provided individual-specific staff competency-based training for AAC devices for four of the ten individuals in Sample R.4 (i.e., Individual #344, Individual #406, Individual #355, and Individual #426) (40%). However, the Monitoring Team was not able to discern if the total number of staff providing support to these individuals had been trained. In addition, the competency performance check-offs provided did not include staff training for all of an individual's AAC devices. For example, Individual #355 used a picture schedule, picture communication book, picture communication board, picture placemat, and shower sequence. However, staff performance check-offs were only completed for a picture schedule. The Competency Based Training Tracking Sheet tracked the individual's name, staff	

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		trained, ID number, position/title, competency trained, shift, location of training, completion date, trainer's name, and position of trainer. However, the Facility should analyze and present data that identifies the total number of staff required to complete individual-specific performance check-offs (N) and the total number of staff that successfully completed the performance check-off for each individual-specific AAC device to substantiate the provision of individual-specific training and performance check-offs.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Monitoring System** The Monitoring Team requested information in the pre-visit document request related to the Facility's monitoring systems for communication supports. The Facility used the Compliance Monitoring form to monitor communication equipment. This monitoring form had been discontinued during the last review, but was recently re-initiated. The staff positions responsible for monitoring were therapists and PNMP Coordinators. The Facility indicated the PNMP Coordinators were responsible for completing one communication monitoring per home every week. In addition, the PNMP Coordinators were to monitor individuals at high risk for challenging behavior monthly. Monitoring results were entered into the Compliance Monitoring Summary Spreadsheet to determine the percentage of staff compliance by month. The Habilitation Therapies Director and/or designee reviewed the Compliance Monitoring spreadsheet. An analysis of the monitoring data from March to September 2012 indicated staff compliance for AAC devices ranged from a low of 77% in March to a high of 100% in April, May, and September. In June, July, and August compliance was reported at better than 92%. The analysis stated that high compliance scores suggested that some needs for corrective action might not have been identified due to misunderstanding of monitoring requirements by monitors. The need for re-training and full implementation of inter-rater reliability checks was identified. In addition, the data indicated that all documentation was not submitted per the established timeline as a result of a misunderstanding of the monitoring schedule requirements by monitors and staff shortages. This resulted in a limited sample size for some months. In addition, a review of the spreadsheet found inconsistencies in data entry, which required re-training of data entry personnel. Finally, the review of the data indicated the need for more frequent review and analysis of data to ensure increased accuracy of data, targeted training of staff, and improved services to individuals. The Monitoring Team's interview with the Director of Habilitation Therapies and review of the analysis of monitoring data underscored the need for the development and implementation of a local Facility monitoring policy for communication devices. The Facility should develop a policy and/or procedures to include the following essential components:	Noncompliance

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		▪ Monitoring for the presence of communication adaptive equipment or other AAC supports/materials; ▪ Monitoring for the working condition of communication adaptive equipment; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work); ▪ The frequency of monitoring; ▪ The process for identification, training, and validation for monitors; ▪ The process of inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). Compliance Monitoring forms for communication the last six months for 10 individuals in Sample R.4 were reviewed and the following was found: ▪ A review of these individuals' monitoring results did not indicate any established frequency for monitoring individuals' communication devices. The frequency of monitoring over the past six months was as follows: Individual #344 - 21 times, Individual #374 – five times, Individual #333 – one time, Individual #406 – five times, Individual #355 – 15 times, and Individual #270 – one time. Four individuals within this sample (i.e., Individual #426, Individual #179, Individual #284, and Individual #409) were not monitored. ▪ Six of 10 individuals' devices (i.e., Individual #344, Individual #374, Individual #333, Individual #406, Individual #355, and Individual #270) (60%) were monitored for the presence of their communication system. However, the frequency of monitoring was not adequate. ▪ Six of the 10 individuals' devices (60%) were monitored for whether or not their communication system was in working order. ▪ Two of the 10 individuals' devices (i.e., Individual #344 and Individual #355) (20%) were monitored for use in a variety of environments. The primary concern was that individuals' devices had not been monitored for the preceding essential components. This was problematic. In addition, the Facility had identified that the data it was collecting likely was not reliable.	

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

1. The Facility should continue to recruit SLPs to provide an adequate number of SLP with specialized education and experience. (Section R.1)
2. The Facility should complete an analysis to determine an appropriate caseload for SLPs at AUSSLC, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. (Section R.1)
3. The Facility should develop and implement a local Communication Services policy and/or procedure and incorporate the following essential components:

a. Roles and responsibilities of the SLPs (e.g., meeting attendance, staff training etc.);
b. An outline of the assessment schedule;
c. Frequency of assessments/updates;
d. Timelines for completion of new admission assessments (i.e., within 30 days of admission or readmission);
e. Timelines for completion of comprehensive assessments (i.e., within 30 days of identification via screening);
f. Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (i.e., within five days of identification as indicated by the IDT);
g. A process for effectiveness monitoring by the SLP;
h. Criteria for providing an update (i.e., Assessment of Current Status) versus a Comprehensive Assessment;
i. Methods of tracking progress and documentation standards related to intervention plans; and
j. Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. (Section R.1)

4. The Facility should review the revised SL assessment template and content guidelines to ensure the essential components for SL comprehensive assessments are addressed. The SLPs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the SL audits should assess these elements. (Section R.2)
5. The Facility should ensure communication assessments and PBSPs address the connection between the PBSP and the recommendations contained in the communication assessment, as well as contain evidence of review of the PBSP by the SLP. (Section R.2)
6. Individuals' ISPs should include: attendance by a SLP for individuals with communication needs unless the team provides adequate justification; the type of AAC device/system and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of communication dictionary, and identification of necessary changes as appropriate; a description of how the individual communicates, including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine. (Section R.3)
7. The Facility should ensure comprehensive progress notes related to communication interventions for indirect supports. Such notes should:
    a. Contain information regarding whether the individual showed progress with the stated goal;
    b. Describe the benefit of device and/or goal to the individual;
    c. Report on whether there is consistency in implementation; and
    d. Identify recommendations/revisions to the communication intervention plan, as indicated, related to the individual's progress or lack of progress. (Section R.3)
8. The Facility's monitoring policy for communication devices should include:
    a. Monitoring for the use of communication adaptive equipment in multiple environments (i.e., home, day program, work);
    b. The process for identification, training, and validation for monitors;
    c. The process to establish inter-rater reliability; and
    d. A process for data trend analysis and utilization of findings to drive training and problem resolution (i.e., individual and systemic). (Section R.4)
9. The Facility's monitoring reports should address, at a minimum, the following indicators:
    a. Compliance with established monitoring frequency;
    b. Equipment presence;
    c. Equipment in working order;
    d. Equipment used in various environments; and
    e. In the case a problem was identified, there was evidence of resolution. (Section R.4)

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation of Section S at the entrance meeting, on 11/5/12; o Presentation Book for Section S; o State Policy 004.1: Individual Support Plan Process, revised 2/8/12; o Draft State Policy 017: Habilitation, Training, Education, and Skill Acquisition Programs, dated 2/2/12; o Active Treatment Consultant Summary, dated 8/15/12; o Engagement Observation and Monitoring Tool Instructions, dated 10/10/12; o Engagement Observation and Monitoring Tool, dated 10/10/12; o Table of Training on Skill Acquisition Plans; o Individual Support Plans for: Individual #273, Individual #175, Individual #210, Individual #369, Individual #160, Individual #184, Individual #154, Individual #263, Individual #325, Individual #450, Individual #213, Individual #146, Individual #357, Individual #435, Individual #319, Individual #123, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #140, Individual #318, Individual #141, Individual #220, Individual #4, Individual #291, Individual #33, Individual #75, Individual #389, Individual #7, Individual #360, Individual #341, Individual #444, Individual #376, Individual #56, Individual #98, Individual #280, Individual #382, Individual #327, and Individual #73; o Skill Acquisition Plans (SAPs) for: Individual #273, Individual #175, Individual #210, Individual #369, Individual #160, Individual #184, Individual #154, Individual #325, Individual #450, Individual #213, Individual #246, Individual #146, Individual #319, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #140, Individual #318, Individual #141, Individual #220, Individual #4, Individual #291, Individual #33, Individual #75, Individual #389, Individual #202, Individual #7, Individual #360, Individual #341, Individual #444, Individual #56, Individual #98, Individual #280, Individual #382, Individual #327, and Individual #73; o Monthly Reviews for: Individual #273, Individual #175, Individual #210, Individual #160, Individual #184, Individual #154, Individual #263, Individual #325, Individual #450, Individual #213, Individual #246, Individual #146, Individual #357, Individual #435, Individual #319, Individual #123, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #318, Individual #141, Individual #220, Individual #4, Individual #33, Individual #75, Individual #389, Individual #202, Individual #360, Individual #341, Individual #444, Individual #376, Individual #56, Individual #98, Individual #280, Individual #382, Individual #327, and Individual #73; o List of Orientation and Mobility Evaluations 2012; o Orientation and Mobility Evaluations for: Individual #369 (3/12), Individual #445 (3/12),

	and Individual #294 (4/12); o ISP Addendum Meeting minutes from 10/15/12 for Individual #327; o Functional Skills Assessments (FSA) for: Individual #273, Individual #175, Individual #210, Individual #369, Individual #160, Individual #184, Individual #154, Individual #263, Individual #325, Individual #450, Individual #213, Individual #146, Individual #357, Individual #435, Individual #319, Individual #123, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #140, Individual #318, Individual #141, Individual #220, Individual #4, Individual #291, Individual #33, Individual #75, Individual #389, Individual #83, Individual #202, Individual #7, Individual #360, Individual #341, Individual #444, Individual #376, Individual #56, Individual #98, Individual #280, Individual #382, Individual #327, and Individual #73; and o Vocational Assessments for: Individual #273, Individual #175, Individual #210, Individual #369, Individual #160, Individual #184, Individual #154, Individual #263, Individual #325, Individual #213, Individual #146, Individual #335, Individual #101, Individual #283, Individual #16, Individual #133, Individual #141, Individual #291, Individual #33, Individual #75, Individual #389, Individual #7, Individual #360, Individual #444, Individual #98, and Individual #382. ▪ **Interviews with**: o Group of Direct Support Professionals, on 11/5/12; and o Holly Lindsey, Director of QDDP Services; Sarah Knowles, Director of Education and Training; Keith Robinson, QDDP Educator; and Derrick Bunton, Director of Residential Services, on 11/7/12. ▪ **Observations of**: o Residence 729, Residence 732-Dove, Residence 732-Eagle, Residence 732-Phoenix, Residence 779-Falcon, Residence 779- Hummingbird, Residence 779-Roadrunner, Residence 781, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797; o Workshop 503, Workshop 527, Workshop 544, and Workshop 779; o Day Habilitation Center 510, Day Habilitation Center 512, Day Habilitation Center 532, and Day Habilitation Center 533; o Computer Lab; o ISP Preparation meeting for Individual #6, on 11/6/12; o Pre-Treatment Sedation Committee meeting, on 11/7/12; and o QA/QI Council meeting, on 11/8/12.
	Facility Self-Assessment: The Facility provided the Monitoring Team with a document outlining self-assessment activities. Activities identified in each section are reviewed below. • Section S.1: As noted by the Facility, consultants had reviewed Skill Acquisition Plans, but a formal monitoring tool was not employed and written feedback was not provided. The Department of Education and Training sampled 16 ISPs in September using a rubric to assess skill plans. They determined 86% of the sample met the guidelines for plan components. It was unclear how many

	skill acquisition plans were reviewed, the degree to which specific plan components were adequately addressed, and inter-rater reliability was not reported. The Facility also referenced reports from the database regarding engagement scores, but the number of engagement measures, the number of program sites, and the program monitors were not identified. The Facility noted concerns about the reliability of the data. • Section S.2: The Facility reported that consultants and the QDDP Educator had reviewed samples of Functional Skill Assessments, but the sample size was not reported. Further, the Facility acknowledged that a monitoring tool was not employed. Other assessments were not reviewed for compliance. Lastly, the Facility acknowledged continued concerns regarding the database. • Section S.3.a: The Facility reviewed attendance at vocational and day programming sites in August and September. An average percentage was reported. Teams met for 55 of 98 individuals who were identified as having low attendance in either the morning or afternoon program. Low attendance was not defined, guidelines for determining the necessity of a meeting were not provided, and actions plans were not described. No measures were collected on skill acquisition training implementation and/or data recording. • Section S.3.b: The Facility reported on the average number of trips made to the community by individuals. However, there was no mechanism in place for tracking training activities in the community. ▪ The Facility rated itself as out of compliance with all subsections of Section S. This was consistent with the findings of the Monitoring Team. ▪ The Facility identified areas of deficiency in all subsections of Section S, but did not indicate if action plans were in place to address these deficiencies.
	Summary of Monitor's Assessment: Several promising developments were introduced during the week of the onsite review. The Facility was holding meetings three months prior to the Individual Support Plan meeting to ensure that all needed assessments were identified and scheduled for completion. Active Treatment Coordinators had been trained to competency in completing the Functional Skills Assessments, and they had received side-by-side training from consultants in developing and writing Skill Acquisition Plans. The Facility had developed individual activity cards to serve as a quick reference to the individual's preferences and special considerations. Skill Engagement Specialists had been introduced to help facilitate a greater range of activities in the home, on campus, and off campus. Each of the three units was assigned two specialists whose schedules of 11:00 a.m. to 7:00 p.m. allowed for assistance and support across two shifts. The workshops had adjusted their hours of operation to better accommodate the needs and schedules of the individuals served. Three new positions had been added to habilitation services. These included one Job Procurement Specialist whose responsibilities included expanding the contract work available on campus and two Community Coordinators to help facilitate involvement in community-based activities. Plans were underway to develop cooking classes, a literacy program, and training in using community-based transportation services. Although steps had been taken to improve the habilitation services offered to the individuals at AUSSLC, problems remained related to comprehensive assessment and program planning, skill acquisition plan development and implementation, and integration in the community environment. The Monitoring Team

	found the Facility out of compliance with all provisions of Section S.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the Monitoring Team's onsite visit, the census of AUSSLC was 321. For Section S, the records of 44 individuals representing a sample size of 14% were requested for review. Documents requested included the following: Individual Support Plan, Preference and Strength Inventory, Functional Skills Assessment, Vocational Assessment, Skill Acquisition Plans, and Monthly Reviews. A total of 42 Individual Support Plans were reviewed. Three of these plans, although all dated between 6/12 and 8/12, employed the older format, the Personal Support Plan. (Missing from the documents provided were the ISPs for Individual #83 and Individual #202.) Below is a summary of the findings from the review: ▪ All 42 ISPs (100%) were dated and all were within the current year. ▪ All 42 ISPs (100%) included information regarding the individual's preferences. ▪ Thirty-eight of the 42 ISPs (90%) included information regarding the individual's strengths. The degree to which this information provided a comprehensive introduction to the individual varied across plans. Examples where it appeared that the team made an effort to clearly outline the individual's preferences and strengths included the plans for Individual #450, Individual #435, Individual #123, Individual #16, Individual #75, and Individual #98. Conversely, this information was very limited in the plans for Individual #146, Individual #133, and Individual #291. The plans for Individual #160 and Individual #263 noted their preferences only. In order to begin to develop a good profile of the individual, the Facility should develop a comprehensive outline of his/her preferences and strengths. ▪ Thirty of the 42 ISPs (71%) included the integrated risk rating form. (The plan for Individual #146 did not address all risk areas, therefore his plan was not included in this count.) For 29 of these individuals, challenging behavior was rated as either a medium or high risk. However, for eight of these individuals, the information related to challenging behavior was missing or incomplete. ▪ Thirty-six of the 42 ISPs (86%) included training objectives to be implemented at the Facility. Four of the ISPs provided to the Monitoring Team did not include objectives, the objectives page for Individual #369 was blank, and the ISP for Individual #123 only identified training objectives to be implemented at school. ▪ The number of training objectives ranged between one and eight per individual. Specific concerns are noted below: o At least three individuals had expressed an interest in cooking, but none had training objectives to address this interest. o Individual #184 had expressed an interest in learning new arts and	Noncompliance

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		crafts activities, but this was not included in training. o Two of the eight training objectives for Individual #146 indicated he was to learn to identify primary colors and basic shapes. It was unclear how these skills would increase this 55-year-old man's independence or quality of life. If the team had some future goal in mind, it was not articulated. o One of four training objectives for Individual #283 addressed his learning to send e-mail. However, his Functional Skills Assessment suggested that he already demonstrated this skill. o Two of the six training objectives for Individual #341 addressed staff behavior. o As noted above, Individual #123 had no training objectives to be implemented at the Facility, although it was noted that her behavior worsened during holidays and school vacations. ▪ The majority of goals identified for an individual were stated in observable and measurable terms in nine of the 42 ISPs (21%). ▪ Only four of the 42 ISPs (10%) included a goal that was specifically designed for training to occur in the community. ▪ Individual-specific positive indicators included the following: o An interpreter was present during the ISP meeting for Individual #210. o The Orientation and Mobility consultant had worked with Individual #369. Included in his ISP were some good recommendations based on this consult. o Data was referenced when discussing challenging behavior in the ISP for Individual #123. o The ISP for Individual #444 included good information in the risk assessment of challenging behavior. The Facility was beginning to hold ISP Preparation meetings during which staff were to review the individual's preferences and strengths, identify needed assessments, and note team members required to attend the ISP meeting. As staff prepare for the ISP, they should ensure the following: a) comprehensive and specific listing of strengths and preferences; b) assessments completed in full with recommendations for habilitation based on assessment outcome; c) comprehensive risk rating assessment; d) identification of objectives designed to address the individual's preferences and assessed needs; and e) to the extent possible, training that occurs in the most integrated setting. Staff are encouraged to consider possibilities beyond what has been accepted practice at the Facility. Teams should continue to explore greater use of the facilities on campus (e.g., the computer lab), as well as accessing opportunities off campus for leisure, educational, and vocational skill development.	

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		Skill Acquisition Plans were reviewed for 38 individuals in the sample. This resulted in a review of 127 SAPs with one to six SAPs per individual. The information contained in these SAPs included the following: objective, operational definition, rationale/goal, source of SAP, training location on and off Facility, schedule of training, materials, special instructions, teaching technique, specific consequences for correct responding, specific consequences for incorrect responding, staff responsible for training, staff responsible for data collection, data/documentation instructions, task analysis, plan for maintenance, plan for generalization, plan for training/impact in community, and program monitor. The results of the Monitoring Team's review of the 127 SAPs is provided below: ▪ A behavioral objective was found in 31 of the 127 SAPs (24%). Conditions under which the behavior was to occur, identification of the behavior in observable and measurable terms, and clear criteria for determining skill acquisition were often missing from the stated objective ▪ Under teaching technique, a specific training methodology was identified in 98 of the SAPs (77%). Sixty-six of 127 programs (52%) identified a forward chain, 28 of 127 programs (22%) identified a total task strategy, and two programs each identified a backward chain (2%) or shaping (2%). Several programs that identified chaining as the teaching technique actually addressed skills that were not behavioral chains. Examples included the naming coins objective for Individual #273. The two steps suggested he would first name four different coins after staff provided the label, and then he would label coins without this model. Similarly, this individual was to learn to match white and colored clothing. Here too, the task required discrimination skills, but it was not a behavior chain. When chaining techniques were appropriately identified, the program suggested the individual would be expected to perform only identified steps of the chain. Chaining techniques allow one to learn complex skills as smooth routines, with each link in the chain serving as the discriminative stimulus for the next link in the chain. These chains should be taught in sequence with fading of prompts determined by the type of chaining technique chosen for instruction. As these SAPs were written, it was unclear how and when the steps in the sequence were to be taught. It was also unclear what criteria were used to determine progress to the next step in the chain. ▪ Where appropriate, a task analysis was provided in 65 of 94 SAPs (69%). ▪ One hundred seventeen of 127 SAPs (92%) included an identified schedule for training. The 10 remaining programs either did not specify training, or used vague descriptors, such as in the morning or evening, at every opportunity, anytime in the community, or at a vending machine. Of the 117 SAPs with specified schedules of training, 62 (53%) indicated training would occur five to seven times each week, 52 (44%) indicated training would occur one to three times per week, and three (3%) indicated training would occur one to two times each month. Only 12 of the 117 SAPs (10%) with identified schedules specified	

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		more than one training opportunity on training days. Unless there are multiple opportunities for an individual to learn a new skill, progress will likely be very slow. Schedules should be developed to ensure that individuals have multiple opportunities to learn and practice new skills. ▪ Eighty-four of the 127 SAPs (66%) identified praise alone as the reinforcer for correct responding. Thirty-seven of the remaining 43 SAPs identified praise and access to an activity or item, or additional physical feedback (e.g., a pat on the back, a hand rub) as the reinforcer. While the item purchased was not clearly identified as a consequence for correct responding in some purchasing programs, it was implied. Staff should clearly state this in the SAP. As noted previously, reinforcers used to teach new skills should be specific to the individual and are best identified through careful preference assessment, particularly for individuals for whom potent preferences are not readily apparent. ▪ While all of the SAPs (100%) included instructions regarding actions staff should take following incorrect responding, these were not always clear or specific to the situation. Some plans suggested that increased levels of assistance should be employed (e.g., the program for Individual #325 who was learning to clear his place after meals). Others suggested that the individual be given some time and then staff should repeat the instruction (e.g., the exercise program for Individual #213). Staff were instructed to provide "encouragement" to Individual #101 if he failed to respond correctly during his work programs. In some cases, the consequence for incorrect responding was the same as that for correct responding (e.g., the program designed to teach Individual #319 to hit a balloon used praise in both situations, Individual #444 was to be praised whether or not he allowed staff to brush his teeth). Staff should design error correction procedures that are individualized and that will result in improved skill development for the individual. ▪ Only one SAP (1%) clearly identified training in the community. This was the purchasing program for Individual #75. While other programs suggested that training could occur in the community, on campus was also listed as an acceptable location (e.g., the counting change program for Individual #160). ▪ Fifty-eight of the 127 SAPs (46%) included appropriate plans for maintenance and generalization of the newly learned skill. A good generalization plan was included in the adaptive switch program for Individual #73. The plan was to teach him to use a switch to turn on music with generalization to other leisure activities. Similarly, Individual #291 was learning to sign in upon his arrival to work. His generalization plan outlined his extending this skill to the computer lab and appointments on and off campus. An example of a poor plan for generalization was found in the following SAP: Individual #146 was to "start working on scheduled objectives," once he learned to wash his hands. Staff are	

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		encouraged to consider the design of generalization plans that will clearly expand the individual's ability to use newly learned skills across different settings, with different materials, or in the presence of different individuals. Generalization planning also could describe using the newly learned skill as a basis for more complex and independent skills. Examples of individual specific programs are provided below to illustrate issues identified: ▪ As each step in a behavior chain serves as a discriminative stimulus for the next step in the chain, staff should refrain from providing verbal instructions for each step. The individual should learn to perform the chain seamlessly, with each step occurring in response to the previous step. Verbal instructions throughout might cause the individual to become reliant on staff instructions versus the discriminative stimulus provided by the steps of the chain. The washing clothing SAP for Individual #75 provided an example of this problem. ▪ Staff are also cautioned to avoid grouping very different behaviors in one SAP. For example, Individual #56 had a purchasing program that included one step in which he was to hand money to a cashier or put coins in a machine. These are two very different means of making a purchase, and as such, two separate SAPs with clear instructions would be more appropriate. Similarly, Individual #33 was learning to shave her chin and legs. It might be most helpful to staff conducting the training if a clear task analysis was written for each of these different self-care activities. Similarly, Individual #7 had one objective that addressed his learning to count the numbers one to 10 and add combinations of the numbers one 10. These are very different skills. Finally, one self-care SAP for Individual #202 included his learning to brush his teeth and take a shower. While eventually a self-care routine could be taught that involved many different skills, the plan as written provided no clear guidelines for the order in which these activities were to be completed (in fact, he was to choose the order each time the task was trained) or the steps involved in completing these skills. ▪ The medication administration SAP for Individual #280 included some thoughtful instructions from the orientation and mobility specialist in the teaching technique. The staff should ensure that the results of these consultations are incorporated into the teaching plans for all identified individuals. ▪ In the hair brushing SAP for Individual #280, it appeared that she was learning to brush a staff member's hair. Efforts should be made to ensure that the skill is relevant and functional to the individual. ▪ SAPs should provide sufficient information so that staff do not need to identify materials that are appropriate to the task. For example, Individual #33 was to learn to choose a healthy snack. The needed materials were identified as "snack	

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		items both healthy and fatty." It would be helpful if the Facility's Dietician provided a list of healthy and unhealthy snacks. Similarly, Individual #291 was to learn to purchase a healthy meal, but there was no indication what foods were healthy for this individual. ▪ Staff should be sure to write the task analysis with sufficient clarity so that all staff conduct the training in the same order. For example, in the task analysis included in the hair brushing SAP for Individual #4, the last step in the chain read: "(individual) will stroke her hair with brush." As brushing hair usually involves multiple strokes, you want to ensure that staff teach the individual to complete the chain in full. ▪ When writing SAPs, staff should consider the typical method for completing work in our culture. Students learn to read from left to right and usually this generalizes to other tasks. Individual #33 was learning to tally her work totals. The teaching technique guided staff to require her to add her work from right to left, noting that she will attempt to complete this task in the opposite order. As this individual might have been exposed to reading instruction when younger, it would appear that she should be encouraged to follow this standard approach to work completion. ▪ Staff should ensure that the discriminative stimulus for all SAPs are individualized and relevant to the task. Individual #175 had four SAPs that addressed her learning to make a smoothie, save her money, tell time, and transfer from her wheelchair to her walker. In every case, the discriminative stimulus or instructional cue was "Obtain materials." This was clearly not relevant to some of these tasks. ▪ Individual #210 had a SAP designed to result in his work attendance at least 14 days per month. However, the plan included no guidelines for motivating this individual to go to work. As noted in past reports, SAPs should include the following: a) a behavioral objective that include the conditions under which the behavior is to occur, description of the behavior in observable and measurable terms, and criteria for determining skill acquisition; b) clear listing or identification of necessary materials; c) teaching guidelines that are clear, comprehensive, and relevant to the identified skill; d) training schedules, including number of trials per training opportunity, that ensure sufficient opportunities for learning to occur; e) guidelines for the application of individually identified reinforcers following correct responding; f) guidelines for individually designed error correction procedures; and g) plans to ensure maintenance and generalization of newly acquired skills. The Facility is commended for the training it provided to Active Treatment Program Coordinators, QDDP staff, and day programming, and vocational staff. As the Facility	

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		reported, consultants worked directly with staff between 4/12 and 10/12 to improve their skills in developing and implementing SAPs. Additionally, Active Treatment Coordinators received training in completing assessments and developing recommendations based on these assessments. Training included didactic instruction and side-by-side training and technical assistance. As staff put these newly trained skills into practice, ongoing monitoring and assistance is recommended. Continued use of the SMART (specific/measurable/achievable or attainable/relevant/time-bound) tool should help ensure that SAPs are written clearly and completely. The addition of an integrity check to each SAP should help ensure that teaching is occurring as designed and scheduled. For the positions becoming available in habilitation and training services, the State and Facility should consider recruiting individuals who have training and experience in the design and delivery of special education services. As the documents provided to the Monitoring Team included data sheets related to both the older Specific Program Objective format and the new SAP format, an analysis of data sheets will be delayed until the next visit when the new format is more fully implemented. Instead, the Monitoring Team reviewed the Monthly Review reports for 39 of the individuals in the sample. Individual #83 and Individual #7 were not included in this analysis because in the documents provided to the Monitoring Team, the Facility indicated that: "QDDP progress notes not available," or "no monthly reviews" respectively. The Monthly Review provided a review of the following: rights, personal support team meetings, training and service objectives, behavioral services summary, psychiatry, observation notes, community programming resources, hospital admissions or visits, appointments and consults, at-risk status, evaluations, and guardianship status. Although the directions indicated that the information should be based upon a review of various documents, including data sheets, actual data on training objectives was reported in for only 12 of the 39 individuals (31%). When reported, the data outlined the number of trials completed in the month on which acquisition criteria were met. For three of the 38 individuals (8%) who had a behavior support plan, data regarding problem behavior was reported. Concerns regarding specific individuals are provided below: ▪ For Individual #273, the monthly reviews from 7/12 to 9/12 noted that the psychologist needed to update the note in the individual's record, because the last one was completed in 9/11. A similar statement was included in consecutive monthly reviews for Individual #210, Individual #283, and Individual #133, with their last notes dating to 1/12. ▪ The reviews for Individual #210 suggested there were no training objectives for him. ▪ The reviews for Individual #263 indicated data was not available across three consecutive months of reporting.	

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		▪ Individual #213 had six identified training objectives. For three of these, the review noted there was insufficient data. Two of the six objectives were not implemented due to the absence of necessary equipment (i.e., a specialized phone). The monthly reviews for 9/12 and 10/12 were "not done." There was no further explanation. ▪ Similarly, three monthly reviews for Individual #220 noted that there was not enough data for three of four training objectives. ▪ Consecutive monthly reviews for Individual #101 suggested his SAPs were being "tracked and trended." Review of progress should be based upon objective measures of the individual's performance on identified SAPs. It will be essential to correct errors in data collection and problems with program implementation in a timely manner. Action plans should be recommended with responsible staff members and due dates identified. 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 is commended for their continued work with consultants trained in the provision of orientation and mobility services to individuals with visual impairment. According to the documentation provided, a total of 79 individuals had received orientation and mobility evaluations in 2012. The video presented at the entrance meeting demonstrated the positive effects this consultation had had for Individual #280. A review of evaluations for Individual #369, Individual #445, and Individual #294 reflected thoughtful recommendations for staff to follow when working with these individuals. A protocol for disseminating this information would be helpful. The Monitoring Team was informed that efforts were underway to respond to an individual's repeated refusals to attend workshop or day habilitation programming. In an effort to understand these efforts, a request was made for the plan for Individual #327 who had repeatedly refused to attend his day habilitation site. As documented in the ISP Addendum Meeting minutes from 10/15/12, the plan consisted of the following: a) once each day, home staff were to "encourage" the individual to attend; b) a desk was to be provided at the program; c) a radio would be placed near the individual; d) home staff would be trained on their job expectations in the day habilitation setting; and e) new materials would be introduced to the individual. This plan was to be monitored, with additional meetings held if the individual's attendance did not improve. While this provided an outline of steps to take, there was no indication that the individual's	

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		preferences were going to be re-assessed. The Facility should consider situational assessments to determine the individual's interests and a structured preference assessment to determine potential reinforcers that could be used to help motivate his participation. Further, as this individual recently had been grabbed by another individual while at day habilitation, it would be appropriate to consider alternative locations for habilitation services. <u>Engagement</u> As has been the case during previous visits, the Monitoring Team conducted periodic checks of engagement while visiting the Facility. Using a Planned Activity Check (PLACHECK), the levels of engagement of individuals in the residences, day habilitation settings, and workshop areas were observed and measured. These are summarized below: ▪ A total of 31 PLACHECKS were conducted across the home environments. Engagement ranged from 0% to 100% with an average engagement score of 44%. Consistently, engagement was greater in homes with fewer individuals present and in homes where the individuals experienced greater independence. On previous visits, individuals were often observed in the late afternoon waiting for dinner. This visit, it was refreshing to visit one home only to find no one present, because the individuals were either at choir or in the computer lab. Individuals in two other homes were preparing for a football game, either as participants or as cheerleaders. It was also encouraging to observe a greater number of individuals being encouraged to participate in home activities including mealtime serving and cleanup. Upon arrival to one home, the supervisor encouraged one of the individuals to welcome the visitor and provide a tour herself. The Director of Education and Training had worked with staff in nine homes to develop individual activity cards. These included the following: a) a photo of the individual; b) a list of allergies, adaptive equipment, and special considerations as appropriate; c) a list of likes and dislikes; d) a list of preferred activities; and e) information related to the individual's behavior support plan, where applicable. This proved a good introduction to the individual and his/her preferences. ▪ A total of 12 PLACHECKS were collected across the workshop areas. The range of engagement was 50% to 100% with an average score of 84%. While it was encouraging to learn that workshop hours had been adjusted to better accommodate the schedules and needs of the individuals, the work itself remained much the same as had been observed during previous onsite reviews. With the addition of a job procurement specialist, it was anticipated that a greater variety of work would be available to individuals in the future. Again, the Facility is encouraged to ensure that workshop staff are taught to provide effective instruction and to work with consultants in designing programs to best	

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		meet the individuals' specific needs and interests. ▪ Two PLACHECKS were conducted in the day habilitation areas. Engagement scores were 38% and 50%, with a mean of 44%. There was evidence of a broader array of activities available to some individuals and on several occasions staff were observed offering choices of activities and materials to the individuals. Two visits to the computer lab revealed 100% engagement. It was encouraging to learn of the plans for developing cooking classes and a literacy program. As these plans for expanded programs move forward, staff are encouraged to consider greater use of the computer lab. Individuals who enjoy reading or math activities could be introduced to a range of programs to expand these skills. Others could learn to use the computers for other nonacademic leisure activities. Touch screens could be added for individuals who might have difficulty learning to use a mouse. As staff work to increase the variety of activities and individualized adaptations to activities to increase active engagement, it would be helpful to work with professionals who have training and experience in the provision of special education services. On 10/12/12, the tool had been revised, making it too early to determine whether it was being effectively implemented. As the Facility implements the revised Engagement Observation and Monitoring Tool, staff should use these monitoring sessions to provide ongoing training and support to direct support and other professionals. This opportunity should be used to expand and individualize activities, including in the area of vocational services, and improved teaching strategies and implementation. In summary, the Facility remained out of compliance with this provision. Although progress had been made in some important areas, the quality of a number of the components the SAPs required improvement, and implementation and assessment of progress of the SAPs as well as other active treatment/habilitation activities continued to require attention.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	The Facility had begun introducing the Preferences and Strengths Inventory (PSI) in place of the Personal Focus Assessment. (The State should review the draft policy regarding Habilitation, Training, Education, and Skill Acquisition Programs, because this continued to reference the Personal Focus Assessment.) Of the 44 individuals whose records were reviewed, 27 (61%) had a PSI on file and seven (16%) had a PFA on file. For nine of the remaining 10 individuals, the Facility indicated there was no PSI, it was not completed, or it was unavailable. For one individual there was no information provided. As noted in the State's policy regarding the Individual Support Plan Process, the PSI "… provides a basis for the development of an individualized, comprehensive array of goals, services, and supports reflecting the individual's preferences, needs, and strengths." As such, it is essential that this be completed for every individual.	Noncompliance

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		As the PSI was the document to be used going forward, an analysis was completed of this inventory only. As designed, the document guided the Team to consider a series of questions related to living options, employment activities, relationships, leisure, and independence. The Team was expected to respond to each question and indicate how the response was communicated. The second section provided a summary of the individual's preferences and strengths. Lastly, the IDT was guided to summarize the individual's goals or desires, identify barriers to attaining these, and list actions necessary to overcome any barriers. Findings are summarized below. ▪ The PSI for 23 of 27 individuals (85%) was dated. ▪ The PSI for 17 of the 27 individuals (63%) was finalized. For 10 individuals, the PSI was identified as a draft even though the date of development ranged between 2/23/12 and 9/10/12. It would seem that these inventories should have been finalized by 11/12. ▪ For all 27 individuals (100%), responses to the majority of questions were provided. ▪ For 16 of 27 individuals (59%), the IDT offered some evidence as to the manner in which the individual's preferences were determined. The PSI for Individual #318 provided an example of where the IDT tried to identify the sources of their information even though the individual had very limited communication skills. ▪ A summary of the individual's preferences and strengths was provided in 26 of the 27 inventories (96%). The quality of the summary varied across individuals. The summary for Individual #33 provided a good amount of information, while the summary for Individual #123 was very brief. The summary for Individual #263 did not correspond to the information found in the document. ▪ The analysis of desired outcomes and the related barriers and needed steps to achieve these outcomes was completed, at least in brief, in the PSI for 15 of the 27 individuals (56%). The Facility continued to employ the Functional Skills Assessment to determine an individual's strengths and needs across 13 broad 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 completed Functional Skills Assessment was reviewed for 44 individuals. A summary of the findings from this review is provided below: ▪ The assessment date was included in 42 of the 44 documents (95%). This was a significant improvement over assessments reviewed in the past. ▪ The person or persons completing the assessment was identified in 44 of 44 documents (100%). ▪ A complete summary of the individual's strengths and needs was provided in 19	

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		of the 44 assessments (43%). The assessment is only useful if a summary of the person's skills and needs is provided to help guide treatment planning. ▪ A list of specific recommendations was provided in 25 of the 44 assessments (57%). In nine of the 19 assessments where recommendations were not specifically identified, ideas for training and habilitation were noted under "Area of Need." Recommendations across all skill areas would be useful in guiding the team to develop comprehensive habilitation services at the annual meeting. Comments specific to individual assessments are provided below. ▪ Staff responsible for the completion of FSAs should ensure recommendations are based upon identified need. Individual #210 had two recommendations, yet the assessment suggested that he already displayed these skills (i.e., exercise and writing). Individual #283 had two recommendations, yet both were in areas where he had been assessed to be independent (i.e., sending e-mails and dressing skills). ▪ Staff also should ensure that recommendations are functional in nature and increase the individual's independence and quality of life. Individual #220 was a 66-year-old whose needs list included learning to point to named body parts. It was unclear how this was a skill that would enhance her independence or quality of life. The Vocational Assessment State Supported Living Center was reviewed for 26 individuals whose ISP was held in 2012. In 25 of 26 assessments (96%), the date of the report was indicated. All 26 (100%) identified the person completing the assessment, but none of the reports were signed. Only three of the 26 assessments (12%) suggested vocational exploration beyond the individual's current job responsibilities. When completed as designed, this assessment can provide a wealth of information about the individual's work history and future interests. However, the assessments reviewed indicated very little effort in exploring work other than what was currently available in the AUSSLC workshops. In no case were situational assessments suggested, even when the individual clearly indicated an interest in more varied employment. Individual specific information regarding vocational exploration is reviewed below: ▪ There was no information provided under vocational exploration for five individuals. Individual #210 clearly had expressed his disinterest in workshop employment, yet there were no recommendations provided regarding vocational exploration for this 21-year-old man. Individual #133 had indicated he would like a job in the community, but no recommendations were made for addressing this interest. Individual #360 had reported she would like to work with animals, but no plans were made for exploring such work. ▪ The assessments for five individuals noted that: "his/her work skills were observed and monitored as he/she worked at the sheltered workshop." This	

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		statement did not address further exploration even for someone such as Individual #154 who had expressed an interest in working at a hospital. ▪ For Individual #325, Individual #213, and Individual #444, vocational exploration was identified as "not applicable." Job possibilities beyond the workshop areas should always be a consideration. ▪ Two assessments (i.e., for Individual #335 and Individual #101) included the following statement: "Due to (individual's) constant need for physical and verbal assistance, he is best suited to on campus work. He should probably continue performing his current tasks." It is suggested that this was short-sighted, because there could be a number of jobs that these individuals could learn to perform beyond their current tasks. ▪ Three assessments identified some areas to explore, although plans were not always outlined. It was suggested that Individual #146 could learn to help people with their groceries at a community store, but there were no clear plans identified for pursuing this possibility. The assessment for Individual #291 noted his current involvement with Department of Assistive and Rehabilitative Services (DARS) and Goodwill Industries. Individual #33 was encouraged to explore other jobs on campus and to consider supported employment in the community. Included in the Section S Presentation Book were guidelines the Facility had developed to ensure comprehensive assessment of functional skills and vocational skills. Additionally, a Vocational Services Assessment Quality Review Tool had been developed. It was anticipated that improvements in assessment should occur when these policies are fully implemented and review mechanisms are routinely employed. However, as detailed above, assessments were not currently adequate to assist teams in consistently identifying appropriate skill acquisition programs or guiding vocational development. AUSSLC remained out of compliance with this provision.	
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	During this last onsite review, there was a noticeable improvement observed in many of the home environments. The total number of unrelated individuals living together had been reduced in several homes, there was a concerted effort to improve the maintenance	Noncompliance

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	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	of the homes (e.g., painting), and staff continued to make an effort to introduce more varied and individualized activities. Residence 787 in particular provided a very welcoming environment and nicely furnished living room upon entering the home. However, some homes remained very crowded and appeared uncomfortable. In particular, the Facility should make efforts to move individuals from the Dove and Eagle homes, or to undertake significant renovations of these residences. As noted in the past, AUSSLC was not the most integrated setting for the development of a range of skills, including many of the independent living skills that would be taught more easily in community programs, such as cooking, home and yard maintenance, community safety skills, interactions with neighbors, etc. Many of these skills that would be functional in a more integrated setting were not being taught due to the current configuration of the Facility (i.e., food being brought in from a central kitchen, staff providing maintenance services, 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, teaching plans should be conducted systematically while employing generally accepted practices, and when appropriate, individuals should be encouraged to participate in all daily activities. Staff are encouraged to consider their own lives and the lives of other adults who do not reside within the confines of a State Supported Living Center. While plans might have to begin with small degrees of integration, efforts should be made to introduce individuals to the range of activities and facilities located in the Austin area. As noted above with regard to Section S.1, the Monthly Reviews for 39 individuals reflected very poor implementation of training. Training programs were not always developed, training was not conducted as scheduled, or data was missing. As individuals' refusal to participate had been an ongoing problem during previous visits, the Facility reported that efforts were underway to respond to this problem. As noted above, in an attempt to understand these efforts, a request was made for the plan for Individual #327 who had repeatedly refused to attend his day habilitation site. As documented in the ISP Addendum Meeting minutes from 10/15/12, the plan consisted of the following: a) once each day, home staff were to "encourage" the individual to attend; b) a desk was to be provided at the program; c) a radio would be placed near the individual; d) home staff would be trained on their job expectations in the day habilitation setting; and e) new materials would be introduced to the individual. This plan was to be monitored, with additional meetings held if the individual's attendance did not improve. There appeared to be no clear identification of responsible parties, no timeline for implementation, and no system of collection objectives measures to determine the success or failure of this plan. Further, there was no indication that the individual's preferences were going to be	

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		re-assessed. The Facility should complete situational assessments to determine the individual's interests and a structured preference assessment to determine potential reinforcers that could be used to help motivate his participation. As noted in the past, there was 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. In summary, although some important progress was noted, the Facility remained out of compliance with this provision. In addition to ensuring that programs were implemented as written and modified as appropriate, improvements were needed with regard to the functionality and meaningfulness of the programs in relationship to individuals' needs.	
	(b) Include to the degree practicable training opportunities in community settings.	The Facility indicated that there was no mechanism in place to track training in the community. In addition, as noted with regard to Section S.1, in reviewing 127 SAPs, only one SAP (1%) clearly identified training in the community. This was the purchasing program for Individual #75. While other programs suggested that training could occur in the community, on campus was also listed as an acceptable location (e.g., the counting change program for Individual #160). In addition, both Psychology Department staff and direct support professionals noted the limited availability of vehicles to allow for community-based activities. With the addition of two Community Integration Coordinators, it was anticipated that this data would be available in the future. As these staff work to establish increased opportunities for individuals to participate in community-based leisure, educational, and vocational activities, they should maintain appropriate levels of monitoring to ensure the individual's success. If difficulties are identified and addressed early on, there will be a greater likelihood that community integration will be a positive experience for all involved.	Noncompliance

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

1. As the Individual Support Plan is the guiding document to ensure adequate habilitation services, it is essential that this be based on comprehensive and current assessment. The Preferences and Strengths Inventory should be completed to ensure that the individual's strengths, preferences, and needs are clearly identified. (Sections S.1 and S.2).
2. As staff prepare for the ISP at the ISP Preparation meeting, they should ensure the following: a) comprehensive and specific listing of strengths and preferences; b) assessments completed in full with recommendations for habilitation based on assessment outcome; c) comprehensive risk rating assessment; d) identification of objectives designed to address the individual's preferences and assessed needs; and e) to the extent possible, training that occurs in the most integrated setting. (Section S.1 and S.2).
3. The Facility should ensure that the assessment of risk is based on objective data provided by the appropriate discipline. (Section S.1).
4. Skill Acquisition Plans should include the following:
    a. A behavioral objective that include the conditions under which the behavior is to occur, description of the behavior in observable and measurable terms, and criteria for determining skill acquisition;
    b. Clear listing or identification of necessary materials;
    c. Teaching guidelines that are clear, comprehensive, and relevant to the identified skill;
    d. Training schedules, including number of trials per training opportunity, that ensure sufficient opportunities for learning to occur;
    e. Guidelines for the application of individually identified reinforcers following correct responding;
    f. Guidelines for individually designed error correction procedures; and
    g. Plans to ensure maintenance and generalization of newly acquired skills. (Section S.1).
5. Preference assessments are recommended particularly for individuals for whom potent preferences are not readily apparent to ensure that potentially effective reinforcers are incorporated into all training objectives. (Section S.1)
6. The Facility should consider recruitment of professionals skilled in the delivery of special education services when positions become available in habilitation and training. (Section S.1).
7. As the Facility relies on the Monthly Report for ongoing monitoring of an individual's progress the following is recommended:
    a. Ensure that assessment of progress is based upon objective measure of the individual's performance;
    b. Correct errors in data collection and problems with program implementation in a timely manner; and
    c. Develop action plans with responsible staff members and due dates identified when progress is impeded. (Section S.1).
8. 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. Data also should be collected to evaluate the success or failure of maintenance and generalization of newly acquired skills. (Section S.1)
9. The Facility should ensure that recommendations consulting orientation and mobility specialists made are disseminated, and included in all applicable areas of programming. (Section S.1).
10. 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).
11. 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).
12. 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 should 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).

13. As recommended previously, staff should expand the variety of home, leisure, and vocational activities available to the individuals served. (Section S.1).
14. Administrative and support staff are encouraged to use their newly revised engagement monitoring tool to provide support and training to staff so that they are better able to teach and engage the individuals served. The provision of immediate positive and constructive feedback is strongly recommended. (Section S.1).
15. The Facility should maintain and expand consultation services provided by orientation and mobility specialists. (Section S.1).
16. The Facility should ensure that regular measures of inter-observer agreement are collected on all skill acquisition programs. (Section S.1).
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 Facility Self-Assessment 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 Information Letter Number 12-77: Expedited Home and Community-based Service Program Enrollment Process for Individuals Transitioning from a State Supported Living Center, dated 9/11/12; o List of individuals who have transitioned to the community, updated during review; o List of current referrals for transition, updated during the review; o List of individuals who have requested community placement, but have not been referred, undated; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed, undated; 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 alternate discharges, since last review; o In response to request for list of individuals who transferred to other SSLCs, the response: "None;" o Community Placement Report, for period of 9/1/11 to 8/31/12; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09, revised 3/10; o AUSSLC Admissions Placement Training offered between January and July 2012; o Facility and Local Authority (LA) staff training curricula related to community living, transition and discharge, including training materials; o In response to request for a list of individuals who have been assessed for placement, date of assessment, and resulting recommendations, the statement that all individuals have had annual ISP meetings and living options are discussed at ISP meetings; 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," the response: "None;" o In response to the request for: "The most recent report of the Facility's annual analysis of major obstacles to individuals' movement to community living identified by the SSLC," the response: "None;" o In response to the request for a list of all deaths that occurred following transitions to the community, the response: "None;" o In response to the request for a list of all individuals returned from a community residential placement, the response: "None;"

	○ ISPs and related assessments for the following individuals: Individual #21, Individual #26, Individual #333, Individual #282, Individual #298, Individual #34, Individual #454, Individual #63, Individual #216, and Individual #32; ○ Community Living Discharge Plans, sign-in sheets, and related assessments for: Individual #380, Individual #194, Individual #83, Individual #108, Individual #241, Individual #52, and Individual #187; ○ For three CLDPs submitted, the State Office review of these plans; ○ List of all Post-Move Monitoring, since the last review; ○ As available, pre-move monitoring documentation and Post-Move Monitoring Checklists for: Individual #187, Individual #342, Individual #156, Individual #165, Individual #52, Individual #241, Individual #350, Individual #326, Individual #242, and Individual #380; ○ Last 10 monitoring tools completed by the: a) Admissions Placement Coordinator; and b) QA staff; ○ For the last one year period, list of individuals who have had police contact, psychiatric hospitalizations, Emergency Room (ER) visits or unexpected hospitalizations, unauthorized departures, transferred, died, and/or been restrained, including brief synopsis of incident, for individuals transitioned since 11/1/11; and ○ Presentation Book for Section T. ▪ **Interviews with**: ○ Andy Maher, Assistant Director of Programs; ○ Nehtra Davis, Post-Move Monitor; ○ Joshua Castro; and ○ William Whitaker, Program Compliance Monitor. ▪ **Observations of**: ○ ISP annual review meeting for Individual #62; ○ Post-Move Monitoring Visits for Individual #380.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 10/22/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section T in conducting its self-assessment, the Facility: ▪ Although not yet reflected in the Facility Self-Assessment, the Facility had begun to use monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, as well as interviews with staff: ○ The monitoring/audit tools the Facility had begun to use to conduct its self-assessment included: 1) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options; 2) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Sections 1 and 4 – Planning for Movement, Transition, and Discharge and Alternate Discharges – Review of CLDP; and

	3) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post-Move Monitoring; and 4) ISP Monitoring Checklist. However, as discussed with regard to Section T.1.f, the Facility just recently had begun implementing these monitoring tools. For most sections of the Facility Self-Assessment indicated: "No data to report." o Although these monitoring/audit tools included indicators relevant to the Facility's compliance with the Settlement Agreement, modifications had been made to the State's systems that were not reflected in the tools. An example of this was that changes had been made to the ISP Meeting Guide to structure the discussion about the types of obstacles teams discussed with regard to referrals and transition. Similarly, the State had set forth a specific process for teams to make independent recommendations to individuals and their guardians about potential transition to the community. These changes impacted the indicators included in the monitoring tools, but the tools had not been changed. In addition, as discussed with regard to Section T.1.f, it appeared some of the language of the indicators was confusing to auditors. The Facility is encouraged to make changes to the tools to make them more user-friendly. As this is done, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did not identify adequate methodologies, such as observations, interviews, and record reviews to ensure that all of the staff responsible for auditing used the same methodologies. o No sample sizes were identified in the Self-Assessment. As noted above, the Self-Assessment generally indicated that no data was available to report. However, moving forward, the Facility should identify the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size) to provide a sense of whether or not they were representative samples. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. In the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team provided some specific comments on how these could be improved upon. o With regard to the staff/positions responsible for completing the audit tools, at the time of the review, due to changes in staffing in the Admissions Placement Department, only QA staff were conducting monitoring. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although the staff responsible had some experience with developing ISPs, completing transition plans, and/or conducting post-move monitoring, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o Adequate inter-rater reliability had not been established between the QA and program staff responsible for the completion of the tools.

	▪ The Facility had not yet used other relevant data sources and/or key indicators/outcome measures. For example, for Section T.1.b, which addresses education about community options, the Facility could have included numbers of individuals that participated in community tours, numbers of individuals and families participating in the Provider Fair, etc. In order for it to be meaningful, such data should be put into the context of measurable outcome indicators. This would need to be accomplished by identifying baselines, and then setting a goal for what would be considered an acceptable or desirable level of participation. ▪ Because the Facility did not yet include data for Section T in its Self-Assessment, the Monitoring Team could not determine if the Facility consistently presented data in a meaningful/useful way. ▪ The Facility rated itself as being in compliance with the following sub-sections of Section T: T.1.g, which requires the development of an adequate report on obstacles to transition to the community; and T.1.h, which requires the Facility to provide a Community Placement Report to the Monitor and DOJ. The Monitoring Team found the Facility in compliance with Section T.1.h, but not T.1.g. It appeared that the difference was the Monitoring Team was reviewing the quality of the obstacles report, but the Facility was not. Section T.1.g not only requires submission of an obstacles report, but submission of a report that is based on valid data, provides an adequate analysis of the data, and shows that the Facility and State have reasonably acted to reduce obstacles within their control. ▪ Although based on the Monitoring Team's review of raw data, it appeared auditors were identifying some relevant issues, the Facility had not yet aggregated data to determine if issues existed, analyzed the data, and/or developed plans to address issues identified.
	Summary of Monitor's Assessment: Prior to annual ISP meetings, each assessor was now expected to include a specific recommendation regarding whether or not the individual could be supported in a less restrictive setting. Most assessments now included such statements, but some did not. Individuals' ISPs generally included determinations by professionals with regard to whether community placement was appropriate. Unfortunately, in about half of the ISPs reviewed, teams had not provided adequate justifications for the recommendations they made to individuals and their guardians. For example, although statements in assessments indicated that supports could be provided in a less restrictive setting to meet the individuals' needs, professionals on teams then concluded that the individual would not benefit from a transition to the community. Teams did not reconcile the statements in the assessments with their final recommendations. Since the May 1, 2012, 13 individuals had transitioned to the community. At the time of the review, 35 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.

	The State had developed a list of standard obstacles to referral that teams had begun to utilize as part of the ISP process. However, IDTs had made little progress in accurately and completely identifying obstacles to referral, and/or developing plans to overcome them. AUSSLC had not yet begun to systematically collect data on obstacles to transition. Although the data could not yet be considered valid, the Facility would soon be submitting its annual report to the State, which should include an analysis of data collected thus far. In developing such a report, it will be important for the Facility to incorporate staff's knowledge of issues that potentially impede transition. Actions the Facility can take locally or with which Transition Specialists can assist, as well as those that fall more into the realm of DADS State Office should be incorporated into the report. The CLDPs reviewed included pre-move and post-move required supports. However, teams still did not consistently identify the full array of pre-move and post-move required 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. Based on the documentation provided, it could not be determined if post-move monitoring had been completed in a timely manner for a number of individuals who had transitioned to the community. With regard to the content of the post-move monitoring checklists, each of the items on the checklists had been addressed. However, a number of concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals. In addition, the post-move monitoring identified some issues with regard to the provision of services at the community sites. Although the Facility had taken some important steps to correct issues, documentation was not submitted to show what the role of individuals' teams was in this process. Although some important improvements were reported as having occurred in recent months, concerns were noted in the documentation reviewed with regard to the timeliness as well as the urgency with which staff addressed some significant concerns for individuals.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of	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 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	Noncompliance

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	professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	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, the State's expectation was that the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. At the time of the review, at AUSSLC, 16 individuals had exceeded this timeframe. Eight of these individuals had referrals pending for over a year. Based on discussion with the Assistant Director of Programs, a focus had been placed on ensuring that the right provider(s) was identified to support each individual, and in some cases, it had been difficult to identify the supports the individuals needed. As was discussed while the Monitoring Team was on site, it will be very important for AUSSLC to identify, document, and share with State Office the obstacles that teams encounter in relation to individuals' timely transition to the community. 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 and/or medical complexities 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. Based on Information Letter Number 12-77: Expedited Home and Community-based Service Program Enrollment Process for Individuals Transitioning from a State Supported Living Center, dated 9/11/12, the Level of Need for all individuals transitioning to the community from SSLCs during Fiscal Year 2013 were automatically increased to Level 6. This level of funding was then available for 12 months, at which point, the community provider needed to submit an ICAP to determine the ongoing funding rate. If certain criteria were met, a Level 9 could be assigned. The stated goal in the information letter was "to ensure necessary support is available for individuals to transition successfully to life in the community." At the time of the review, most assessments prepared for annual ISP meetings included the assessor's opinion regarding transition to the community. In addition, generally, individuals' ISPs included a summary or conclusion with regard to the professional team members' determination regarding whether or not transition to the community was	

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		appropriate. Based on a review of 10 ISPs (including those for Individual #21, Individual #26, Individual #333, Individual #282, Individual #298, Individual #34, Individual #454, Individual #63, Individual #216, and Individual #32), in nine of the 10 ISPs reviewed (i.e., Individual #32, Individual #216, Individual #63, Individual #34, Individual #282, Individual #292, Individual #333, Individual #26, and Individual #21), the team had documented a determination of the professionals regarding whether or not transition to the community was recommended. However, for only five of these individuals (56%) was adequate justification provided. The following provide examples of inadequate justification for teams' conclusions: ▪ Although Individual #32's team made a recommendation that the individual was not appropriate for transition to the community, it was not independent of the guardian. The team used the guardian's desire for the individual to remain at AUSSLC as its justification for not recommending the individual transition to the community. Given that the assessments (except for nursing and vocational, which did not include the required statements) all indicated the individual could be supported in a less restrictive environment, it was unclear why the team did not recommend transition to the individual and guardian. ▪ Individual #34's team concluded he: "would not benefit from moving to a less restrictive environment at this time," but no justification was provided. The team stated that they agreed he would enjoy living closer to his family, and his sister was looking to move him to Brenham SSLC. The lack of justification was concerning given that the teams' assessments all said he could be supported in a less restrictive setting (only the nursing assessment did not include a recommendation)]. ▪ Although the professionals on the team concluded that Individual #298 "would not benefit from moving to a less restrictive environment at this time," inadequate justification was provided. The team stated this was based on the individual's personal preference, which they earlier said they could not determine, and the Primary Correspondent's preference. This was not an opinion independent of the individual and family. It also was inconsistent with the statements in the assessments, which all stated she could be served in a less restrictive setting. No reconciliation of the professional team's final recommendation with these statements was provided. ▪ For individual #282, the ISP stated: "facility discipline members (independent of the resident and LAR/family) determined that [individual] would not benefit from moving to a less restrictive environment on this time." As its justification, the team quoted assessments that indicated she could be served in a less restrictive setting. The team's justification for its conclusion was unclear. Within the overall sample of 10, one individual's team had referred the individual for transition to the community (i.e., Individual #26).	

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		With regard to the requirement that "the transfer is not opposed by the individual or the individual's LAR," for four individuals (i.e., Individual #216, Individual #333, Individual #21, and Individual #63), 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 May 1, 2012, 13 individuals had transitioned to the community. At the time of the review, 35 additional individuals had been referred for transition to the community. The Facility remained out of compliance with this overarching provision of Section T of the Settlement Agreement.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	In response to the Monitoring Team's pre-visit document request, the Facility did not provide any updated Facility policies related to transition and discharge. For the last review, the Facility had included a statement that: "In process not completed." It was anticipated that DADS would issue a revised policy on Most Integrated Setting soon. Over a year ago, the three Monitoring Teams had submitted comments on the DADS draft policy for the State's consideration. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	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	In a review of 10 recently developed ISPs, they included two sections related to "Living Options." These sections 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 specific requirements of this provision are discussed below, including: 1) the identification in the ISP of the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles.	Noncompliance

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	obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	<u>Identification in ISPs of Needed Protections, Services, and Supports</u> The first sentence of this provision states: "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." Based on an agreement of the parties reached on September 7, 2012, substantial compliance with the first sentence of this provision equates to substantial compliance with the following provisions of Section F: Section F.1.d, which requires Facilities to 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; Section F.2.a.1, which requires ISPs to address, in a manner building on the individual's preferences and strengths, each individual's prioritized needs; and Section F.2.a.3, which requires ISPs to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. As noted above with regard to Section F of the Settlement Agreement, although AUSSLC had continued to make efforts to improve ISPs, the Facility remained out of substantial compliance with Sections F.1.d, F.2.a.1, and F.2.a.3. Additional details are provided in the sections of this report that address these provisions. 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 served by AUSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) as the process progresses, the ISP will be the key document that is used to ensure that pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> As noted above, the newer ISP formats included a section on obstacles to referral. In reviewing the sample of 10 ISPs, teams had discussed some obstacles. Of the 10 ISPs reviewed, nine should have defined the obstacles to referral, because one of the individuals had been referred to the community (i.e., Individual #26). Of the nine plans,	

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		five (56%) included an adequate list of obstacles (i.e., Individual #63, Individual #454, Individual #282, Individual #333, and Individual #21). The problems associated with the obstacles in the plans included the following: ▪ Sometimes no obstacles were identified (e.g., Individual #32, Individual #216, and Individual #34). ▪ In one, the obstacles identified did not appear to be valid (i.e., Individual #298's obstacle of "LAR Choice," when she did not have a guardian, or "Individual Choice," when the team indicated she could not provide informed consent and had had a good time on visits to community homes). Often times, though, the obstacle to referral to the community was listed as "LAR Choice." However, adequate definition of the guardian's specific concerns had not been documented (i.e., Individual #63, Individual #454, Individual #282, Individual #333, and Individual #21). This is very important information to collect and analyze, but it did not appear it was being captured regularly or in enough detail. As a result, adequate action plans could not be developed to potentially address guardians' concerns. Action plans to overcome the obstacles to referral often were not developed, and those that were generally were not adequate. Of the nine ISPs, three (33%) included an action plan to overcome obstacles identified (i.e., Individual #454, Individual #298, and Individual #21). Of these, none (0%) were adequate. Some of the concerns included: ▪ Timeframes were missing, or too lengthy. For example, for Individual #21, an action plan was developed for the QDDP to work with the Transition Specialist and Local Authority to identify options and present them to the guardian. Depending on the guardian's reaction, tours might be arranged. Although it was good that the team was taking this step, it was unclear why the due date was a year from the time of the ISP meeting. To hold various people accountable, it would have been good to separate out tasks, and provide timeframes for each task. ▪ The plans were not adequately individualized. For Individual #21, the action step discussed above also did not provide any detail with regard to the types of settings or providers that would be sought. ▪ In addition, plans to address guardian reluctance were generally nonexistent, and when they did exist, they were inadequate. For example, for Individual #454, the only action plan to address the guardian's reluctance read: "[Guardian] will be provided information at least annually about community living options that may be beneficial to [Individual]." This was not individualized and did not address any specific concerns the guardian had regarding community transition. As has been noted previously, when a guardian is reluctant, to the extent possible, the related action plans should address the specific issues about which the guardian is concerned. For example, if the	

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		guardian were concerned about the behavioral supports available in the community, then more education or research about the individual's options would be appropriate topics for an action plan. Sometimes, the action plans will involve staff action as opposed to guardian action. ▪ At times, the activities included in the action plan had little, if anything to do with addressing the obstacle. For Individual #298, the obstacles were the individual's preference, which she could not articulate (and the team indicated she could not provide informed consent, but said she was curious when she went to visit group homes), and LAR Preference, but she did not have a LAR, only a primary correspondent. The only related objective was for her to participate in community outings four times a month. Given that community outings should be part of anyone's ongoing schedule and she already seemed to enjoy them, it was unclear how the team believed this action step specifically related to further education about living in a community setting. Of note, the team also noted that she liked living with her current roommate, but it was unclear if any discussion had occurred about the possibility of them living together in a community setting, or making visits together. The Facility was not yet documenting obstacles to transition. Although as noted in previous reports, the State Office had developed a list of obstacles to transition, a system for capturing such obstacles during the transition process, in ISPAs or the CLDP documentation, and then entering such information into a spreadsheet or database had not yet been operationalized. Anecdotally, some individuals had encountered obstacles to transition, and, as noted above, teams were being careful to ensure that providers could meet people's needs before they moved. However, as individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as the team's plans to overcome them. As discussed while the Monitoring Team was on site, this should be viewed as an opportunity to ensure State Office is aware of the types of protections, supports, and services that require attention and/or expansion. 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, some limited improvement was seen in these areas. The Facility remained out of compliance with this provision.	
	2. The Facility shall ensure the provision of adequate	As described in previous reports, AUSSLC had engaged in a number of activities to provide education about community placements to individuals and their families or	Noncompliance

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	education about available community placements to individuals and their families or guardians to enable them to make informed choices.	guardians to enable them to make informed decisions. Based on documentation provided, this had taken a number of forms, but work was still needed to ensure adequate education was provided. The following summarizes the actions taken as well as areas in which additional work was needed: ▪ **Annual provider fairs**: On 6/8/12 and 6/9/12, the Facility conducted the "Passport to Your Future" provider fair. It occurred over a Friday and Saturday. A questionnaire was available for individuals' use to provide some guidance regarding questions they might want to ask providers. Based on the information provided, it did not appear that outcome measures had been established with regard to attendance and/or satisfaction. However, based on data provided, participants at the June fair included 115 individuals, nine family members and/or guardians, 130 staff, and 32 provider staff. This data was summarized in a chart, but it was unclear if it had been formally analyzed. In addition, no data related to satisfaction or recommendations from participants was provided. Review of such data would be important to allow the Facility to determine whether changes needed to be made to future provider fairs. Based on discussion with the Assistant Director of Programs, one of the options under consideration for future provider fairs or other forums was the use of panel discussions that would allow Facility clinicians (such as nurses, habilitation therapists, psychologists, etc.) to interact with their equivalents in the community. This would be a creative way to expand Facility staff's knowledge, help improve the content of Community Living Discharge Plans, and potentially provide other provider fair participants with additional knowledge about supports available in the community. ▪ **Education about community options:** Individuals and their guardians also were provided information through the Local Authority CLOIP process. Based on review of ISPs, it appeared that this occurred regularly as part of the individual planning process. However, it did not appear that outcomes/measures had been determined and/or data collected regarding the number of individuals and families/LARs who agreed to take new or additional actions regarding exploring community options, or the number of individuals and families/LARs who refused to participate in the CLOIP process. Collection and review of such outcome data would allow the State to evaluate the effects of the process and make changes made to future educational activities. ▪ **Tours of community providers**: Based on data the Facility provided, it appeared that tours were occurring regularly. However, it could not be determined with any certainty how many individuals participated, how many locations individuals had visited, or the size of the groups that went on visits.	

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		It was unclear if data had been analyzed to ensure that: a) all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours); b) places chosen to visit are based on individuals' specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed. ▪ **A plan for staff to learn more about community options**: Although AUSSLC had not provided a formal plan to address education on community living options to management staff, clinical staff, and direct support professionals, they had continued to take a number of steps to provide educational opportunities. However, this should be formalized in a plan. It also was not clear if data regarding staff training were being aggregated and analyzed. Some of the examples of training for staff that the Facility had documented included: Post Move Monitoring and Admissions Placement Coordinator training with State Office in May and June 2012, respectively; Community Transition training for QDDPs; Every Child, Inc. Informational Session; and Level of Need training. Although a presentation entitled: "Local Authority Overview of Services and Supports" was submitted, it was unclear when this presentation occurred and/or who attended. ▪ **Individuals and families have opportunities to learn about success stories:** The Facility had not yet addressed the following areas adequately: o The Facility should include success stories about individuals in newsletters or other forums, and/or have individuals or their guardians present information about their experiences in other forums (e.g., Family Association meetings, provider fairs, or small group settings); o The Facility should provide opportunities for individuals to visit friends who live in community; o As appropriate, the Facility should pair families/LARs who have experienced a successful transition with families/LARs who are reluctant; and o If aggregate data showed that families and guardians had similar concerns, then the Facility should use mechanisms to provide information on specific topics. For example, offering specific educational seminars might be useful. ▪ **Education may be provided at Self-Advocacy, house, and Family Association meetings, or other appropriate locations:** It did not appear that the Facility was currently engaging in educational activities in these forums. However, hopefully, as staffing in the Admissions Placement Department stabilized, such activities could begin to occur. ▪ **Regular SSLC meeting with the Local Authority:** Based on interview with staff,	

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		meetings with Local Authority staff had begun to occur. However, this was an area that was expected to expand in the coming months. One of the goals was to have the Home and Community Services Coordinator involved sooner in the transition process. ▪ **Individualized Plans:** The most challenging area with regard to education of individuals and LARs/families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. In reviewing 10 recently completed, one individual had been referred to the community, and another's guardian had refused any further information about the community. For the remaining eight, four (50%) had a plan that addressed education about community options. However, none of these (0%) were adequate. The following concerns were noted: o None of the plans were individualized to address the individual and/or the LAR's particular needs or concerns (e.g., those for Individual #454 and Individual #34, the only action step was providing information annually to the guardian). The action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals or their guardians' questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans using the information that the team is able to gather about the reasons for the individual, family member, or LAR's reluctance. For example, if an LAR has questions about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. At the time of the review, this had not yet occurred. Creative ideas and brainstorming within AUSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. o As noted above with regard to Section T.1.b.1, at times, the activities included in the action plan had little, if anything to do with providing education about community supports available to the individual. For Individual #298, Individual #333, and Individual #21, the only related objectives were for them to participate in community outings a specific number of times a month. Given that community outings should be part of anyone's ongoing schedule, it was unclear how the teams believed this action step specifically related to further education about living in a community setting. Moreover, if there was an explanation for how these outings would assist the team in, for example, determining the individuals' preferences, these plans did not provide for the team's	

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		follow-up to determine the individual's reaction to the activities offered. ISPs had begun to indicate whether or not there was a plan the previous year and/or if it was completed. Although the Facility was continuing to complete some of the basic activities related to education, minimal progress had been made since the last review in individualizing the process. Although some individuals had a plan in their ISPs, the plans generally were not individualized or measurable. The individualization of this process is key to ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. The Facility remained out of compliance with this provision.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all 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, the Facility submitted a statement that all individuals had had annual ISP meetings and living options were discussed at ISP meetings. The Facility also submitted a document entitled: "A description of how the Facility assesses an individual for placement," undated. The document indicated that there is no assessment for transition to the community. At the individual's annual ISP meeting or at ISPAs 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. As is discussed above with regard to Section T.1.a of the Settlement Agreement, at the time of the review, most assessments prepared for annual ISP meetings included the assessor's opinion regarding transition to the community. Some consistent exceptions to this included the nursing assessments, and vocational assessment. In addition, generally, individuals' ISPs included a summary or conclusion with regard to the professional team members' determination regarding whether or not transition to	Noncompliance

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		the community was appropriate. Based on a review of 10 ISPs (including those for Individual #21, Individual #26, Individual #333, Individual #282, Individual #298, Individual #34, Individual #454, Individual #63, Individual #216, and Individual #32), in nine of the 10 ISPs reviewed (i.e., Individual #32, Individual #216, Individual #63, Individual #34, Individual #282, Individual #292, Individual #333, Individual #26, and Individual #21), the team had documented a determination of the professionals regarding whether or not transition to the community was recommended. However, for only five of these individuals (56%) was adequate justification provided. The following provide examples of inadequate justification for teams' conclusions: ▪ Although Individual #32's team made a recommendation that the individual was not appropriate for transition to the community, it was not independent of the guardian. The team used the guardian's desire for the individual to remain at AUSSLC as its justification for not recommending the individual transition to the community. Given that the assessments (except for nursing and vocational, which did not include the required statements) all indicated the individual could be supported in a less restrictive environment, it was unclear why the team did not recommend transition to the individual and guardian. ▪ Individual #34's team concluded he: "would not benefit from moving to a less restrictive environment at this time," but no justification was provided. The team stated that they agreed he would enjoy living closer to his family, and his sister was looking to move him to Brenham SSLC. The lack of justification was concerning given that the teams' assessments all said he could be supported in a less restrictive setting (only the nursing assessment did not include a recommendation)]. ▪ Although the professionals on the team concluded that Individual #298 "would not benefit from moving to a less restrictive environment at this time," inadequate justification was provided. The team stated this was based on the individual's personal preference, which they earlier said they could not determine, and the Primary Correspondent's preference. This was not an opinion independent of the individual and family. It also was inconsistent with the statements in the assessments, which all stated she could be served in a less restrictive setting. No reconciliation of the professional team's final recommendation with these statements was provided. ▪ For individual #282, the ISP stated: "facility discipline members (independent of the resident and LAR/family) determined that [individual] would not benefit from moving to a less restrictive environment on this time." As its justification, the team quoted assessments that indicated she could be served in a less restrictive setting. The team's justification for its conclusion was unclear. Within the overall sample of 10, one individual's team had referred them for transition to the community (i.e., Individual #26).	

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		For four individuals (i.e., Individual #216, Individual #333, Individual #21, and Individual #63), 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 some improvement was seen with regard to this provision, the Facility remained out of compliance. Of note, although issues still existed with teams' interpretation of the requirements, the new template of the ISP seemed to be helping teams answer the relevant questions. As described above, teams were not necessarily justifying their conclusions, but conclusions were being documented, which had not necessarily occurred in the past.	
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:	Since the last review, some progress had been made with regard to teams' development of CLDPs. However, this progress varied widely from CLDP to CLDP. Some of the CLDPs included a wider scope of pre-move and post-move required supports (it was agreed the terminology "essential and nonessential supports" would be replaced with "pre-move and post-move required supports"), and the supports were more detailed (e.g., Individual #194 and Individual #187). However, this was not consistent across plans, including some of the most recently developed plans. In addition, although some improvements were seen, team members needed to improve the assessments that contributed to the CLDPs, and ensure that a comprehensive set of protections, supports, and services were detailed in the CLDPs. Community Living Discharge Plans were reviewed for five individuals (i.e., for Individual #187, Individual #340, Individual #194, Individual #83, and Individual #108). Since the Monitoring Team's abbreviated review in May 2012, 11 individuals had transitioned to the community, resulting in a review of 45% of the plans developed. With regard to the timeliness of the Community Living Discharge Plans, one CLDP (20%) included documentation to show that it was developed sufficiently prior to the individual's transition (i.e., Individual #194, for whom it appeared the team met numerous times and appropriately delayed the transition to ensure an appropriate day/vocational program was identified). This was determined based on the narrative, and the information included in the CLDP regarding the team's deliberations. Based on this information, it appeared this one individual's 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.	Noncompliance

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		For the remaining four individuals various issues were noted that raised questions about the timeliness of the CLDP development process. For example, for some individuals, it was unclear when the team first identified the pre-move and post-move required supports. As has been discussed previously, they should be identified early in the process to assist the team, the individual, and his/her guardian to determine whether or not providers with whom the individual conducts pre-selection visits are able to meet the individuals' needs. For Individual #108 and Individual #83, it appeared that this did not occur, and the supports were identified just a couple weeks prior to the individuals' transitions. For Individual #187, the guardian's decisions appeared to impact the timely completion of a CLDP. For Individual #340, it appeared that due to staffing at AUSSLC, there was a long delay between initial transition activities, and then quick development of the CLDP only a few weeks before the individual's transition to the community. With regard to the timeliness of the development of CLDPs, work was needed to improve this area. In addition, 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 often identified the need for training for community provider staff. However, they very seldom defined 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.). An exception to this was Individual #194. Although it was positive that this plan better defined some of the training, some problems still existed. For this individual, competency-based training was mentioned in a few supports, with "competency test" as one of the pieces of evidence, but the specific competency test was not identified. Staff requiring training were generally defined as both the direct support professionals, and the "professional" staff. However, only the "professional staff" were to be trained on the BSP. It was unclear what this meant exactly, but it did not make sense that direct support professionals would not be included. ▪ Again, although Individual #194's CLDP 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	Noncompliance

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		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., a pre-move required support), or, at a minimum, evidence should be 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, a specific competency test or checklist should be identified. ▪ 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 include pre-move required supports defining AUSSLC's staff's involvement in evaluating potential sites at which individuals would be served. It appeared from the narrative of the CLDPs that this had occurred for some individuals, but it had not been defined as a specific support. As a result, it was difficult to tell if the team had thought through the environmental issues to which attention needed to be paid. For example, when the Post-Move Monitor visited the home shortly before Individual #340 was scheduled to transition, potential safety issues were noted, and the transition was delayed. Although it was positive that the Post-Move Monitor identified the issues before the individual moved, these were issues that could have been identified and addressed earlier in the process had the team recognized the need for specific environmental characteristics, and assigned a team member to ensure these were in place before a final selection was made. Other 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 modifications are needed 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 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	

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		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. ▪ Generally, the monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, in at least one instance, this was left blank (i.e., Individual #108). In addition, no action steps were designed to ensure that the Post-Move Monitor worked together with the Local Authority Service Coordinator to pass on important information or ensure monitoring continued to occur of pre- and post-move required supports. 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 pre-move required 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.	All five of the CLDPs reviewed (100%) generally included a timeframe for completion, as well as the specific name of the Facility or provider staff responsible for the completion of the actions identified. The Facility was found to be in substantial compliance with this provision. However, in order to remain in substantial compliance, the Facility is cautioned to ensure that as the supports included in CLDPs expand that adequate timeframes and persons responsible are assigned. The Monitoring Team had begun to see some supports for which adequate timeframes and specific staff responsible had not been adequately detailed, and/or the term "ongoing" was used, when a specific date should have been identified for initiation of an activity with the expectation stated that it then would occur on an ongoing basis. Although many supports included a specific date or frequency, others did not (e.g., for Individual #194, involvement of psychologist, completion of BSP data, reminders for toileting at night; for Individual #83, the frequency of supports such as psychiatry were not defined or for Individual #108, the support requiring the community provider to assist in making an appointment with rehabilitation services was listed as an ongoing need, but no specific deadline was included for making the appointment). This likely will become more of an issue going forward as more complex supports are included in the CLDPs. For example, implementation of plans, such as PNMPs, health care plans, and PBSPs, will require a start date, and then a frequency to be stated for a number of different aspects of plan implementation (e.g., daily implementation and documentation, monthly review by a clinician, at least annual review or as needed modifications to the plan, etc.). This will require a lot more detail regarding both timeframes and persons responsible.	Substantial Compliance

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	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 transition. For five of the five plans reviewed (100%), sign-in sheets were provided that confirmed the presence of the individual and his/her guardian at the final CLDP meeting. Given that the CLDP format requires that teams meet multiple times to complete various portions of the transition process, 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 individual's leaving.	This requirement of the Settlement Agreement includes two components, including the timeliness of assessments (i.e., within 45 days of the individual leaving the Facility), and the comprehensive nature of the assessment. Although the Facility had made progress with regard to obtaining timely assessments, the quality (i.e., comprehensiveness) of the assessments was significantly lacking. 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 and/or late. For example, medical and dental assessments were sometimes late (i.e., submitted after the CLDP date), and vocational/day assessments sometimes were not included and/or merely had the same information from the previous assessment with a new date. In addition, the quality of these assessments was lacking. None of the five CLDPs reviewed (0%) were based on adequate assessments. However, some improvements were beginning to be seen with some of the 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. One exception to this was some of the psychiatric assessments reviewed. For a number of individuals, the psychiatrist had provided a succinct summary of treatment throughout the individual's stay at AUSSLC. The summaries highlighted medication changes, including the individuals' reactions to the changes, as well as psychiatric hospitalizations. This would appear to be a helpful document for both the community provider agency as well as the new psychiatrist supporting the individual in the community.	Noncompliance

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		▪ In addition, although some improvement was seen, a focus was need on ensuring assessments set forth a comprehensive list of protections, supports, and services the individual would need in a community setting. They should 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.). ▪ Assessments generally 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 sections of this report, the underlying assessments were not of adequate quality. ▪ In the section of this report that addresses Section M.2 of the Settlement Agreement, the Monitoring Team has provided some specific findings regarding nursing assessments for individuals transitioning to the community. ▪ 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. 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	The CLDPs reviewed included pre-move and post-move required supports. As noted above, some of the CLDPs showed progress, while others did not. Some of this appeared to be due to the fact that over the last year, a number of staff had been involved in the CLDP process, including Facility staff, as well as staff from State Office. At the time of the review, State Office staff were no longer as involved, and the Facility Administration was	Noncompliance

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	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.	still in the process of stabilizing the staffing in the Admissions and Placement Department. As Facility staff recognized, stable staffing was needed to provide leadership to the CLDP development and implementation process. The other group that played a major role in the development of CLDPs was the QDDP Department, and that Department also had experienced significant turnover with efforts underway to further stabilize the staffing there, as well as train the new members of that team. 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. As noted in previous reports, 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. However, at the time of the current review, teams did not consistently identify all the pre-move and poste-move required supports that the individual needed to transition safely and successfully to the community. Although the measurability of supports was improving, this was an area that required attention, particularly as more complex supports were included in the plans. Moreover, 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 individual's transition to the community. As noted above with regard to Section T.1.c, some of the plans included a more comprehensive list of supports (i.e., Individual #194 and Individual #187). However, even for these individuals, numerous supports were missing. In fact, in none of the five plans reviewed (0%) was a comprehensive set of pre-move and post-move required supports identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. The following summarizes the general concerns as well as some of the progress noted: ▪ 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	

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		knowledge, the foundation for the CLDP could be built. ▪ An area in which improvement was noted was in supports related to the clinical services (e.g., psychology/behavior, psychiatry, habilitation therapy, etc.) that were sometimes now referenced in the CLDPs. Often, the need for such supports was identified. However, the intensity of the supports generally was not identified, nor were the qualifications or the roles of clinicians clearly defined. Sometimes the teams had discussed the qualifications for psychologists, but had not then memorialized this in a pre-move or post-move required support. Although not consistent across all relevant plans, some definition was provided of what they would do. However, this generally was not a comprehensive list, and it is necessary for all of the clinicians involved with the individual. The post-move required supports should address issues such as clinical staff's involvement in staff training, review of data, monitoring of the implementation of programs, etc. 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. For example, for an individual that had a number of nursing supports or habilitation therapy needs, work needed to be done with the community providers to determine how equivalent supports would be provided in community settings where nurses were not stationed in each home, and habilitation therapists generally were external vendors. ▪ In addition, often, 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, although teams had begun to reference some portions of nursing care/health management plans in CLDPs, their implementation was not specifically required. In addition, little, if any, detail was provided about how they would be implemented in the community. For example, the role of nursing staff in the community versus direct support professionals generally was not defined. It was not at all clear what level of nursing staff (i.e., RN or LVN, and/or the amount of time per day/week) was necessary. Likewise, individuals who were receiving habilitation therapies supports at AUSSLC did not have functionally equivalent supports identified in their CLDPs. Therapists at AUSSLC played a number of roles, including staff training, provision of direct therapy, monitoring of programs, monitoring of equipment, etc. Other than initial appointments with therapists in the community, it was unclear how these functions were being transitioned. ▪ 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, generally were not reflected in action plans included in the CLDPs reviewed. As is discussed with regard to Section I of the	

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		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 trained on existing plans. As noted above, concerns existed with regard to the lack of expectations for the quality or outcomes of this training. ▪ An area in which some improvements were noted was in the inclusion of various plans to be implemented (e.g., BSPs, PNMPs, diets, etc.). However, this was an area that required continued attention. For some individuals, some essential plans were not identified as requiring implementation (e.g., Individual #108's BSP, and Individual #340's BSP), or it appeared that staff at the home were required to implement plans, but not the staff at the day program (e.g., BSP for Individual #194). ▪ 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.), some, but not many 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 the team required the development of a Safety Plan for Individual #340, 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. For example, the narratives in some individuals' CLDPs identified ways in which they calmed down when upset. At times, this involved walking outside (e.g., Individual #83). Planning would need to occur to ensure a safe place to walk was identified at the community home and/or day/vocational program. However, this was not included as a pre-move or post-move required support. ▪ Generally, direct support staffing ratios and requirements were not specified. Sometimes, the level of supervision was noted (e.g., Individual #194). However, 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	

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		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., Psychology, SPL, and OT/PT therapy recommendations, 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.) generally were not included as part of the day/vocational component. ▪ On a positive note, some of the plans identified the need for clinicians or medical practitioners to be identified prior to the individual's transition (i.e., a pre-move support). This was an improvement from the past. However, care needs to be taken to ensure that as individuals with complex behavioral or medical needs transition to the community, supports adequate to meet their needs are 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. As noted above, some of the CLDPs showed some improvement. However, teams were still working from inadequate ISPs, and the CLDPs continued to be missing many necessary protections, services, and supports. As previously reported, with regard to monitoring by the Local Authority or other means to ensure pre-move supports were in place prior to an individual's transition, it was the Monitoring Team's understanding that the LAs were conducting reviews (albeit inadequate). However, in response to the document request of pre-move reviews, no copies were provided of the LAs' reviews. However, the Facility continued to implement the process of having the Post-Move Monitor conduct a pre-move site visit designed specifically to determine if the pre-move required supports were in place. Nine individuals' pre-move documentation was reviewed, as provided by the Facility (i.e., Individual #156, Individual #165, Individual #350, Individual #242, Individual #342, Individual #52, Individual #241, Individual #326, and Individual #380). For one individual (i.e., Individual #380), no pre-move monitoring form was submitted. For the remaining eight individuals, none had adequate pre-move reviews completed. Concerns included: ▪ For three individuals (i.e., Individual #52, Individual #326, and Individual	

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		#241), it was not clear from the documentation whether or not monitoring actually occurred. For example, for Individual #52, the form was filled out with the pre-move required supports, as well as the evidence the Post-move Monitor was supposed to review and the due dates. However, actual evidence was only discussed for some supports, and it remained unclear if the other supports were in place. In the evidence column, a number of the supports indicated the evidence "will be" provided, or that the supports would be monitored during the seven-, 45-, and 90-day monitoring. Although many of the supports required ongoing monitoring, they also needed to be in place and confirmed as being in place at the time of the pre-move visit. ▪ For the remaining five individuals, the thoroughness of the reviews was an issue. Some examples included: o For many individuals, a number of pre-move required supports were the training of community provider staff to a competency level. Frequently, the Post-Move Monitor indicated that "competency based training material and signed rosters" were submitted. There was no indication whether all applicable staff had completed the training and/or whether all had attained the required level of competency. o For Individual #242, the CLDP included some specific staffing requirements. The Post-Move Monitor indicated an organizational chart was provided including: "staff person's name, and days of the week they are scheduled to work." However, it was unclear if the Post-Move Monitor conducted an analysis to ensure this chart demonstrated that the specific staffing needs of the individual were met. o Individual #342 required a wedge for her bed. The pre-move report indicated it would be moved with her on the day of the move, but there was no confirmation of this. A finding of noncompliance was made for this component of the Settlement Agreement. Some regression was noted with regard to the confirmation of pre-move required supports. In addition, substantial work was still needed in adequately delineating the pre-move and post-move required 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 responsible, consistent with the	AUSSLC had made some limited progress with regard to the development of quality assurance processes related to Section T. Specifically: ▪ Quality Assurance Department staff were conducting some audits. In approximately August 2012, the Facility began using a monitoring tool entitled: "ISP Monitoring Checklist." It included indicators that addressed the team process related to education of individuals and guardians prior to and during ISP meetings about community options, the identification of plans to increase awareness of living options, and whether IDTs were making recommendations	Noncompliance

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	provisions of this Section T.	about community transition independent of the individual and guardian. Based on review of some of the most recently completed audit checklists, the auditors were generally finding that teams were making independent recommendations, but found issues with plans developed to provide more education about community options. ▪ The Facility also was using the tool entitled: "Settlement Agreement Cross Referenced with ICF-MR Standards: Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Subsection 1 – Planning for Movement, Transition, and Discharge." This tool addressed the teams' recommendations regarding community transition, lack of opposition to community referral by the individual or guardian, comprehensiveness of the ISPs' descriptions of supports the individual required, identification of obstacles to referral, and development of plans to overcome obstacles to referral. Based on review of some of the most recently completed audit checklists, concerns were identified regarding the validity of the data. Based on some of the ratings, it appeared there were misunderstandings about the meaning of some of the indicators. A couple of a number of examples included: the rating of "N/A" was assigned to the section on the identification of obstacles even when the narrative indicated the individual was not being referred due to guardian reluctance, which should have been identified as an obstacle; and the section on the comprehensiveness of supports and services was marked as "N/A" when a guardian indicated no interest in community placement, although the ISP should adequately define supports, services, and protections regardless of whether or not the individual was planning to move soon or not. Areas in which additional efforts were needed included: ▪ Due to staffing changes in the Admissions Placement Office, although the QA staff had conducted some monitoring, programmatic staff had not yet begun to conduct monitoring. ▪ Based on interview with QA staff, because monitoring tools had just been put in place and problems had been encountered with the data system, it was anticipated that December 2012 would be the earliest that data reports would be available to allow any trending or analysis of the information. ▪ Inter-rater reliability had not yet been established, nor had the accuracy/validity of the monitoring data. As noted above, based on the Monitoring Team's review of raw data, some concerns were identified with regard to the validity of the data results, and specifically, the auditors' understanding of and competency with regard to completing the audit tools. ▪ 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	

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		ensure accuracy in monitoring as well. ▪ An important part of quality assurance for Section T will be review of the outcome data for individuals that transition to the community. Analysis should include review of supports that might have prevented negative outcomes, and a determination of whether or not such supports were included in CLDPs, as well as whether or not community providers provided the necessary supports. Based on data the Facility provided, since the Monitoring Team's last compliance review in November 2011, of the thirteen individuals listed (i.e., some of the individuals that had transitioned since that time had recently transitioned and the documentation the Facility submitted did not include them), five had experienced one or more negative outcomes, including: o Two individuals had had police contact, including one individual that had two instances of police contact, and one individual with one instance. For one incident, the individual required six officers to safely escort her out of a restroom. o Both of these same individuals had psychiatric hospitalizations. One had one, and the other had three psychiatric hospitalizations. o Two individuals had one Emergency Room visit each, and one of these individuals was hospitalized overnight. o An additional individual had two episodes of unauthorized departure from her day program. o Three of the above individuals had had changes in placement (i.e., one to a new home, and two others to new day programs). All of these appeared to be due to behavioral issues that the original placements could not effectively address. o Finally, one individual had had three restraints. In its comments to the draft report, DOJ requested a different breakdown of this same data. Specifically, they asked for the numbers of types of incidents discussed above by individual. The following provides this breakdown: o One individual had two police contacts, three psychiatric hospitalizations, one medical ER visit and hospitalization, and transferred to a different day program. o Another individual had one police contact, one psychiatric hospitalization, and moved to a new home. o One individual had two unauthorized departures, and transferred to a different day program. o One individual had three restraints. o The final individual had one medical ER visit. The Facility is strongly encouraged to conduct such reviews in the spirit of	

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		identifying ways in which improvements can be made to prevent negative outcomes in the future. 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 transition to the community. 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 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	At the time of the Monitoring Team's review, the DADS Annual Report: Obstacles to Transition Statewide Summary, Fiscal Year 2011 was over a year old, and the State had not provided an updated one. In response to request for: "A printout of the database/report summarizing the obstacles identified for individuals' movement to the most integrated setting appropriate," the Facility's response was: "None." In response to the request for: "The most recent report of the Facility's annual analysis of major obstacles to individuals' movement to community living identified by the SSLC," the response: "None." Based on these responses, it was unclear whether or not the Facility was regularly reviewing and analyzing the data related to obstacles (e.g., through its QA/QI Council and/or meetings between the QA Department and the Admissions and Placement Department). As a result, it was unclear if the Facility had developed any plans or taken any action to address obstacles within its control. The State had developed a list of standard obstacles to referral that teams had begun to utilize as part of the ISP process. However, AUSSLC had not yet begun to systematically collect data on obstacles to transition. As discussed with regard to Section T.1.b.1, as individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as the team's plans to overcome them. As discussed in detail with regard to Section T.1.b.1, concerns continued to exist with teams' accurate and complete identification of obstacles. As a result, the validity of the data was questionable.	Noncompliance

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	from other agencies or the legislature.	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, patterns regarding recent admissions and referrals to the Facility also were indicative of concerns in the community system, resulting in individuals requiring placement in more restrictive settings. The Facility would soon be submitting its annual report to the State, which should include an analysis of data collected thus far. In developing such a report, it will be important for the Facility to incorporate staff's knowledge of issues that potentially impede transition. Actions the Facility can take locally or with which Transition Specialists can assist, as well as those that fall more into the realm of DADS State Office should be incorporated into the report. Improvements in data collection and analysis, implementation of new ISP processes, and actualization of activities to overcome or reduce obstacles will be necessary for substantial compliance to be achieved.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to,	In response to a document request, the Facility submitted to the Monitoring Team a Community Living Placement Report, for the period between 9/1/11 and 8/31/12. 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. Thirty-three individuals were included on this list. However, since the list had been generated four of these individuals recently had transitioned to the community. In addition, more individuals had been referred for transition. At the time of the Monitoring Team's onsite review, the total number of individuals referred was 35. ▪ 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 16 individuals, including seven since the Monitoring Team's onsite visit in May 2012. As noted above, another four individuals recently had transitioned to the community. Three individuals' referrals had been rescinded. 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	Substantial Compliance

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	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.	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: No individuals were listed in this category. ▪ 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**		
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	Timeliness of Checklists: Post-move monitoring documentation was reviewed for nine individuals, including Individual #156, Individual #165, Individual #350, Individual #242, Individual #342, Individual #52, Individual #241, Individual #326, and Individual #380. Of the 22 required visits, 11 (50%) had been documented as having been completed. The only individuals for whom complete documentation was submitted were Individual #380 and Individual #156. For the remaining individuals, documentation for one or more post-move monitoring visit was missing. For example, for Individual #242, a seven-day report was submitted and dated, but it had not been completed (i.e., most of the form was blank). In addition, it appeared that the Facility did not respond to the Monitoring Team's document request #XVI.30 that asked for: "During the onsite review, please provide pre-move and post-move monitoring checklists that have been completed since #20 above was produced (these should only include reports for individuals for	Noncompliance

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	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.	whom this Facility's Post-Move Monitor was responsible for monitoring), including additional documentation, if any, that reflects follow-up activity taken by the PMM, IDT, or the Facility in response to issues identified in the post-move monitoring checklists." As a result, a number of post-move monitoring reports that likely had been produced since the original document request was generated were missing, and the Monitoring Team could not confirm that the visits that should have been done were completed or assess the quality of these visits. Of these 11 post-move monitoring reports provided, 10 were documented as having been completed on time. The seven-day visit for Individual #326 should have been done by 8/10/12, but it was completed on 8/16/12. The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was documented in the reports. For all of the 11 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. <u>Content of Checklists</u> AUSSLC continued to use the revised format that the State Office had developed for post-move monitoring activities, which had been modified in May 2011. Each of the items on the checklists reviewed had been addressed. Additional information had been added regarding the interviews conducted, the documents reviewed, and the observations made. Although the checklists reviewed showed thorough review of a number of supports and services, a number of issues were noted. To put this in context, because many additional supports were appropriately being added to the CLDPs, the post-move monitoring activities had become more complicated. However, some concerns were noted with regard to ensuring and/or documenting that each pre- and post-move required support was in place in a timely manner. More specifically: ▪ As noted above with regard to Section T.1.e, some issues were noted with regard to the evaluation of training provided to community provider staff during pre-move reviews. These same issues were noted when changes in staff occurred, and training needed to be completed. ▪ In some cases, the documentation did not support the Post-Move Monitor's thorough review of the support stated in the CLDP. For example: o One support required Individual #342 to have specific staff, including five-minute checks when in the bathroom and one-hour checks at nighttime. Although some information about staffing was provided in the report, no evidence was presented to confirm that these checks	

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		were being completed. For a number of supports, the report read: "This support remained in place," without providing any specific evidence. Sometimes the frequency of measurable objectives was not specifically assessed (e.g., "Opportunity to be able to cook and clean in her own kitchen at least 1x/week."). The quality of the community provider's implementation of the PBSP was not assessed. o For Individual #156, review of the support for obtaining employment and submitting a DARS application was inadequate. For example, the 45-day review said nothing about either of these, and merely said he had been talking about wanting to work. The 90-day report did not address bike riding, which was a post-move required support. The Post-move Monitor did not provide adequate information about whether the requirement for four community outings per month was met. Except for the seven-day report, general statements were made that did not address this measurable support. o For Individual #326, the support related to the identification of and appointment with a psychiatrist addressed psychology, but not psychiatry. <u>Use of Facility's Best Efforts to Ensure Supports Are Implemented</u> The primary reasons for conducting post-move monitoring are to identify if the protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the seven individuals reviewed (i.e., two of the nine did not have any post-move monitoring documentation submitted (i.e., Individual #241 and Individual #52), six of them (86%) had needs identified for which follow-up was necessary to ensure supports were implemented. The only person for whom follow-up was not needed was Individual #165. ▪ Of the six individuals for whom follow-up was indicated, documentation was present to show that for one individual (17%), adequate follow up had occurred (i.e., Individual #326). In some instances, it appeared that the Post-Move Monitor had taken a number of steps to follow-up. However, despite the Monitoring Team's request for post-move monitoring documentation: "including additional documentation, if any, that reflects follow-up activity taken by the PMM, IDT, or the Facility in response to issues identified in the post-move monitoring checklists," no documentation of team meetings was submitted. 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	

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		identified during the post-move monitoring visits, this was not consistently done or documented (e.g., Individual #156), or the review was significantly delayed. For example: ▪ Individual #342, even after two psychiatric hospitalizations in quick succession, no documentation was provided to show that her team met to review the implementation of the supports, and /or to make any necessary changes. A note separate from the post-move monitoring documentation indicated in-service training occurred for new day habilitation staff, and close to a month and a half after the first incident and three weeks after the second psychiatric hospitalization, the team met. No details were provided regarding the meeting or steps taken. ▪ Although the Monitor is aware of a number of actions the Facility took to address issues with Individual #350's transition, these were not included in the documentation submitted. One major issue was the failure of the community provider to identify a psychologist to support Individual #350. At the 45-day review, Individual #350 had already been psychiatrically hospitalized due to her behaviors. In the documentation provided, there was no urgency in the Facility's response. It was unclear if the team met or precisely what was done other than notifying the community provider. An email from the community provider indicated they were working on it. This was an inadequate response given the potential risk to Individual #350 and others. Although the Facility's efforts at and after the 90-day review are applauded, and from verbal accounts, these efforts had resulted in Individual #350 successfully remaining in a community setting, these efforts were overdue and were not included in the documentation the Facility provided to the Monitoring Team. Based on the Monitoring Team's review, issues were identified with regard to both the timeliness/completion and quality of the post-move monitoring activities, as well as the Facility's efforts to ensure supports were implemented. The Facility remained out of compliance with this provision.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on a monitoring visit to Individual #380's home. The Post-Move Monitor also conducted a review of the individual's day program, but the Monitor was not able to attend this portion of the review. As a result of not observing the entire post-	Not Rated

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	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.	move monitoring visit, the Monitor has not rated this provision. However, based on the Monitor's limited observations, the Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. Importantly, the Post-Move Monitor was very cognizant of safety issues that had been identified during the pre-move visit. The Post-Move Monitor took care to ensure that the community provider was continuing to adequately attend to these issues.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency	The parties 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, one individual had had an alternate discharge. Individual #157's guardian had moved him to a nursing home without going through the CLDP process. However, in error, the Monitoring Team did not request the documentation related to his discharge. As a result, this provision was	Not Rated

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	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.	not rated.	

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

1. The professional teams supporting individuals at AUSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. (Sections T.1.a and T.1.b.3)
2. With regard to policy:
    a. State policy should be modified to reflect the changes that have occurred regarding transition procedures so that expectations regarding practice are clearly delineated.
    b. In addition, as appropriate, the Facility should include in its local policies any Facility-specific details that are relevant to full implementation of the State policy. (Section T.1.b)
3. Teams should demonstrate competence in the identification of obstacles to referral as well as obstacles to transition of individuals to the most integrated setting appropriate to their needs and preferences. (Section T.1.b.1)
4. 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)
5. Likewise, when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the State. (Section T.1.b.1)

6. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based. (Section T.1.b.1)
7. As individuals go through the transition process, it is essential for teams to identify and document any obstacles to transition the individual encounters, as well as teams' plans to overcome them. (Section T.1.b.1)
8. The Facility is encouraged to continue to offer and expand the 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. A written plan should be developed for the education of staff 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 annual education process, and provider fairs.
    d. It is particularly important for individualized activities to be identified in individuals' ISPs, as appropriate, and implemented. (Section T.1.b.2)
9. 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. In addition, sign-in sheets should be maintained with the CLDP document that show the attendance at the various meetings held. (Section T.1.c.3)
    b. The Facility should begin using the pre-transition time to more effectively define the pre- move and post-move required supports. (Section T.1.c)
    c. 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., a pre-move required 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;
    d. 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;
    e. With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of

clinicians;

f. 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;
g. 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;
h. 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;
i. Teams should factor in modifications that need to be made to current programs or plans, and write such modifications into the pre-move or post-move required supports;
j. As appropriate, teams should identify as a pre-move or post-move required 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;
k. 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;
l. As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move required supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting;
m. 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.);
n. 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 a pre-move or post-move required support;
o. 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;
p. 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;
q. 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
r. Focused effort should be placed on ensuring each of the supports identified is measurable. (Sections T.1.c.1 and T.1.e)

10. 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)

11. 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)
12. As has been recommended in previous reports, 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), whose community transitions are in jeopardy, or who experience other significant negative outcomes (e.g., police contact, arrest, unexpected hospitalizations, unauthorized departures, etc.). (Section T.1.f)
13. 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 and Facility Self-Assessment)
14. As has been recommended previously, 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)

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section U; o Facility Self-Assessment, dated 10/22/12; o Blank template for Physician's Certificate of Medical Examination; o Brochure entitled: "Your Duties as Guardian of the Person," dated 6/4/12; o Guardian of the Person Only: Court-Ordered Instructions, dated 6/4/12; o Guardianship Report, printed on 11/5/12; o DADS Policy Number 019: Guardianship, dated 3/7/12; o Guardianship Priority Rating Tool, undated; o List of individuals without a guardian, undated; o List of new guardians, since April 2012; o Guardianship Actions, since April 2012; 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: "Training curricula has not been created." ▪ **Interviews with**: o Nicole Hinajosa, Human Rights Officer; and o Amy Owen, Human Rights Officer.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U, dated 10/22/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section U, in conducting its self-assessment: ▪ Based on interview with Facility staff, work had been done to refine the original Section U monitoring tool, and use of a new tool recently had begun. The Facility reportedly had conducted one month of monitoring using the new tool. However, the Facility Self-Assessment did not yet include the results from such monitoring. For example, in the current Facility Self-Assessment, no sample sizes were provided, or results from review of individuals' records. According to the Human Rights Officer, she and a member of the QA Department conducted monitoring in October 2012. However, inter-rater reliability had not been formally established. In addition, based on review of the revised tool, it included minimal instructions, and appeared to result in a composite or overall score. As indicated previously, overall scores for this type of audit would provide little if any useful information. In addition, it was not clear how the tool would be completed or how some of the data collected would provide a status of compliance with the Settlement Agreement. The tool was written more in terms of a checklist teams might use to evaluate an individuals' needs with regard to informed consent, as opposed to indicators that would evaluate whether or not teams had completed this process appropriately. For example, it was unclear what a "yes" or "no" rating would mean from a compliance perspective for the indicator that an individual was able to

express him or herself verbally, nonverbally, or using sign language and/or gestures. This would be information that teams would need to discuss, but monitoring of this process would need to involve assessment of whether teams had used appropriate assessment information, for example, to make this determination. Without further instruction on use of the tool, it is unlikely that valid and useful results would be obtained.

- In its current Self-Assessment, the Facility used other relevant data sources. For example, the Self-Assessment provided numbers of individuals with guardians as well as numbers of individuals for whom guardians had been appointed.
- The Facility rated itself as being in compliance with none of the subsections of Section U. This was consistent with the Monitoring Team's findings.

Once State Office issues procedures for formally assessing individuals and pursing guardianship or other decision-making resources, then the self-assessment process will need to be modified. For example, 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. As noted above, it was unclear how the revised audit tool would be used to effectively evaluate these areas. In addition to providing statistics, the self-assessment should include analyses of the audit results.

Summary of Monitor's Assessment: On 3/7/12, DADS State Office issued Policy #019: Guardianship. The Facility had not yet developed a local policy, and the Facility was in the initial or planning stages of many of the requirements of the State Office policy. A second policy on consent remained in the development phase. The State is encouraged to finalize this policy, because it should assist the Facilities in moving forward 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, 80 of the 321 individuals the Facility served (25%) did not have guardians. In addition, 64 individuals had lapsed guardianships. It was positive that the Facility had reduced this from the approximately 150 individuals originally identified as having lapsed guardians, but this remained a significant number. Courts had found that these individuals lacked the capacity to make decisions when they appointed guardians, and in some cases, the guardianships had lapsed months or even more than a year ago.

As noted in the report for the Monitoring Team's visit in November 2011, AUSSLC had developed a document entitled: "Guardianship Priority Rating Tool." However, the Facility had made a reasonable determination that prioritization of individuals in need of guardians should not occur until an adequate process had been implemented to assess individuals' functional decision-making capacity.

As the Monitoring Team reported in previous reports, Facility staff made ongoing attempts to obtain guardians for individuals. Since the baseline review, a total of 30 individuals had obtained guardians, of which 19 had been appointed since April 2012. An additional five individuals had had hearings, but paperwork was pending. Three additional individuals had guardianship applications pending. The

	majority of new guardians were family members. For some of the individuals for whom hearings had been held, it was anticipated that the local nonprofit guardianship agency would be appointed as guardian.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	On 3/7/12, DADS State Office issued Policy #019: Guardianship. A second policy on consent remained in the development phase. The State is encouraged to finalize this policy, because it should assist the Facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. According to the Human Rights Officer, steps also would be taken to re-establish a Guardianship Committee. Based on the State Office policy on guardianship, the Guardianship Committee would be responsible for "developing, prioritizing and maintaining a list of individuals who: Do not have the functional capacity to make decisions regarding their own health or welfare; and do no have an existing LAR to make such a decision." The Human Rights Officer had begun to make contacts regarding potential candidates for the committee. 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, 80 of the 321 individuals the Facility served (25%) did not have guardians. In addition, as indicated in the Monitoring Team's abbreviated report, dated, 7/6/12, the Facility had checked the documentation available for all Legally Authorized Representatives (LARs), and identified significant issues related to current Letters of Guardianship not being available for approximately 150 of the individuals with guardians. However, since then, using a number of methodologies ranging from sending requests to LARs for copies of guardianship papers to assisting LARs in submitting needed paperwork to the Court, this number had been reduced to 64. This was an ongoing process, and the Facility had developed a spreadsheet to track guardianships and the dates of expiration. The Human Rights Officer also now was provided a copy of all letters of guardianship upon receipt. In addition, the Human Rights Officer worked with the Records Department to add guardianship paperwork to the Active Records. These activities were essential to ensuring that the correct person provided consent. As noted in the report for the Monitoring Team's visit in November 2011, AUSSLC had developed a document entitled: "Guardianship Priority Rating Tool." The 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-	Noncompliance

#	Provision	Assessment of Status	Compliance
		risk screening process, use of a PBSP and/or crisis intervention plan, and a past history of a need for frequent medical concerns, fractures, or surgical interventions. However, at the time of the review, the Facility had not implemented the tool. The Facility had made a reasonable determination that prioritization of individuals in need of guardians should not occur until an adequate process had been implemented to assess individuals' functional decision-making capacity. Until it was known which individuals required guardians, a list could not be prioritized. As a result, AUSSLC was not maintaining a prioritized list of individuals needing guardians. 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 addition, the Human Rights Officer indicated that Facility staff intended to review other Facilities' draft functional capacity assessment tools, as well as continue to work with State Office to identify a viable tool and/or process. As discussed during the onsite review, efforts also should be made to identify other supports that might assist individuals to make decisions. 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; 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 Facility remained out of compliance with this provision of the Settlement Agreement. However, AUSSLC continued to identify individuals without guardians as well as individuals with lapsed guardianships.	
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	Since the previous review, the Facility had made some progress with regard to this subsection of the Settlement Agreement. At the time the Monitoring Team's report was issued for its November 2011 review, a total of 11 individuals had obtained guardians since monitoring began. As the Monitoring Team reported in previous reports, Facility staff made ongoing attempts to obtain guardians for individuals. For example: ▪ In April 2012, through ongoing work with local probate court, two days of	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	hearings were held on the AUSSLC campus, resulting in a number of individuals obtaining new guardians. Some additional individuals had obtained guardians outside of this process. A total of 19 individuals had obtained guardians since April 2012. An additional five individuals had had hearings, but paperwork was pending. Three additional individuals had guardianship applications pending. ▪ One individual obtained a limited guardian, which was a less restrictive option than full guardianship. This was very positive, and showed a commitment on both the Facility's part to provide the probate court with information about individual's ability to make decisions, as well as the court's commitment to consider it. ▪ Based on review of documentation provided, Facility staff continued to make contact with families and other interested persons to discuss the possibility of petitioning for guardianship. At the time of the Monitoring Team's review in November 2011, a Guardianship Committee had been formed, and met twice. This Committee was developed in response to the State Office's draft policy, which since had been finalized. However, at the time of the most recent review, the Committee was not meeting, and as noted above, Facility staff were in the process of recruiting community members to participate. This will be an important activity to complete. Such a group, if properly constituted, might be helpful in identifying resources related to alternatives to guardianship, as well as potential guardians. 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. As noted above, the Facility had a good relationship with the court, and this valuable resource had been utilized to assist a number of families interested in becoming guardians to complete the process. 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. 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	

#	Provision	Assessment of Status	Compliance
		(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 Office policy on consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding, in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either, allow an individual to make informed decisions, or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.); and
    c. 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 policy is finalized, the State should provide key Facility staff with training on their implementation. (Section U.1)
3. AUSSLC should develop policies on guardianship and consent, once the State Office policy is issued, 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. The Facility should then prioritize the list. (Section U.1)
5. The Facility should continue to identify and address the needs of individuals with lapsed guardians. Given that courts have identified these individuals as requiring guardianship, for individuals for whom the Letters of Guardianship cannot be updated, steps should be taken to identify appropriate guardianship supports for them. (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. The Facility Self-Assessment 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 Approved policy training and checklists and supporting documentation; o Policy Review/Update Status, dated 11/8/12; o Policy and Procedure Overview, effective September 2012; o Table of Contents for Policies, dated 10/30/12; o For Policy and Procedure Overview Policy: a) policy training checklist; b) correspondence regarding policy issuance; c) curriculum and/or training materials; d) training rosters; e) exception report/list of staff still requiring training; and f) numbers of staff completing training/number of staff requiring training (i.e., percentage trained); o Copies of communication to staff informing of policy and copies of competency evaluation tools for selected policies, various dates; o Notation that not changes made to AUSSLC draft Policy entitled "Recordkeeping Practices, dated 4/15/11; o Presentation Book for Section V; o Draft Procedures for Flow of Materials from Production to Filing in the Record, undated; o List of staff responsible for records management, undated; o Active Record Order and Guidelines, revised 4/3/12; o Index for Master Records, as of 3/15/11; o Individual Notebook and Guidelines; revised 9/19/12; o Description of quality assurance procedures, undated; o Active Record Order Guidelines Audit Tool, dated 2/14/12; o Individual Notebook Guidelines monitoring tool, undated; o Settlement Agreement Cross Referenced with ICF/MR Standards – Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4, revised 10/1/10; o Settlement Agreement Provision V.4 – Interview Tool for Use of the Record, revised 1/26/12; o Completed quality assurance checklists for last 10 records reviewed; and o Plans of correction related to record review for the three months prior to the review. ▪ **Interviews with**: o Bailey Kessler, Unified Records Clerk; o Annabelle Cantu, Unified Records Clerk; and o Cheri Grimm, Data Analyst.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V, dated 10/22/12. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

	For Section V, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Section V – Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4 review tool with guidelines; Settlement Agreement Provision 4 – Interview Tool for Use of the Record with guidelines; Active Record Order Guidelines Audit Tool; review of check-in/check-out sheets; and the Individual Notebook Guidelines. Although the tools included a number of indicators related to the Settlement Agreement, the Facility Self-Assessment did not yet include indicators that were adequate to measure all aspects of compliance with the Settlement Agreement. As one example, Section V.1 required adherence to the requirements in Appendix D, but many of the requirements of Appendix D were not addressed in the Facility's Self-Assessment. o The monitoring tools did not yet include adequate methodologies. For example, more work was needed to obtain more information about the quality of the records (e.g., skill acquisition and behavioral data). o The Self-Assessment identified the sample(s) sizes. Often, it also included the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. It will be important as criteria for monitoring are developed and methodologies finalized that these be memorialized in the form of formal instructions/guidelines. o The following staff/positions were responsible for completing the audit tools: the Unified Records Coordinators and the Medicare Population Clerk. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although all of the staff responsible had varying levels of experience with records management, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o The staff involved in conducting the audits were actively working to establish inter-rater reliability. Although staff reported that the two Unified Records Coordinators had established inter-rater reliability between the two of them, the Medicare Population Clerk was new to the process. ▪ The Facility used to a limited extent other relevant data sources. For example, with regard to Section V.2, the Facility reported the numbers of new or revised policies issued. The Facility also recognized the need to track training of staff on new or revised policies. This would be an area where key indicators/outcome measures could be developed to measure compliance. ▪ The Facility rated itself as being in substantial compliance with none of the subsections of Section V. This was consistent with the Monitoring Team's findings. ▪ In the Facility Self-Assessment, some areas in need of improvement were identified. The Facility had identified some limited actions it had taken to address issues identified.

	Summary of Monitor's Assessment: At the time of the review, staff reported that each individual had an Active Record, a Master Record, and an Individual Notebook. In the Monitoring Team's report based on its onsite review in November 2011, a number of issues were noted with regard to the Individual Notebooks. Since then, a workgroup had met, and developed a revised Table of Contents for the Individual Notebooks. The Notebooks had been revised to the new format. However, only the File Clerks had been trained and further training was being planned for all staff that would have responsibility for the Individual Notebooks. In March 2012, a revised Active Records checkout process began. The Administrative Assistants were supposed to check weekly to ensure all records were in the residences. This partially addressed the issue of security of the records. The Facility recognized more work was needed in this area. At the time of the review, as required by the Settlement Agreement, at least five audits were being completed of records each month. These audits were identifying problems with the records, and some follow-up was occurring on an individual record basis. The next step would be aggregating and analyzing information gained through record audits in more depth to determine if more systemic or targeted corrective action was needed. The Facility was making progress in updating and/or developing policies to address the various requirements of the Settlement Agreement. In addition, the Facility had developed what appeared to be a viable process for identifying the training needs for various policies, providing the training, and tracking the training's completion. Based on observations of team meetings, teams were more consistently using data, and other information contained within individuals' records, to make care, treatment, and training decisions. However, improvements in this regard were still necessary. In addition, issues related to the completeness of the records, and the maintenance of complete data, had the potential to impact negatively on teams' decision-making ability.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Progress had been made and/or sustained with regard to the establishment and maintenance of a unified record consistent with the guidelines in Appendix D of the Settlement Agreement. Positive developments included: ▪ Since the Monitoring Team's last review, the Client Records Coordinator had moved to a different position, and one of the Unified Records Coordinators was filling in until a replacement was hired. The Facility still 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, one vacancy existed for a File Clerk. It was	Noncompliance

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		anticipated this position would be posted soon. In the meantime, the remaining clerks were assisting with the duties in the four residences. ▪ 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 dated 4/3/12. ▪ During the initial presentation to the Monitoring Team, the Facility reported that 70% of the Master Records had been audited to ensure conformance with the Facility's Master Record Table of Contents. ▪ Beginning the week after the Monitoring Team's onsite visit, an Active Records Taskforce would begin meeting. The purpose was to provide a forum for decisions to be made about adding or removing documents or tabs from the Active Records Guidelines, and modifying or developing forms. It was anticipated that this would be an interdisciplinary group. ▪ In March 2012, a revised Active Records checkout process began. The Administrative Assistants were supposed to check weekly to ensure all records were in the residences. They sent their reports to one of the Unified Records Coordinators. Staff reported that it was helpful, and if after a call to the home, records were identified as being missing, an email was sent out, resulting in quick location of the missing records. Data was entered into a database. At the time of the review, aggregate data was available to allow the Records Department to identify, investigate, and respond to any potential issues in particular Units or residences. ▪ In the Monitoring Team's report based on its onsite review in November 2011, a number of issues were noted with regard to the Individual Notebooks. Since then, a workgroup had met, and developed a revised Table of Contents for the Individual Notebooks. The group used the State Office guidelines, and individualized them to meet the needs of AUSSLC. Importantly, this group included direct support professionals, who provided their input as the direct users of the Notebooks. The "I-Book Task Force Final Report," dated 10/3/12, reflected group discussion and deliberation focused on resolving practical problems. ▪ The Taskforce also had developed methodologies to assist in ensuring the Individual Notebooks remained up-to-date. Two Fridays each month, the books would remain in the residential programs for maintenance. This had some implications for the access to which direct support professionals would have to the information in the Individual Notebooks on those days. However, there was a practical issue in ensuring they were kept current. The Facility should continue to evaluate the impact this has on data collection and access to necessary information, and make changes as necessary. Data sheets also would	

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		be pulled on a specific schedule. ▪ On 10/11/12, the File Clerks completed refresher training on the records policy. Based on interview with staff, this training was completed to review some of the common issues identified through record audits. ▪ Due to issues related to psychiatrists being able to find consents in the records, a corrective action plan was developed and implemented to specifically address the problems noted. This involved retraining of the Records Clerks, and then checking and corrections made to all Active Records. ▪ As noted in the Monitoring Team's last compliance report, 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. Reportedly, this system was sill in place, and it appeared to have significantly improved the availability of such information. ▪ To assist with tracking the status of information sent for filing, a system was set up on the Facility's shared drive. Based on interview with staff, three Departments (i.e., Psychology, Food Services, and Vocational) were using this system. For this limited number of departments, the File Clerks used it to log when they received information, and document the date documents were filed. Reportedly, this system had helped to increase accountability with these departments. Although not yet fully implemented, the Medical Department had begun to send their documents to the Mail Room, from which they were sent to the Records Department. The QA Nurse was beginning to work on a check-in system for Nursing Department documents. ▪ In the Monitoring Team's last compliance report, an issue was raised regarding ongoing training for staff on recordkeeping and privacy/security requirements. Since that review, the Facility responded to the Monitoring Team's recommendation. The Records Department worked with the Competency Training Department and developed an Info Learn module to refresh staff's knowledge on recordkeeping. It had been posted three weeks prior to the Monitoring Team's most recent onsite review, and staff were in the process of completing it. Importantly, the training provided an example of use of the record that emphasized how accurate recordkeeping can impact the lives of individuals the Facility supports. The expectation was that refresher training would be repeated annually for all staff. In addition, a recordkeeping component had been added to the On-the-Job portion of New Employee Orientation. New staff came and spent time with the Records Department staff to orient them to the records and the recordkeeping policy. These were all very good developments that should assist staff in keeping up-to-date on recordkeeping requirements.	

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		Areas in which improvements or further efforts should be made in order to achieve compliance, included: ▪ At the time of the onsite review, only the File Clerks had been trained on the new Individual Notebook Table of Contents. The Notebooks had been revised to the new format. However, further training was being planned for all staff that would have responsibility for the Individual Notebooks. It was anticipated that on 11/15/12, the QA/QI Council would review the training proposal. ▪ The Facility recognized that it had not yet adequately addressed the issue of security of the records. This was a piece that further work was needed. ▪ As Facility staff recognized, challenges remained with regard to ensuring that the records met all of the requirements of Appendix D. Although as discussed with regard to Section V.3, aggregate data from the record audits was not yet being analyzed, anecdotally, based on their experience with the records, the Unified Records Coordinators reported ongoing issues with legibility, and to some extent documents missing from the records (e.g., bowel records, diet records, etc.), as well as some misfiled documents due to staff other than the File Clerks putting documentation in the records. However, these issues had not yet been addressed on a systemic level. ▪ At the time of the most recent review, the Facility had drafted a "Procedures for Flow of Materials from Production to Filing in the Record" document. Once finalized, this should define better the filing responsibilities and further decrease missing documents. 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. Based on interview with staff, the Facility had identified the need to update many of its policies, and had developed a new numbering convention. The new leadership team recognized the AUSSLC had not adapted or posted a number of State Office policies, so they were in the process of working to localize these policies. Based on the chart submitted, many policies were in the process of being developed or updated/revised, the Facility appeared to have a process for accomplishing this task, and a way of tracking its progress. In an attempt to set forth a standardized process for policy, a policy entitled: "Policy and Procedure Overview," effective September 2012, was issued. According to this policy: ▪ A Department Head or designee would be responsible for the development	Noncompliance

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		and/or revision to a policy. ▪ They were expected to complete a Policy Training Checklist for each new of revised policy. This checklist identified "the staff to be affected by the new/updated policy, the mechanism needed to communicate the issuance of the policy, the degree of training required, and the responsible party to ensure applicable staff receive the training. The checklist will also identify the system that will be utilized for tracking the training through to completion." ▪ The draft policy was sent to the Administrative Project Coordinator with the Training Checklist. ▪ The Administrative Project Coordinator reviewed the policy to ensure compliance with various requirements. ▪ Once any corrections were made, it was sent to the Executive Leadership Team for review and approval, including review and approval of the Policy Training Checklist. ▪ Once signed by the Director, the Policy Training Checklist would be implemented, and documentation maintained. The Competency, Training, and Development Department was responsible for maintaining all training records, some of which the various Departments would submit to them. ▪ Policies and procedures were expected to be reviewed annually, and revised, as appropriate. This policy and the related Policy Training Checklist appeared to provide a reasonable mechanism for developing/revising, reviewing, and training staff on policies. The Facility was in the initial stages of implementing it. At the time of the review, the only policy that had gone through the entire process was the Policy and Procedure Overview. The Facility provided documentation of the notification of relevant staff on this new policy, as well as sign-in sheets for staff trained on it. In response to the Monitoring Team's request for an exception report to show staff that still required training, the Facility indicated this information was not available. However, the Facility did provide a list of staff trained, and a summary that no staff were delinquent on the training. The Facility also provided some examples of other policies that had been approved, but training was pending. Still other policies had been approved, but required an email notification (e.g., use of electronic devices or tobacco use). These showed examples of how the Policy Training Checklist appeared to be used effectively. The Facility was making progress in updating and/or developing policies to address the various requirements of the Settlement Agreement. In addition, the Facility had developed what appeared to be a viable process for identifying the training needs for various policies, providing the training, and tracking the training's completion. Although it was not yet in compliance with this provision, progress had been made.	

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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: ▪ The Unified Records Coordinators and the Client Records Coordinator had been conducting record reviews. With the departure of the Client Records Coordinator, the Medicare Population Clerk had begun to assist with record audits. ▪ Based on the documentation provided, it appeared that more than the required five reviews had been conducted in a month. Based on interview, a total of 16 audits were done each month. This represented five percent of the census at the Facility. Each of the three auditors conducted five reviews each, and all of them reviewed the same record for the sixteenth record to establish and maintain inter-rater reliability. ▪ 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." They also had begun to use the Individual Notebook Guidelines to review Individual Notebooks. ▪ In addition, although for a time this tool was not used, beginning in late July 2012, an individual's team for one record review 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 and/or a series of emails was sent to the responsible party until the issue was resolved. A tracking log was maintained for missing documents, including the name of the person contacted, the date of notice, and the date and response from the Department contacted. For the File Clerks, individualized training or technical assistance was provided. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, the Facility was using some data as well as information from the Monitoring Team to determine issues that required correction. However, the next step in the process was reviewing aggregate data to identify unresolved issues, analyzing the data in more depth to identify specific issues or departments requiring more attention, and developing corrective actions, as appropriate, to address them. ▪ Efforts to establish inter-rater reliability between the Unified Records Coordinator and Medicare Population Clerk were underway. ▪ Although the Facility had taken steps to close the loop with regard to missing	Noncompliance

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		documents, it was unclear if the feedback provided to File Clerks regarding specific records also was tracked to ensure necessary changes were made. Although the Facility continued to complete some of the tasks 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 limited work had been done to implement actions necessary to correct deficiencies identified systemically.	
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.	Since the Monitoring Team's last compliance review, the Monitors and the parties agreed to a list of actions that the SSLCs would engage in to demonstrate substantial compliance with this provision item. The Facility had not yet incorporated all of the following into its monitoring. The following represent the Monitoring Team's findings with notations of where the Facility was conducting some level of review: ▪ **Records are accessible to staff, clinicians, and others**: Although AUSSLC was not yet self-assessing this, the Monitoring Team observed that: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. o As noted with regard to Section V.1, three Departments (i.e., Psychology, Food Services, and Vocational) were using a system in which the File Clerks logged in information as they received it, and documented the date documents were filed. This system seemed to be helpful, and other Departments were working on other systems to ensure documents reached the Records Department in a timely manner. o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc. o From a limited review of records while on site, it was noted that some of the Comprehensive Nursing Assessments and HMPs were missing from the Active Records. 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. ▪ **Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)**: The Monitoring Team observed some problems. For example: o Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. In reviewing the collection of data for Positive Behavioral Support Plans and skill acquisition goals, it was determined that staff might not have	Noncompliance

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		been accurately, consistently, and timely documenting data, and processes were not in place to ensure data reliability. ▪ **Staff surveyed/asked indicate how the unified record is used as per this provision item:** Beginning in late July 2012, the Unified Records Coordinators were asking a sample of team members to complete the questions that State Office had sent related to Section V.4. Review of a small sample of these completed forms generally showed that staff were able to articulate how they used the records. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** Based on the Monitoring Team's observations: o At ISP meetings during the week of the Monitoring Team's review, the records were available and often teams referenced them when they required more details. o However, although improvement was noted, as discussed with regard to Section F of the Settlement Agreement, ISPs continued to lack evidence of teams making data-based decisions. For example, although improvements were seen with data included in the IRRFs, some data was still missing. Data frequently was not discussed with regard to other aspects of care, such as PBSPs or skill acquisition programs. Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions.	

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

1. As the Facility implements the process for holding Individual Notebooks back on the residences two Fridays each month, it should evaluate the impact, if any, this has on data collection and direct support professionals' access to necessary information, and make changes as necessary. (Section V.1)
2. The Facility should work on improving the security of records. (Section V.1)
3. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures. (Section V.2)
4. 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)
5. 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)

6. 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. (Section V2 and 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
BTC	Behavior Therapy Committee
CAP	Corrective Action Plan
CAPPS	Comprehensive Assessment Program Planning System
CBC	Complete Blood Count
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
DARS	Texas Department of Assistive and Rehabilitative 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
pH	Potential Hydrogen
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