

United States v. State of Texas

Monitoring Team Abbreviated Report

Austin State Supported Living Center

Dates of Visit: August 19 through 23, 2013

Date of Report: November 20, 2013

Submitted By: Maria Laurence, MPA, Monitor

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

Table of Contents

Introduction	1
Section C: Protection from Harm – Restraints	3
Section D: Protection from Harm - Abuse, Neglect and Incident Management	7
Section I: At-Risk Individuals	13
Section J: Psychiatric Care and Services	17
Section K: Psychological Care and Services	21
Section L: Medical Care	27
Section M: Nursing Care	42
Section N: Pharmacy Services and Safe Medication Practices	46
Section O: Minimum Common Elements of Physical and Nutritional Management	50
Section Q: Dental Services	61
Section T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	67
Appendices	
Appendix A – List of Acronyms	i
Appendix B – Review Methodology	iii

Introduction

In 2009, the State of Texas and the United States Department of Justice (United States) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated State Supported Living Centers (SSLCs), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences, including the Austin State Supported Living Center (AUSSLC). Beginning in January 2010, the Monitoring Team has conducted reviews of AUSSLC as required by the Settlement Agreement, and in May 2012, the Monitoring Team conducted an abbreviated review based on an agreement of the parties.

In June 2013, the State of Texas again requested an abbreviated review of AUSSLC. The State made this request in order to dedicate intensive resources and staff time to respond to the Department of Aging and Disability Services (DADS) Survey and Certification Team's findings. This activity was necessary for the Facility to maintain federal Medicaid funding.

The Monitor worked with the State and United States to develop a process for an abbreviated review. The United States and State agreed upon the following format for the abbreviated review:

1. The full Monitoring Team would visit Austin SSLC for five days during the week of August 19, 2013, to conduct an abbreviated review focused on individuals' health and safety. This would not be considered a compliance review, but a status review. On the morning of the fifth day, provide an exit conference with a limited audience from the Austin SSLC and State Office, and the Department of Justice.
2. Entrance conference: Entrance conference will consist of the monitoring team and limited DADS' staff. Matt McCue and Holly Lindsey to present summary of the work completed since the last monitoring visit, particularly the efforts on the Regulatory activities. Section Leads will present updates on their department achievements since the last monitoring review.
3. Visit activities may include:
 - a. Informal meetings with the discipline leads to ascertain the departments' perceptions of their current status and work products;
 - b. Limited onsite reviews of areas of focus and review of records that most closely reflect conformance to the requirements of the Settlement Agreement, and/or chosen by the Monitoring Team based on risk information, incident data, etc.;
 - c. As appropriate, attendance at scheduled meetings and observations of individuals and discussions with residential and day/vocational staff to assess protection from harm, and basic health and safety assurances;
 - d. As appropriate, conversations with direct line clinical staff (e.g., nurses, primary care practitioners, psychologists, psychiatrists, therapists, etc.) to determine the existence of basic systems and resources necessary for them to do their jobs, and
 - e. Austin SSLC staff will provide a schedule of meetings for the week of the review, such as Medical Morning Meeting, etc.
4. Areas of Focus: The following are the areas on which the Monitoring Team would focus its efforts in order to provide the parties with a status update on the key issues related to health and safety. However, time permitting, the Monitoring Team might conduct record reviews and/or talk with staff about other components of the Settlement Agreement not listed here:
 - a. Section C (Restrains), focusing on intervention and redirection techniques; approved techniques, adequate supervision of individuals in restraint, and the facility's restraint review processes (taken from C3 and C7);
 - b. Section D (ANE [abuse, neglect, and exploitation] and Incident Management), focusing on all provisions under D2, except for D2g and h, on D3e, f, and i, and on D4;
 - c. Section I (At Risk), focus on status of identification of individuals at risk, and development and implementation of at-risk action plans/IHCPS;
 - d. Section J (Psychiatry), review of small sample of records to assess status with completion of CPEs and updates, and review of committee meeting minutes related to polypharmacy;
 - e. Sections K (Psychology), focus on Behavior Support Plans (BSPs) and their implementation, including individuals with at-risk behaviors, and development and implementation of crisis intervention plans;

- f. Section L (Medical), focusing on delivery of medical care and mortality reviews;
 - g. Section M (Nursing), focusing on identification of changes in individuals' health status, including processes necessary to do this (i.e., IHCPs, ongoing assessments, etc.), and medication variances;
 - h. Section N (Pharmacy) – focus on medication variances;
 - i. Section O (PNM), focusing on implementation and monitoring of mealtime and positioning plans, and status of PNMT, and development of plans to address individuals at highest risk;
 - j. Section Q - (Dental), focusing on adequacy of dental assessments and services, and
 - k. Section T (Most Integrated Setting), focusing on development of the CLDP, and the Facility's responses to issues, if any, identified through post-move monitoring.
5. Records Requests – Austin SSLC will provide lists for the monitoring team in advance of the onsite visit. The monitoring team will provide the topics for the lists. Austin SSLC will provide only a limited quantity of documents. On Monday of the review week, Austin SSLC will make requested information such as mortality reviews and committee meeting minutes available to the monitoring team. During the review, the Monitoring Team may request only limited documents (e.g., spreadsheets or other summary documents that staff is able to print during discussions with the Monitoring Team to provide an overall picture of timeliness of supports and services). For example, the Monitoring Team may request lists of psychiatric evaluations completed, list of individuals with dates of approvals of restrictive practices, etc. A portion of onsite review time will be used to conduct record reviews. The Monitor will work with DADS staff to determine the least intrusive way to accomplish this task. The Monitoring Team may ask for a limited amount of hard copies of records to take home.
 6. Self-assessment Report – Austin SSLC need not provide a self-assessment report prior to the visit.
 7. Austin SSLC will provide current action plans for each of the Settlement Agreement sections for the Monitoring Team's review and comment.
 8. Monitoring Report – Following the review, the Monitoring Team will issue a brief (i.e., 75 pages or less) report, identifying any major safety or health issues noted, briefly outlining status of Facility's plans to comply with each section of the Settlement Agreement, providing feedback on documents reviewed, observations, etc., and making recommendations related specifically to plans of improvement and/or areas requiring focused efforts over the next six months. The report will not necessarily address all sections of the Settlement Agreement.

At the time of the review, AUSSLC was in the process of responding to the DADS Survey and Certification Team's findings. The Facility was not accepting admissions, and since the last review, no individuals had been admitted to the Facility.

As during past reviews, the Facility staff worked hard to provide the Monitoring Team with documents requested, and to meet with members of the Team. The Monitoring Team appreciates staff's willingness to spend time sharing information about their plans for improvement and the current status of some of the activities related to implementation of the Settlement Agreement, as well as candidly discussing the challenges they were working to overcome.

Since the Monitoring Team's last review, a number of staffing changes had occurred at the Facility, including the Facility Director position, and some other discipline leadership positions. A number of basic issues that had been problematic since the Monitoring Team had begun monitoring continued to negatively impact the Facility's ability to deliver adequate and appropriate protections, services, and supports. The Facility's plans to address the DADS Survey and Certification findings were relevant to some of these issues (e.g., some components of each of the following: active treatment, the provision of behavioral supports, protection from harm, and staffing, including some pieces of staff training). However, the plans addressed only pieces of some of these, and it did not address other key supports that the Settlement Agreement does address related to individuals' health and safety (e.g., the provision of necessary health care supports, particularly related to nursing services and physical and nutritional supports), for which the Monitoring Team continued to find significant problems. The Facility Director expressed the intent to develop one internal action plan that would address both the requirements of the Settlement Agreement as well as the findings of the DADS Survey and Certification Team. This was a reasonable approach, and the Monitoring Team strongly encourages the Facility to develop and implement a comprehensive plan that results in improvements across all areas in

which deficiencies continue to exist. In this report, the Monitoring Team has attempted to highlight some of these areas that relate directly to the Settlement Agreement and comment on the Action Plans the Facility provided in relation to the Settlement Agreement. In addition, although compliance determinations have not been made, the Monitoring Team has identified areas in which it appeared progress had been made or maintained. Although this was not a full review, and so not all areas of the Settlement Agreement are addressed, the Monitoring Team hopes that some of this feedback will be of assistance to the Facility.

The Monitoring Team looks forward to its next onsite visit, and hopes that the plans discussed during this abbreviated review will have been implemented, others will have been developed, and they will have had positive changes in the lives of individuals AUSSLC supports.

Based on the limited review the Monitoring Team conducted, for the sections of the Settlement Agreement on which the parties agreed this review should focus, the following report summarizes the Monitoring Team's conclusions. Again, no findings are made with regard to the Facility's compliance with the Settlement Agreement.

SECTION C: Protection from Harm – Restraints

Description of Any Safety or Health Issues Noted:

Individual #403 was observed in her residence with wide band-aids on both cheeks. When asked, staff explained that these were regularly applied so that the woman would not scratch her face. A request was made for information regarding the plan supporting this strategy. The Facility provided the individual's PBSP, but it did not address the use of band-aids to prevent self-injurious behavior. Further, this individual did not have a Crisis Intervention Plan. As this is a restrictive practice, which could potentially cause harm to her skin, a plan for its use and eventual fading of the same should be presented for review and approval.

Findings regarding Areas of Focus:

It was agreed that the areas of focus for Section C would be intervention and redirection techniques, approved techniques, adequate supervision of individuals in restraint, and the Facility's restraint review processes. These are based on Sections C.3 and C.7. Section C.3 reads: "...each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques, approved restraint techniques, and adequate supervision of any individual in restraint."

For this abbreviated review, the Monitoring Team considered a reduced sample of 15 restraints for crisis intervention. Based on this review:

- In 100%, the documentation indicated that the supervision of the person in restraint was one-to-one.
- All restraint checklists included information in a check-box style in the field: "information about attempts to avoid restraint." In some of the checklists, there was additional information in the field: "description of behaviors prior to restraint" to indicate the order of the attempts, the results, and the time over which attempts were made. This was valuable information, because it helped establish the circumstances of the restraint and assisted teams in identifying additional interventions.
- Some issues with the printed restraint checklists were identified. Printed forms were not printing out the complete entry for "description of behaviors prior to restraint." However, after discussion with Facility staff, they were able to draw down a version of the restraint checklist that included the complete text. Information about attempts to avoid restraint were in check box form, without explanation making it difficult to assess how effective or extensive those efforts had been, but the expanded text in the "description of behaviors" field, and the additional information in the Face to Face and/or the Debriefing forms supplemented what appeared in check box fashion.
- The delinquency report for training on PMAB indicated 14% of staff were delinquent in completing training as of 8/12/13, and on RES0105 about 11% were delinquent. Given how critical staff training on restraints is to keep both staff and individuals safe, this finding was concerning, and is an area on which the Facility should focus its efforts.

According to the Facility's audit report of restraints between 1/1/13 and 6/30/13, a total of seven individuals were placed in restraint in response to a crisis more than three times in any rolling 30-day period. A sample of four of these individuals was selected for review. The following documents were reviewed: Active Record (volume I), I-Book, Psychological Evaluation, Positive Behavior Support Plan, Crisis Intervention Plan, Monthly Psychology Progress Notes, and ISPAs. Additionally, the Administrative Review Team meeting minutes were reviewed for three individuals, and the Root Cause Analysis document was reviewed for one individual. The results of this review are discussed below.

Based upon the documentation the Facility provided to the Monitoring Team, none of the teams met regularly following more than three restraints in any rolling 30-day period.

- The team for Individual #406 met on 7/19/13, at which time they reviewed the variables outlined in Section C.7 of the Settlement Agreement. However, his repeated restraints took place between 2/25/13 and 3/24/13. There was no documentation indicating the team had met during this period of time.
- Although the progress notes for Individual #421 indicated that team meetings were held 10 times between 4/8/13 and 6/26/13 to review her repeated restraint (84 incidents), there was no documentation summarizing the discussion or outcome of these meetings. An Administrative Review Team meeting was held for her on 6/26/13, and a Root Cause Analysis was completed on 8/7/13. However, neither of these reflected a comprehensive review of potential factors contributing to her worsening behavior.
- The team for Individual #344 met on 3/15/13 and 3/25/13 to discuss more than three restraints in a rolling 30-day period. The minutes were almost identical with very limited suggestions for actions to be taken by staff. An earlier meeting on 2/25/13 noted that the team had met to discuss repeated restraints occurring between 12/23/12 and 2/4/13. However, this documentation was not provided to the Monitoring Team. An Administrative Review Team meeting was held on 1/18/13 during which several recommendations were made. The team should have met more frequently, because this individual was repeatedly placed in restraint between 1/1/13 and 6/28/13 (54 incidents).
- The team for Individual #56 met on 4/8/13, 4/12/13, and 5/8/13 to review more than three restraints in a rolling 30-day period. Here too, the team should have met more frequently as repeated restraints occurred between 3/10/13 and 6/20/13.

The team for Individual #344 reviewed his use of sign language and a communication schedule. It was noted that: "when he chooses to use these types of communication, he communicates very well." It was unclear why speech and psychology staff had not worked together to ensure that this young man consistently employed the communication skills he had.

At the 4/8/13 meeting for Individual #56, members of the team suggested that the individual was sensitive to the changing seasons and had difficulty adapting to daylight savings time. There was no indication that historical data had been reviewed to support this hypothesis. Further, staff suggested that he was missing specific staff members or missing peers at the workshop. The action plan indicated the psychologist would request an emergency psychiatry clinic to "help reduce possible anxiety or other symptoms underlying his increased agitation." It was unclear why the psychologist also had not scheduled repeated observations in the workshop to determine antecedents and consequences to these reported behaviors.

The team for Individual #56 did note that he had first displayed increased rates of problem behavior when he was required to wait for meals or extra servings. Similarly, the staff for Individual #344 noted that he became upset when his meal was not ready. While these were appropriate observations, there were no plans identified to address this difficulty. This suggested that alternative activities should be explored to eliminate or minimize down time prior to meals.

At meetings on 3/15/13 and 3/25/13, the team for Individual #344 indicated that his functional behavior assessment was still valid. As the FBA provided to the Monitoring Team was completed in 9/10, it appeared that an updated assessment was overdue and of critical importance.

All of the individuals in the sample had a PBSP. The teams for Individual #56 and Individual #344 reviewed the plans. Of concern was the plan for Individual #344, because it had been developed in 6/11, and although

it had been revised four times between 12/14/11 and 1/29/13 (removal of monitored behavior), it had not undergone substantial review in a year. His team reviewed this plan and found it “still valid.” This plan should have been updated to address the individual’s current needs.

The results of a review of the Crisis Intervention Plan for each of the four individuals is summarized below:

- In each plan, the type of restraint authorized was identified. The plan for Individual #344 was less clear, because it indicated that physical procedures “up to a two-person horizontal restraint” could be used.
- The maximum duration of restraint was identified as 15 minutes in three of the four plans. The plan for Individual #344 did not specify a maximum duration.
- The designated approved restraint situation was specified in three of the four plans. The plan for Individual #421 did not clearly identify the behavior that would result in restraint.
- The criteria for terminating restraint were specified in three of the four plans. The criteria for release for Individual #406 was most specific, because he was to be released when he stopped struggling or yelling for three consecutive minutes. Individual #421 was to be released when she stopped struggling, yelling, cursing, or trying to harm others for up to five minutes. Because this suggested staff judgment in determining the appropriate passage of time without problem behavior, the criteria for release was less clear. This individual was also to be released if a seizure was suspected or if she fell asleep. Individual #56 was to be released if he reported that he could not breathe, if he appeared to be experiencing physical distress or a medical emergency, or as soon as he stopped trying to harm himself or others. There was no release criteria included in the plan for Individual #344.
- Three plans had been developed within the previous 12-month period. The plan for Individual #344 was developed in 7/12 and should have been updated to meet expected requirements.

Monthly Psychology Progress Notes were requested from 2/13 through 7/13. Over the course of six months, measures of treatment integrity were reported for Individual #406 only. There were no reports of treatment integrity for Individual #421 or Individual #56. Only two months of progress reports were provided for Individual #344. Treatment integrity was noted to be “fair.” During a team meeting held on 4/12/13 for Individual #56, discussion was held regarding the degree to which staff accurately implemented training on his replacement behavior. The psychologist was scheduled to review treatment integrity. This was an appropriate action plan that was reviewed at a later meeting held on 5/8/13.

While ISP addenda meetings did not identify changes to the PBSP, the plan for Individual #421 had been revised on 5/9/13.

Other Findings:

Some additional observations in reviewing the records included:

- Restraint monitors for the sampled restraints appeared on the list of restraint monitors. However, the Facility listed only twelve restraint monitors, which might not be sufficient to assure that monitors arrive within 15 minutes of the start of restraint.
- The consultation between the prescribing physician and the psychologist should take place prior to administration of the medication used as chemical restraint. It did not appear that was done in the chemical restraint of Individual #421 in the sample.
- An issue was identified with documenting and counting restraints, and this issue needs to be resolved. The Facility should confer with State Office on this issue. When restraints occurred close together, the Facility was counting restraints as separate restraints, and documenting them with separate Restraint Checklists. However, there was not full documentation (i.e., a checklist, a face-to-face, debriefing, etc.) of each of the separately recorded restraints. Instead, there was a Restraint Checklist completely filled out for the first restraint in the series. The checklists for the subsequent restraints had only the times filled in. And, there was one copy of the face-to-face, debriefing, etc. to cover all the restraints in the series. The need to accurately document the total restraints an individual was experiencing appeared to be the reason for this method of documentation. The problem was that the documentation of the restraints that followed the original did not reference the original or subsequent restraints as part of an episode, making it unclear where to look for documentation of the events surrounding the connected restraints. One solution to this issue would

be to reference the original restraint in the documentation of all subsequent restraints that were connected to it. Another solution would be to consider closely occurring restraints that result from an initial failed restraint (e.g., individual could not be held or individual became calm and escalated again as soon as released) as one restraint with multiple attempts at release. The Restraint Checklist appeared to have the necessary codes to document the releases and re-restraints accurately, allowing for judgments to be made on whether the restraint was the correct one for the individual or the criteria for release might need modification. Whatever solution is adopted, a policy and/or procedure should describe how such series of restraints should be documented.

- The debriefing form sometimes included recommendations from staff that were interviewed. It was not clear what happened to those recommendations. At a minimum, they deserve consideration by the IDT and the IDT's response should be documented.

Status of Facility's Plans to Comply with Section C:

The Facility provided information on their plans to comply with this section in the: "Action Plan," updated 8/1/13. The Action Plan contained action steps for each of the provisions in Section C. Each step indicated what evidence was needed, the responsible person, the start and completion dates, and the completion status. The Action Plan called for such initiatives as: updating local policy to reflect State Policy changes; modifying the monthly Quality Assurance/Quality Improvement (QAQI) report to include numbers of prone restraints, discussions of the definition of "convenience of staff," developing a quiz for staff to test understanding of restraint use, and a list of other data that would be useful to the QAQI Council in determining where to direct resources. Generally, the Action Plan indicated that a precursor to the outlined steps was the acquisition of an Access program to draw data from AVATAR and that had been accomplished. It appeared upon interview with the Section Lead that the barrier to performance was the development of a system for extracting data from the AVATAR system into reports. Two data analyst positions had been established and actions were underway to consult with other Facilities on how they draw data.

It was not clear, however:

- How the timeframes for the various steps were determined, how often they had been changed, and what the current status of a step was. One example: step 2 of C.2 was to add the number of prone restraints to the monthly QAQI report and that step was scheduled for completion on 9/30/13. Upon interview, it was learned that the timeframe had been changed several times, but those changes were not noted in the plan. To be useful, the plan needs to include ongoing information about progress, such as when dates change and reasons for delay.
- The purpose for including the action steps was not always evident. For example, the necessity for a plan to track prone restraints in AVATAR was not clear, when prone restraints are forbidden and unlikely to be documented. In fact, it appeared the information was already available through the implementation of the current system. In the Monitoring Team's last report, there was no indication of a report of prone restraint use, nor any question raised about the adequacy of the available information.
- Similarly, Section C.3 of the Action Plan included adding the PMAB compliance rate to the monthly QAQI plan. The start date was January 2013, the completion date was 9/30/13, and the status was "not started." Yet, when the Monitoring Team asked for a delinquency report for those who had not completed PMAB in the last year, the Facility provided one. Why a plan was needed to do something that can already be done was unclear.
- To move towards compliance in Section C, the Facility should revise its Action Plan to focus on actions that require time to complete and address identified gaps in performance.
- The major barrier to moving forward appeared to be organizing and prioritizing tasks including: the supervision of the electronic entry of data on restraints; the production of reports and trend analyses to guide discussion and decisions on where to take corrective actions; updating Facility policy; and completing annual training for staff who are called upon to use restraints.

The Section C.7 Action Plan indicated that the Qualified Intellectual Disabilities Professionals (QIDPs) would be trained to use the "four or more" ISP addendum template that the Director of Behavioral Services developed. This training was identified as "in process" with an expected completion date of 8/31/13. The plan also indicated the Director of Behavioral Services would review completed addenda to ensure that team review met the requirements of the Settlement Agreement. This had not yet been started.

When the Director of Behavioral Services was interviewed, he explained that addenda might not have been completed when teams met to review multiple restraints, because it was the responsibility of the QIDP to record these minutes. Until training of all QIDPs is completed, it is recommended that the individual's psychologist or another designated staff member record the minutes of meetings to ensure that action plans are outlined and addressed to facilitate reduced use of restraint.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- The Action Plan should be revised to prioritize actions that are most important to compliance.
- The Facility should consider adding a segment to its Action Plan for development of the monthly report to QAQI Council.
- The Action Plan should track what is happening with steps that were targeted to start and did not, or are not on track. The plan needs a space to document a failed, delayed, or derailed effort.
- Teams should meet whenever an individual is placed in restraint more than three times in a rolling 30-day period. Discussion should address all areas identified in the Settlement Agreement. Action plans should be developed, noting the responsible staff member and the expected date of completion. All team meetings should be well documented.
- Data should be presented and reviewed when formulating hypotheses about variables maintaining problem behavior.
- Psychology staff should take the initiative to conduct observations of individuals in the settings in which repeated restraint occurs. This FBA should occur in a timely manner.
- Staff should explore a range of solutions to identified problems. This might include a change in work or habilitation activities, a change in schedule to ensure limited wait time for meals or other preferred events, completion of preference assessments to ensure that potential reinforcers are identified, development of structured shaping programs to increase participation in activities outside of the residence, and enhanced use of tangible reinforcers to support positive behavior change.

SECTION D: Protection from Harm – Abuse, Neglect, and Incident Management

Findings regarding Areas of Focus:

At the last review, the Monitoring Team found the Facility in compliance with 14 out of 22 provisions in Section D. For this abbreviated review, no compliance findings were made, and only ten of the 22 provisions were given focus. For this abbreviated review it was agreed that the areas of focus for Section D would be all provisions under D.2 (except for D.2.g and D.2.h), D.3.e, D.3.f, D.3.i, and D.4.

For purposes of this abbreviated review, the requirements of the Settlement Agreement have been summarized to provide a reference point for the Monitoring Team's comments. For the full text of the requirements, the Settlement Agreement should be reviewed.

Section D.2.a of the Settlement Agreement requires development and implementation of policies that mandate reporting of serious incidents to the Director and to other agencies as required by law (usually DFPS for Facility residents). The State Policy #002.4, revised 12/20/12, and State Policy #021.2, revised 12/4/12 mandated reporting and AUSSLC issued Incident Policy #II.B.4 in March 2013 and Abuse/Neglect/Exploitation Policy #II.B.13 in August 2012 to implement the State Office policies. The Facility policies mandated reporting of serious incidents, including ANE, to the Director and for ANE cases, to the DFPS hotline. Based on a review of a sample of ten DFPS investigation files and four Facility-only files, five were not reported within the first hour following the incident including:

- Sample #D1.5 involving a break in supervision that was determined to constitute neglect. There were staff present who should have reported timely, but did not.
- Sample #D1.7 was unfounded, and Samples #D1.3, #D1.4, and #D1.9 were determined to be unconfirmed or inconclusive. Based on the circumstances of the allegations in conjunction with the investigation report, there was not an expectation of reporting because there was not a confirmation or reasonable cause to believe that abuse, neglect, and exploitation occurred.

Generally, staff called DFPS directly via the 800-number to report allegations of ANE. Unusual incidents, including ANE, were reported to the Director through the central call number and that call served to activate the Unusual Incident Report (UIR) process.

Both UIR and DFPS investigation reports were completed on standard formats.

Section D.2.b of the Settlement Agreement requires that when allegations of ANE are made or when serious injuries are discovered, that action is taken to protect the individuals, including removing alleged perpetrators from direct contact with individuals. Generally in reviewing ANE investigations, evidence was found to show staff were reassigned from direct contact with individuals until the investigation had been completed. When the perpetrator was unknown, additional monitoring was placed in the residence to assure safety. In cases involving serious injury, where there was no suspicion of abuse or neglect, staff were not generally removed. However, during interviews, it was learned that due to some confusion in recent cases, staff in serious injury cases had begun to be reassigned to allow time to evaluate whether individuals might be at some risk from staff actions or inactions. This would be the preferred practice.

In the sample of DFPS investigations (Sample #D1), it appeared that alleged perpetrators were reassigned in all cases. In two cases, staff resigned or were terminated and the rest returned after the investigations ended.

In the sample of Facility-only investigations (Sample #D2), in three cases, the staff were not reassigned, since it appeared clear that the injuries were self-inflicted and witnessed or accidental. Steps were taken to obtain medical treatment in all cases. In the fourth (Sample #D2.4), it was not clear whether staff were reassigned or whether they chose to stay out of work. The record should be clear in documenting whether staff involved in an incident were out of contact with individuals and for what time period. In this case, which questioned performance during a call for assistance, it would have been appropriate to reassign the nurses involved until investigators could determine what transpired and whether there was any on-going risk to other individuals.

Section D.2.c requires competency-based training at least yearly for all staff on identifying and reporting ANE. A list of staff who had not had training in ANE (ABU0100) in the last year was reviewed. The data indicated that approximately 13% of the staff had not received training within the last year. A similar list of staff who had not received training in reporting incidents (UNU0100) revealed that approximately 7% of staff had not received their annual training. This is a provision where the Facility had been in substantial compliance in the past. However, statistics similar to these would not support substantial compliance in a future review. This is essential training for which action should be taken as quickly as possible to ensure all staff are trained annually.

Section D.2.d requires notification of staff of their responsibility to report ANE, including a signed statement to show their understanding of those responsibilities, and Facility action, when staff fails to report. Since signing of the acknowledgement document is tied to taking the annual training, it is possible that not all acknowledgement documents were up-to-date. No sample of staff was reviewed. However, the document provided in response to III.10 of the document request revealed that four people had been disciplined for failure to report ANE. The combination of not assuring that all staff received their annual training as noted above, and the fact that there were documented failures to report, suggested that prior to the next review improvements were needed for the Facility to maintain a substantial compliance rating as was noted in the last review.

Section D.2.e requires mechanisms to educate and support individuals, primary correspondents, and LARs to identify and report unusual incidents including allegations of ANE. A review of six ISPs was conducted to determine if they contained documentation of having provided information on identifying and reporting during the annual ISP meeting. One of the ISPs did contain documentation that the Resource Guide was provided to the individual and the LAR. In the remaining five ISPs, the Monitoring Team did not find a clear reference. Of note, all of these ISPs were done in 2012. The one containing the correct documentation was done in May 2013. These findings appeared to be consistent with the Facility's Action Plan that indicated that Qualified Intellectual Disability Professionals (QIDPs) were trained on providing the Resource guide in September 2012, and most of the ISPs were prior to or close to that date, meaning that the QIDPs could not

have been expected to correctly discuss, distribute, and document the provision of the Resource Guide in those meetings.

The Action Plan for this provision documented the completion of training of QIDPs on including discussion and documentation of the ANE Resource Guide in the annual ISP meeting, and provided for retraining of QIDPs based on monitoring results. The Facility provided a list of individuals/LARs who were known to have reported incidents of ANE, which included one guardian. In addition, some allegations, determined as unfounded, appeared to have been made by the individual, which indicated some individuals were supported in making allegations and were not afraid to do so.

Section D.2.f requires posting of a statement of individuals' rights in each residence and day program. The required posters were in place in all the homes and day programs visited. The posters were up-to-date, providing information on how to report ANE and how to obtain help from the Human Rights Officer and the Ombudsman. A system appeared to be in place for checking the posters and replacing them as needed.

Section D.2.i requires audits at least semi-annually, to determine whether significant resident injuries are reported for investigation. Identification of significant injuries requires identification of serious injuries as determined by DADS policy, non-serious injuries on parts of the body that might indicate potential abuse or neglect, or patterns of minor injuries (e.g., several injuries at the same time or over time, patterns of types of injuries to specific individuals or in a particular living unit, locations of injuries, etc.). Such injuries might be of "known" or "unknown source."

Based on interview, the Director of Incident and Risk Management indicated that auditing of records for injuries that had gone unreported had been underway since November 2012, and that the audits of individual records were not uncovering many unreported injuries.

A comparison of a list of serious injuries against a list of UIR reports and ANE investigations indicated that serious injuries were being investigated, either by the Facility or by DFPS.

The Monitoring Team's cursory examination of a report on peer-to-peer aggression revealed that there were eleven individuals who were the victims of aggression ten or more times in a six-month period, often resulting in physical injury, in addition to emotional injury. The frequency of aggression against these individuals suggested investigation might be needed to discover why these individuals cannot be protected from their peers. A similar examination of a report on all incidents and injuries by individual for the past year revealed that at least eleven individuals had 50 or more injuries. The frequency of injury to these individuals suggested an investigation might be useful in some of these cases to determine why individuals were experiencing such frequent injuries and whether there was any possibility of neglect or abuse involved.

The Action Steps for this provision did not include examination of lists of reports on injuries or peer-to-peer aggression to look for patterns that might need investigation. The Action Steps did show progress on use of the Injury Audit Review Monitoring Tool to complete a 2% per month random sample of individual records (about 72 records per year.) The Director of Risk and Incident Management reported that a Client Injury Specialist had been hired to review injury reports, make recommendations to interdisciplinary teams (IDTs) and to red flag injury reports for special attention. The Monitoring Team will be interested in the results of this addition and how this person will interface with the Injury Audit Process.

Section D.3.e requires that each investigation of a serious incident commence within 24 hours of the reporting of the incident, be completed within 10 days unless granted an extension, and result in a written report including a summary, findings and recommendations for corrective action.

The review of ten DFPS investigations in Sample #D1 indicated that all had begun within 24 hours; nine had been completed within ten days or had extensions noted in the record and one (Sample #D1.6) had not; all resulted in a written report (or in one case a referral back to the Facility as not within the DFPS mandate for investigation); and four included recommendations or concerns. One concern (Sample #D1.1) involved staff working 16-hour days, sometimes two to three times per week. This was a particularly important concern to

raise, and one that deserved analysis and attention by the Facility. It was not clear in the record that this happened.

The review of four Facility-Only reports indicated that all had begun within 24 hours; two had been completed within 10 days and those that had not, did not have extensions on record (Sample #D2.1 and D2.3); all included recommendations; and all included a summary and findings.

To demonstrate completion of a UIR, the Facility needs to attend to when the final signatures, approving the report, are added, and assure that all signatures include the date when they were signed. This establishes when the report was completed, which is essential for any document that could be used in personnel proceedings. When a UIR cannot be completed on time, the Director of Risk and Incident Management needs to request an extension and document the approval in the record.

The Monitoring Team encountered some confusion about whether the date the UIR was “finalized” in the electronic system marked the date the report was concluded. Staff at the Facility reported the State Office Incident Management Discipline Coordinator had instructed them not to key in the finalization of reports, because doing so locked the report and precluded future additions or modifications that might be needed due to such events as appeals to staffing decisions. Others in the State Office appeared to have been viewing summary reports, based on those entries, to determine if Facilities were closing cases promptly and those summary reports indicated that large numbers of UIRs at AUSSLC had not been “finalized” in the system, causing concern that the Facility was not closing the cases. The process for finalizing cases electronically should be clarified to facilitate the monitoring of cases for completion.

Section D.3.f of the Settlement Agreement lists the required content of an investigation report. Two requirements are: 1) that all sources of evidence be considered including previous investigations of serious incidents involving the alleged perpetrator; and 2) that the report contain the investigator’s findings.

For this review the Monitoring Team focused on these two requirements. With regard to the first requirement on which this review focused, generally, DFPS noted in the report that a review of the history of both the victim and the alleged perpetrator(s) was conducted and no relevant information was found. The Monitoring Team checked the corresponding UIR for a listing of the history to verify that there was no reason to consider that history in the DFPS report. However, in the review of the UIRs in the sample, the Monitoring Team noted that histories of alleged perpetrators were not routinely pulled into the UIRs, so no verification could be made. In discussion with the Director of Risk and Incident Management, it was learned that this was not being routinely done since the lists could be quite long and often not relevant, so the investigator was making a determination of relevancy and sometimes not including the list. A better practice would be to copy the list of the last two years of allegations for the UIR file, then enter an evaluation/analysis of relevancy, making clear why a long list of prior involvement in allegations would not be relevant.

With regard to the second area on which the Monitoring Team focused, generally investigation reports contained the findings of the investigator, and there was a clear basis for those findings.

Section D.3.i of the Settlement Agreement requires the Facility to take disciplinary or programmatic action whenever necessary to correct a situation and/or prevent recurrence, to implement the action promptly and thoroughly, and to document the actions and corresponding outcomes.

In the four cases in Sample #D1 where abuse or neglect was confirmed and disciplinary action was warranted, the staff responsible were terminated or resigned. In one case where staff did not report a breach in supervision retraining was provided.

In most cases there were recommendations to provide staff with additional training and/or to have the IDT review and make programmatic recommendations. For example in Sample #D1.8, an individual alleged that his money had been stolen by staff. Before the investigation was complete, the money had been found. However, the report contained recommendations to the IDT to find a way to secure the individual’s money and still provide a mechanism for him to have control. The IDT recommended purchase of a lock-box with two keys: one key to be held by staff and one by the individual.

While disciplinary action was generally taken promptly and programmatic recommendations were carried out and documented, it was not always clear from the record that the corresponding outcomes had been achieved. The Director of Risk and Incident Management indicated that the minutes of the IMRT meetings served as a log of recommendations and actions taken, and that there was a staffing status log, and at least one other related tracking device related to actions. The Director of Risk and Incident Management indicated that she was planning to combine the various logs into one that could be monitored efficiently, shared at IMRT meetings, and would include information about outcomes. The plan appeared to be that QA Program Compliance Monitors would check on outcomes and document results, but this plan had not yet been incorporated into the Facility's Action Plan.

Section D.4 requires that the Facility have a system to allow the tracking and trending of unusual incidents and investigation results by: type, staff alleged to have caused the incident, individuals directly involved; location of the incident; date, time, and cause; and outcome of the investigation.

The Unusual Incidents Trending report for March to May 2013 was reviewed. The report did not include trending of allegations of ANE. The report provided basic numerical data and some graphs displaying incidents by residence, by day of the week, by top ten incident types, and by location. The report did not provide data across at least a year to make it possible to identify trends, nor did it include data about the outcome of investigations.

The Action Plan for this provision provided steps, but none had been started. The steps needed further development to assure success in establishing an adequate tracking and trending system. For example, the first step was to "Develop trending report to track incidents, injuries and restraints to be reviewed by QA/QI Council." That statement might describe a goal, but the Action Plan needed steps to show how that goal would be achieved and a timeframe for accomplishing those steps. In discussion it was clear that the Director of Risk and Incident Management intended to seek ideas and advice from another SSLC and had established a date to visit that Facility. Documenting those unwritten plans in the Action Plan would be helpful in understanding and tracking progress.

It was the general impression of the Monitoring Team that the Facility knew there was much to do to operationalize tracking and trending reports that provided useful guidance to the IMRT and the QA/QI Council about aspects of the system and individuals that require focused attention, and then to develop, implement, and monitor plans to correct issues identified. The challenge will be to assemble a workable plan and to implement it to attain substantial compliance with this provision.

Status of Facility's Plans to Comply with Section D:

Comments on specific components of the Action Plans have been included in the findings section of this report. Many action plan steps had been completed and some key Action Steps remained. Specifically, AUSSLC had made several changes since the last review, which should promote progress going forward, including:

- Staff had been added to the Incident and Risk Management Department including: a Nurse Investigator, two Campus Administrator positions, a Lead Campus Administrator, and a Client Injury Specialist.
- An auditor competency process had been established with the three Facility investigators and a quality assurance auditor on the use of the Section D monitoring tool.
- The Facility Incident Management Policy, ANE – Protection from Harm Policy and an Incident Management Process for Serious Injuries/Incidents had been added.

The Facility's Action Plan for Section D, as it related to the focus provisions for this review, showed three provisions with completed action steps (D.2.a, D.3.e and D.3.i). As described in the comments in the findings section above, two of these provisions (D.3.e and D.3.i) could benefit from some additional work, which could be facilitated by adding steps to the Action Plan.

Most of the plans for each provision included a step that indicated QA auditors would monitor ongoing compliance. Attending to the results of such monitoring will be critical to achievement and/or maintenance

of substantial compliance. For example: all eight steps for the action plan for provision D.2.a were marked as completed. One step was to run a report on staff who were within 60 days of becoming delinquent in training, to share that report with supervisors, and to schedule training. Yet, 13% of staff were not current in training on ANE. Clearly, the established system was not working. The Action Plan needs to include steps to indicate that when monitoring reveals a problem with compliance, that a corrective action plan will be put in place and followed until the problem has been solved.

For those provisions that had incomplete action steps, most related to program audits and corrective action plans. These are important elements and need to be completed and working.

As indicated above under findings, the action plan for Section D.2.i should be revised to include review of data reports on injuries and peer-to-peer aggression, to assure that any patterns of injuries or aggression that suggest the possibility of abuse or neglect are identified and investigated.

For Section D.4, the action plan had not been started. The Facility should consider expanding the steps needed to develop the trend reports, and steps to indicate how the Executive Safety Committee will analyze and make recommendations based on the reports.

Other Findings:

In reviewing the samples, the Monitoring Team noted some issues with staffing that need attention. In Sample #D1.1, neglect was confirmed when a staff member was found asleep while assigned one-to-one supervision of an individual. The investigator registered concern that staff had been working 16-hour days two to three times per week. That concern did not appear to have been addressed. Given that there had been an increase in allegations related to breaches of levels of support, such concerns should be thoroughly addressed.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- The Facility should consider the findings and recommendations in this report and modify or expand the Action Plan accordingly.
- The Facility should address some of the technical issues found during this site visit including:
 - Include dated signatures on UIRs to indicate when the report was completed;
 - Include copies of lists of previous allegations in the investigation files, and provide a summary analysis of the relevance of the previous history of alleged victims and/or alleged perpetrators in the UIRs; and
 - Include evidence of completion of the recommendations in the record and document a review of the attainment of the outcome for each recommendation.
- The Facility should address data system issues, such as the processes for drawing reports from AVATAR data, particularly with regard to trend analysis reports.
- The Facility should establish a procedure for analyzing data for systemic issues or complex individual issues that might benefit from corrective action plans, thereby preventing recurrence.
- The Facility had been involved with complex investigations involving some serious safety issues, and the Facility will need to persist with efforts to prevent recurrence:
 - An investigation involving nursing's lack of adequate response to an emergency call made it clear that a protocol for response was needed to avoid delay in getting to emergencies. Based on interview, it was learned that the procedures had been clarified to empower nurses in the residences to call 911 on their own initiative without needing a Campus or Infirmity Nurse to do that for them. This was a good example of preventative action. The Facility should stay alert for opportunities to make changes that will result in reduced confusion in emergencies and thereby assure effective responses.
 - Another example of efforts at prevention was an investigation of an individual sustaining a burn injury. It led to review of the water temperature controls and installation of procedure requiring measuring water temperature on a regular basis and before anyone is bathed.
 - The Facility had experienced an increase in cases that involved neglect as a result of breach of the assigned level of supervision. A review of the cases would be in order to determine if

that increase was related to holding staff over, staff working double shifts, or to other issues with staffing, such as scheduling comfort breaks for staff assigned one-to-one coverage.

- The Unit Morning Meeting in Wood Hollow that a member of the Monitoring Team observed during the site visit was generally good with the leader asking good questions, probing for information, and engaging staff in discussion. However, this was not observed across the board for Unit Morning Meetings the Monitoring Team observed. Working on team process to assure meetings of the higher caliber would help to assure that issues are identified, thoroughly understood, and appropriate action taken to address them.

SECTION I: At-Risk Individuals

Description of Any Safety or Health Issues Noted:

There continued to be significant numbers of acute respiratory distress from various causes among individuals at AUSSLC. The Facility provided a list of cases of pneumonia from November 2012 through June 2013. The data reviewed with regard to Section L indicated that 39 percent of admissions to the hospital were related to respiratory disease. There were three deaths since the Monitoring Team's last visit that were related to respiratory disease and complications of respiratory disease. An aggressive collaborative effort between the Medical, Dental, Residential Departments and Facility Administration will be required to prevent and reduce morbidity and mortality due to respiratory tract illness.

Findings regarding Areas of Focus:

In reviewing the areas regarding the identification of individuals at risk, and development and implementation of at-risk action plans/Integrated Health Care Plans (IHCPs), the Monitoring Team's findings are noted below:

- Since the last review, the Facility indicated that the training addressing the Integrated Risk Rating process was completed and the new form was implemented for use in February 2013. In addition, the Facility indicated that at this same time, they initiated the use of the IHCPs. Interviews with the ADOP and the Habilitation Therapies Director indicated that although these processes had been initiated, there was still considerable work to be done regarding the quality of these documents that probably rendered some of the information on the Facility's current At-Risk List inaccurate. At the time of the review, the Facility indicated that there had been no type of monitoring conducted addressing the Settlement Agreement requirements for Section I.
- A review of the IRRFs and IHCPs for Individual #73, Individual #180, Individual #423, Individual #363, and Individual #93 found that 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 risks. In addition, a review of the IHCPs for these same individuals found that the plans were clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, contained mainly generic action steps, were not adequately individualized, and were not in alignment with the assessments that the nursing protocols required for specific health issues. As discussed with regard to Section O, PNMT action plans were still missing important components, and had not been integrated into individuals' ISP action plans, IRRFs, and/or IHCPs. Clearly, the Facility had a significant amount of work yet to be done in improving the quality of the IRRFs and IHCPs for individuals with health risks.
- As another indicator that the Facility's at-risk identification system was not working as it should, forty-six individuals at AUSSLC received enteral nutrition. The State Supported Living Center Risk Guidelines required all individuals who received enteral nutrition to be ranked at high risk for aspiration. However, 18 of these 46 individuals (39%) were ranked at medium risk for aspiration (i.e., Individual #351, Individual #178, Individual #430, Individual #34, Individual #398, Individual #434, Individual #45, Individual #182, Individual #422, Individual #318, Individual #385, Individual #57, Individual #306, Individual #389, Individual #456, Individual #51, Individual #50, and Individual #189). The Facility should correct these individuals' aspiration risk ratings. These individuals should receive enhanced compliance monitoring.
- In July 2013, the Facility established Critical Incident Teams that conducted reviews of individual cases for specific situations, such as deaths, pica incidents, or injuries in order to identify any problematic issues that warranted corrective actions. While this promising concept was relatively new at the time of the review, the ADOP indicated that from the Critical Incident Team's recent

review of a mortality, recommendations were generated regarding the need to review the current system for mealtime supervision and adherence to the Physical Nutritional Management Plans (PNMPs). The Facility staff indicated that the review of the system addressing this area had been initiated at the time of the review.

- In addition, Facility staff indicated that in April 2013, a “Look Back” process was initiated. It required that within five days of an unplanned Emergency Room (ER) visit, hospital admission, or Infirmary admission, the RN Case Manager was to review the active record 30 days prior to the event to identify any problematic issues that might have contributed to the ER visit/admission, using the newly developed Look Back auditing tool. The Medical Compliance Nurse was then to present these findings at the Morning Medical Meeting, and an Individual Support Plan Addendum (ISPA) meeting was to be scheduled if problematic issues were identified. From April through June 2013, when the “Look Back” process first started, the PNMT Nurse conducted the reviews. Since that time, the process was delegated to the Case Manager assigned to the particular individual warranting the review. Although this process holds much promise, the accuracy and reliability of the data generated from this audit process is completely dependent on the clinical competency of the auditors and their understanding of the use of nursing protocols when assessing the quality of nursing assessment, care plans, and nursing documentation. The Monitoring Team’s review of the active records and the “Look Back” audits for the most recent hospitalization for Individual #73, Individual #50, Individual #423, Individual #246, Individual #93, Individual #363, and Individual #274 resulted in significant discrepancies between the clinical findings of the Nurse auditors and the Monitoring Team. For example, all seven Look Back tools indicated that: “nursing assessments were done as dictated by the affected system(s).” However, the findings of the Monitoring Team indicated that none of the seven individuals records reviewed included the appropriate nursing assessments. It was very troubling at this juncture to observe clinically erroneous data consistently generated and accepted as reliable for individuals with the highest health risks. Unfortunately, at the time of the review, the data being generated from the Look Back process were not accurately identifying problematic issues related to the individuals’ health care. Additional findings from the Monitoring Team regarding changing in status for at risk individuals are discussed with regard to Section M.
- Eight active records were reviewed, including those for Individual #204, Individual #6, Individual #34, Individual #93, Individual #4, Individual #22, Individual #90, and Individual #81. Based on this review, seven of eight individuals had been hospitalized in the prior year for pneumonia or aspiration pneumonia. One individual had been hospitalized twice for pneumonia, and one individual had been hospitalized four times for pneumonia. Four of eight had a diagnosis of GERD. One had a diagnosis of gastritis. Seven of eight had been prescribed a proton pump inhibitor. One had a fundoplication. The following provides examples of concerns noted:
 - For one individual (Individual #6), who had been hospitalized in the past year for pneumonia, the individual had been seen in the past by Ear, Nose, and Throat (ENT) (2007), and Gastroenterology (2007). There was ongoing follow-up by pulmonary medicine (2011, and 2013). On 3/27/13, bronchoscopy was completed, and the results indicated a stable pneumonitis and bronchiectasis. In November 2012, the individual had a Modified Barium Swallow Study (MBSS), which indicated gross aspiration with nectar and thin liquids, moderate aspiration with honey thick liquids, and trace aspiration with puree and pudding thick liquids. No GERD was noted on that exam, but an earlier MBSS of 10/12/11 indicated moderate GERD. The individual required one-to-one assistance with meals, an upright position of 90 degrees during meals and no straws. All medications were to be crushed. The individual was on a regimen that included nebulizer treatments and inhalers. At times, the individual was resistant to the diet texture and liquid thickening. At times, the individual ate too fast, and required verbal cues to slow down. The IRRF of 12/12/12 indicated OT had stated the individual had reflux and would benefit from another MBSS or repeat esophagogastroduodenoscopy (EGD) (last EGD 4/22/07). The IDT agreed the individual would benefit from suction tooth brushing, but as of August 2013, the individual was not on the list of those receiving suction tooth brushing, nor on the waiting list for suction tooth brushing. The individual was prescribed Valproic Acid (VPA) and Zyprexa. Although not a statistically common side effect, VPA can cause or aggravate dysphagia, which may be of heightened concern in the IDD population, but the poly-pharmacy/drug side effect risk section did not provide a review of medications (other than Zyprexa) to minimize the side

effect of dysphagia. The Pharmacy and Medical Departments are encouraged to review articles available from professional governmental and non-governmental agencies/organizations that focus on opportunities and challenges of those with disabilities, including the IDD population. One or more focused reviews include the potential medication side effect of dysphagia in individuals at risk. In summary, the individual was identified as someone who would benefit from suction tooth brushing, but remained without this procedure, despite the risk of aspiration and poor oral hygiene. That the individual was not on the list receiving or awaiting this procedure was concerning, and the Facility might need to review the process by which the IDTs refer the individual to the Dental Department. Despite severe dysphagia and continued coughing during meals, along with periodic mention of GERD, there was little information to determine whether GERD was a significant risk factor in aggravating her respiratory status, or at times, causing the wheezing to occur should the reflux lead to aspiration. It was not known if keeping the individual upright for 30 minutes after meals was a sufficient length of time. There was no information as to whether there was a delayed gastric emptying. The need for increased monitoring of positioning was not further reviewed. The flow diagrams and clinical pathways for aspiration risk reduction and GERD interdisciplinary protocol included reference to GERD evaluation ("refer for diagnostic evaluation: GI Consult, ...pH probe test, EGD..."; as well as the worksheet for aspiration pneumonia ("when was the last MBS? Does it need to be repeated? When was the last EGD? Is it time to consider fundoplication?"). These are questions in the clinical guidelines that should be addressed aggressively in individuals that are hospitalized for pneumonia. The local hospital might be able to offer additional tests to rule out or determine the severity of GERD. If there has been long-standing GERD, consideration should be given to ruling out Barrett's esophagus. Given the hospitalization for pneumonia for this individual, another question the team should have asked, but it was unclear if they had was whether nursing staff were ensuring the medications were crushed and placed in pudding thickened liquid when administered. The IRRF mentioned resistance to the diet, but there was little information regarding the seriousness of the behavior or how staff were to prevent this behavior. There was no discussion concerning access of the individual to foods that could cause the individual to choke.

- o Another individual (Individual #93) was hospitalized for pneumonia once in the past year. Despite a history of spitting up/regurgitating after meals, and despite orders for head of bed elevation and upright positioning after meals, along with orders for a proton pump inhibitor, there was no diagnosis of GERD on the active problem list. An MBSS was completed on 7/12/12, as well as during the January 2013 hospitalization, and both recommended enteral tube feeding. The team determined that a tube was not indicated, and awaited review and change of psychotropic medications. Zyprexa was tapered off as a possible contributing cause of dysphagia, although the individual was also on VPA and there was no discussion of reducing or changing the VPA. It was noted that despite the recommendation for an enteral feeding tube on 7/12/12, this did not occur until August 2013, following a diagnosis of aspiration pneumonia. In the meantime, the individual was maintained on a pureed diet with honey consistency liquids. The individual had been followed by gastroenterology, and was seen on 2/20/13, at which time an EGD and possible esophageal dilatation was recommended.

In reviewing this case, there was concern about increased risk to the individual while the IDT was awaiting changes in psychotropic medication, which could take considerable time. The individual was noted to have weak and ineffective cough, and appeared to be refluxing after meals, with regurgitation which mimicked vomiting. There was no evaluation documented for GERD or an evaluation of any severity if it existed. It appeared the individual might have refluxed to the mouth, and it appeared by history the individual was at risk for aspiration due to the potential reflux. A component of rumination was not described. The flow diagrams and clinical guidelines for GERD and aspiration prevention did not appear to be followed. Questions also were raised about the clinical guidance provided to the team in allowing a year to pass before a feeding tube was placed, precipitated by an aspiration pneumonia. Rationale for delay as well as how the team was to provide health and safety

while the psychotropic medication was being adjusted were important aspects of care not documented in the ISP, or the IRRF. It is important to identify medications that might be causing or contributing to dysphagia, but when an individual aspirates on all consistencies, immediate action needs to be taken to minimize a bad outcome at that moment. The IDT did not appear to address the immediate need for health and safety. The role of the PCP in discussing the MBSS results, and recommendation for feeding tube placement was not known, and the communication of the IDT's decision to the Medical Director was not known.

Other Findings:

As mentioned with regard to Section L, there appeared to be a high number of fractures, and the circumstances of the fractures needed to be reviewed. Behaviors, peer aggression, level of supervision, unsafe environments causing falls, vision difficulties, poorly fitting clothes, worn shoes, etc., all needed to be considered when reviewing the cause of fractures. Separating pathological causes such as osteoporosis would also be important in providing guidance to the Facility and the Medical Department in treating high-risk conditions to prevent complications.

Status of Facility's Plans to Comply with Section I:

An interview with the ADOP indicated that the Facility planned to focus its attention on issues related to aspiration and pneumonia due to the significant increase in hospitalizations related to this area. Although the concepts of the Critical Incident Teams and the "Look Back" process were positive, the Facility first should ensure that the conclusions and/or data generated from each of these processes is accurate. This is necessary in order to assist the Facility in implementing the appropriate action steps that actually address the problems identified. A review of the Facility's plan for Section I indicated that the only action step implemented and completed addressed training regarding the integrated risk process. In addition, the plan itself did not reflect the focus and direction reported by the ADOP while the Monitoring Team was on site, so it did not provide an adequate description of the Facility's stated plans.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- The Facility should review and revise the current plans addressing Section I to adequately reflect the needed action steps, and focus efforts in the areas identified by the Facility as priority. Due to the critical nature of the clinical at-risk health issues that Section I addresses, the revised plans should be promptly formalized and implemented.
- The Facility should review each aspect of care that impacts the risk of pneumonia and aggressively address them. For example:
 - For dental care, ensuring that suction tooth brushing is available when the IDT determines it is necessary should be a priority. If the Dental Department verifies the need, delays in the individual's access to suction tooth brushing should be minimized. There should be no waiting list for suction tooth brushing for those that need that procedure. The IDT in collaboration with the Dental Department should also address ways to improve the oral hygiene score of those with recurrent pneumonia or potential for aspiration.
 - The Facility currently had one filled position for a respiratory therapist. Given the number of hospital admissions for pneumonia, the number of deaths attributed to respiratory disease, and the number of cases of pneumonia at AUSSLC, the Facility is encouraged to provide respiratory therapy services 24 hours per day seven days a week. The expertise and technique of this specialty should be available beyond routine business hours. Having staff dedicated to respiratory therapy care has intuitive benefits to the population, as well as allowing the Nursing Department to complete needed nursing duties.
 - The Medical Department should review the current flow diagrams and clinical guidelines for GERD as well as prevention of aspiration. A more detailed policy/procedure/protocol would be an important document in guiding an aggressive approach to evaluation and treatment of this clinical area. Determining the presence of GERD, the degree of reflux into the esophagus/potential for lung aspiration, and the potential for gastroparesis or delayed gastric emptying need to be considered according to the clinical guidelines for each individual at risk for repeat pneumonia. For an individual with severe GERD causing or exacerbating repeated pneumonias, treatment will not be effective until this is treated. This

provides the opportunity to collaborate with local specialists or medical centers with expertise in GERD in determining what test or procedure to order, when it should be ordered, and how to follow the individual (frequency of testing) in order to provide information as to whether GERD is occurring, and if so, whether it is a threat to the respiratory tract. GI should follow those with GERD, for periodic testing to rule out Barrett's esophagus or to monitor the condition at periodic time intervals if present.

- Pharmacy should be involved in the IRRF and during the ISP process to determine whether medications are being prescribed that can cause or aggravate dysphagia in those with IDD and in those with comorbid neurodegenerative diagnoses. A discussion of results of the review and a discussion of alternative choices of medications should be documented.
- Monitoring for positioning is a constant need in the residences. For those with dysphagia and GERD, this is an important step in maintaining health and safety. There was little information in the IRRFs concerning increased monitoring by residential supervisors, RN Case Managers, QA Department staff, or Habilitation Therapies for those with dining plans requiring positioning needs and requiring upright positioning after meals. A system approach to monitoring for compliance with dining plans and post meal positioning is recommended, with a heightened frequency of monitoring for those with complex dining plans.

SECTION J: Psychiatric Care and Services

Findings regarding Areas of Focus:

The Areas of Focus for Section J, which were outlined in the objectives for this abbreviated review, included review of committee meeting minutes related to polypharmacy (Section J.11); and the status of the initiative to complete the CPEs as well as the annual updates to those documents (Sections J.2 and J.6). The CPE documents are significant, as they contain information that directly or indirectly relates to seven of the 15 provisions of Section J.

The polypharmacy statistics were closely reviewed, as one might expect that the use of psychotropic medication might inappropriately increase at a time when the staff and Facility were operating under stressful conditions. The overall rate of polypharmacy had been maintained at 14 percent. When one considers those individuals for whom the Psychiatry Department had been able to empirically demonstrate that the continued use of their medication was necessary for their continued stability, the rate of active polypharmacy diminished to the range of seven to eight percent, which is an exceedingly low rate by contemporary standards.

The Psychiatry Department had assembled historical data for those individuals for whom they had determined that the continued use of polypharmacy could be justified. This information was summarized in the minutes of each of the monthly Polypharmacy Committee meetings, and CPEs. The information also contained the dates of the historical data that was referenced as support so that it would be possible to verify the findings in the individual's clinical record, although this verification process was not carried out during this abbreviated review. This data took the form of pre-and post-baseline frequencies of the target symptoms of their psychotropic medication, as well as the results of failed, prior attempts to taper a medication. Overall, the data used to determine clinical justification for the use of psychotropic medication appeared to be thorough and compelling. However, during upcoming reviews, the Monitoring Team will review a sample to verify the data.

Section J.2 primarily relates to the integrity of the psychiatric diagnostic process, and Section J.6 specifically addresses the requirements related to the completion of the CPEs for the individuals who are prescribed psychotropic medications. Although the psychiatric diagnosis appeared in a number of different locations in the individuals' records, the most complete documentation of the individuals' history and the additional information necessary to describe the context for the individuals' psychiatric diagnoses was contained in the CPE.

The Department had continued to make progress with the completion of the CPEs, which, according to their internal data, had now been completed for 100 percent of the individuals who were prescribed psychotropic medication. The review of the ten CPAs alluded to above as well as the examples that were reviewed in the prior two monitoring reviews indicated that these were extremely thorough and detailed documents, which

could reach 30 to 40 pages in length. They followed the format specified in Appendix B of the Settlement Agreement. The length of the documents was primarily related to the extent of the historical information that was provided. For example, rather than just listing the prior psychotropic medications that were prescribed for an individual, they also listed the date of each dosage change and/or change in medication, along with the reason for that change. Another related sub-section entitled: "Course of Psychiatric Treatment" went into further detail concerning the individual's overall clinical status during the corresponding chronological time periods. The information related to the individual's psychiatric diagnosis also contained a detailed description of the symptoms that justified the diagnosis, as well as the history of those symptoms over time. For the sample of 10 individuals, the psychiatric diagnosis was also well documented in the Quarterly Psychiatric Review Notes. These documents ranged in length from 12 to 16 pages, depending on the complexity of the individual's psychiatric disorder. They also contained a justification for the individuals psychiatric diagnosis, which frequently included a direct reference to the corresponding criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* of The American Psychiatric Association, Fourth Edition.

At the time of the next full review, the consistency of the diagnosis throughout the individual's record will be assessed. However, based on this limited review, it appeared that the Department had continued to make progress in this area.

As noted above, this was an abbreviated review, and as a result, a full sample of records was not reviewed and so a compliance determination cannot be made. However, based on this review, the small sample of records showed consistent implementation of the requirements for both the quality of CPEs as well as their timely updates (i.e., within a year of the previous assessment or update). The latter observation relating to the timeliness of the annual updates was based on the review of the Facility's internal tracking system and was not verified by a review of individual records. At the time of the next review, this material will be verified through the review of individuals' records.

Status of Facility's Plans to Comply with Section J:

During the course of the onsite review, the status of the Facility's initiatives regarding each of the 15 provisions of Section J was reviewed in an abbreviated fashion. This process involved the observations, interviews, and review of documents described at the beginning of this report. At the State's request, the current review was not designed to assess for compliance with each of the provisions of Section J. Accordingly, a sufficient number of individual records and corollary information that would be required to assess for compliance were not reviewed. Any positive comments that follow should not be construed as indicating that the Facility would be found to be in substantial compliance with a specific provision. However, this abbreviated report discusses the 15 provisions according to functional groupings with the intention of providing the Facility with information to assist it as it continues to implement action plans to address the requirements of Section J. Three of the provisions are discussed above in the Areas of Focus, and the remaining 12 provisions are discussed below.

Sections J.1 and J.5: Collectively, these provisions address both the quality (Section J.1) and quantity (Section J.5) of the psychiatric services at AUSSLC. With regard to Section J.1, the three Psychiatrists who provided services to the individuals residing at AUSSLC had all received certification from the American Board of Psychiatry and Neurology. The Section Chief for Psychiatry had prepared detailed documentation to illustrate that the current number of Psychiatrists was sufficient to provide psychiatric care to the individuals residing there. This analysis also took into account the specific requirements of the Settlement Agreement, such as attending the individuals' annual ISP meetings.

The current group of Psychiatrists was practicing at the Facility at the time of the Monitoring Team's previous review. However, in the interim since the last review, the part-time Psychiatric Consultant had resigned. The caseload followed by this Psychiatrist had been redistributed to the remaining three Psychiatrists. Due to the overall reduction in the Facility's census since the last review, this did not result in a significant increase in the caseloads of the full-time Psychiatrists.

Section J.3: This provision focuses on the potential misuse of psychotropic medication, either as punishment or for the convenience of staff, which would primarily be in the form of excessive use of psychiatric

medications inappropriately prescribed to sedate individuals exhibiting problematic behavior. During the Monitoring Team's prior reviews, no evidence was found that the "standing" orders or daily administration of psychiatric medications were used with this intent. In addition, during this onsite review, the direct observation of approximately 10 percent of the individuals prescribed psychotropic medication did not indicate that the individuals appeared to be either sedated or were manifesting side effects, such as drooling or gait disturbances, which could be related to the excessive use of psychotropic medication. These findings were consistent with those of prior reviews, which included observations of a larger number of individuals. The review of the small number of Chemical Restraint Forms listed above in the documents reviewed section, indicated that there was a continued problem with the completion of the forms. Specifically, the section that prompted the staff members involved to "describe the antecedent events that led to the restraint," frequently only described the overt behavior itself. As part of this review, the psychiatrist's review of the use of chemical restraints was not reviewed, but is an important part of compliance with this section.

Section J.4: Pre-Treatment Sedation: The observation of the Pre-Treatment Sedation Meeting on 8/22/13, coupled with the review of the related documents, indicated that the Facility had made incremental progress with regard to this provision. Specifically, there still continued to be a lack of clarity regarding the basic issue of developing criteria related to identifying which individuals would benefit from a Pre-Treatment Sedation Plan. The Section Chief for Psychiatry was chairing the Committee responsible for the Facility's efforts to develop and implement a coherent plan to address this provision. Members of the Monitoring Team observed the meeting of this Committee that occurred during the current onsite review. A member of the Monitoring Team also observed the corresponding meeting that occurred during the prior onsite review. The Committee was composed of members of all of the relevant disciplines. However, as noted above, the Facility was still attempting to formulate a cohesive plan to identify those individuals who were appropriate candidates for a Pre-Treatment Desensitization Plan. This is a fundamental step in meeting the requirements of this provision of the Settlement Agreement.

Section J.7: This provision primarily addresses the utilization of the Reiss Screening instrument to detect for evidence of behavioral symptoms that might be indicative of a psychiatric disorder in individuals not prescribed psychotropic medication. The limited review performed during this visit indicated that the Facility was utilizing the Reiss Screen when an individual was referred for a Psychiatric Consult, and the Facility had performed a CPE when the score on the Reiss Screening instrument was above the clinical cut-off score of nine. The Facility's plan for the coming months included the administration of the Reiss screening instrument whenever the Psychiatry Department was asked to perform a formal or informal consultation relative to a change in an individual's status. In this regard, it should be noted that a member of the Behavioral Services Department administered the screening instrument itself. The Psychiatry Department also planned to perform a CPE for individuals who scored above the clinical cutoff score on the Reiss. As noted above, a full review of the requirements related to this provision of the Settlement Agreement was not completed at the time of this abbreviated review. It will be important to ensure that the Psychiatry Department in coordination with the Behavioral Services Department defines the types of changes in status for which a re-administration of the Reiss should occur (e.g., onset of dementia, strokes, etc.).

Sections J.8 and J.9: These sections of the Settlement Agreement fundamentally address different aspects of the integration of clinical services between the Departments of Behavioral Services and Psychiatry. The report from the Monitoring Team's previous review indicated that the Facility had made significant progress toward integrating the Psychiatric and Psychological Treatment Plans of the individuals receiving services from both Departments, but that work still was needed to achieve substantial compliance. This progress appeared to have been maintained.

There are three provisions (Sections J.8, J.9, and J.10) that directly relate to the information contained in the psychiatric section of the ISP and the IRRF. The review of the information that the Psychiatry Department had developed for inclusion in the ISP and the IRRF appeared to be adequate, based on the content and specific wording of these provisions. However, this initial assessment was based only on the preliminary review of two recently completed documents that the Department felt represented their best efforts to comply with these requirements. Based on the interviews with Psychiatry staff, the Department had been working with the QIDPs and other members of the IDT to develop a system that would ensure that this material was integrated into the final ISP documentation. The content of these provisions also emphasizes

the importance of the team discussions during the ISP meetings. In order to facilitate those discussions, the Psychiatrists reportedly had been routinely attending the ISP meetings, but this was not confirmed through this limited review.

Sections J.10 and J.14: Section J.10 focuses primarily on the risk-benefit assessments related to the use of psychotropic medication. The Facility had developed a detailed risk-benefit process. It was documented in the CPEs, the Quarterly Review documents, and the IRRF. In addition, in the future, this information reportedly also would be contained in the ISP.

Observations of the Psychiatry Clinics, both during the current and prior reviews, indicated members of the IDT that attended the Psychiatry Clinics routinely discussed these issues. The Monitoring Team's previous review found that the documentation described above fulfilled the requirements of the Settlement Agreement. However, this information did not carry over to the annual ISP meeting and related documentation.

As indicated in the discussion of the current status of Sections J.8 and J.9, the Psychiatry Department, working in conjunction with the other members of the IDT, had been developing the documentation they believed would address this deficit, as well as a mechanism to ensure that the material was both reviewed with the entire IDT during the ISP meeting, and also referenced in the related documentation.

Section J.14 relates to the process for obtaining consents for the use of psychotropic medication from the individual's Legally Authorized Representative (LAR) or the Facility Director, for those individuals who do not have a guardian. At the time of the Monitoring Team's previous review, the Psychiatry Department recently had assumed this responsibility from the Department of Behavioral Services. During this most recent review, the Department's internal tracking system indicated that the completion rate for this process was 100 percent. During the interview with the Human Rights Officer, she also confirmed this observation. Members of the Psychiatry Department also had been able to regularly attend the HRC meetings to discuss the risk-versus-benefit material discussed above with regard to Section J.10. On 8/22/13, members of the Monitoring Team also observed the HRC Meeting. The Monitoring Team also reviewed the informational material that had been submitted to both the guardian and the HRC for the five individuals whose Psychiatric Medication Treatment Plans were discussed during the HRC Meeting. This review indicated that this information was thorough, while not overwhelming, and particularly focused on the risk-versus-benefit issues, as discussed with regard to Section J.10. Again, this was a limited review of a small sample of records so compliance was not measured, but the Facility appeared to be moving in the right direction.

Section J.12: The Facility's internal tracking system indicated that the Psychiatry Department had significantly improved both the timely completion and prescriber review of the MOSES/DISCUS evaluations, through close collaboration with the Nurse Case Managers who actually administered the evaluations. In some instances, this involved performing a MOSES/DISCUS evaluation (even when it was not necessary) in order to meet the requirements of the Settlement Agreement. Specifically, this involved performing the MOSES evaluations at three-month intervals rather than the six-month requirement in the Settlement Agreement. This was done to simplify the protocols, and create a consistency in their implementation, because both evaluations would be done together, eliminating the need for two separate tracking systems. Based on interview, the Facility believed that the small amount of extra work involved was justified by the degree to which this decreased the possibility of failing to complete a MOSES evaluation that would be out of sync with the DISCUS evaluation process. Compliance with this provision is based on a review of a sample of individual records to assess for the timely completion of these evaluations, as well as the review and signature by the prescribing psychiatrist. This assessment was not completed as part of this abbreviated review.

Section J.13: The phrasing of this section overlaps with some of the factors discussed in other provisions. The quality and frequency of the Quarterly Review documentation is one of the primary pieces of documentation reviewed for this subsection. During the course of this review, a member of the Monitoring Team observed the Psychiatry Clinics of each of the Facility Psychiatrists, and also observed the individuals who were discussed in those reviews in their residences. The reviews were approximately 30 to 40 minutes in duration, and there was no sense of time pressure. The Psychiatrist engaged the other team members in the discussions and particular attention was paid to the risk-versus-benefit issues related to the use of the

prescribed psychotropic medications. During the visits to the individuals' living units, there did not appear to be any instances of individuals who presented as lethargic or displayed side effects, which would be indicative of excessive use of medication. However, a full review was not completed of the entirety of the psychiatric review process, and so no further feedback is offered at this time.

Section J.15: This provision is related to the integration between psychiatric services and those provided by the Consulting Neurologist. During the interview with the Section Chief for Psychiatry, he indicated that the Psychiatrists continued to attend the Neurology Clinics whenever one of the individuals on their caseloads was being reviewed. The language of this provision narrows the focus of the collaboration between the Psychiatry and Neurology Departments to just those individuals prescribed an anticonvulsant medication for treatment of both a seizure disorder and a mood disorder. The current policy of the Psychiatry Department was to attend the Neurology Clinic for all of the individuals who were reviewed jointly by both Departments, regardless of the reason, and, thus, exceeded the requirement of this provision of the Settlement Agreement. However, during this review, the consistency and/or quality of the interactions between the two disciplines for individuals prescribed anticonvulsant medication for treatment of both a seizure disorder and a mood disorder was not reviewed.

Monitoring Team's Recommendations Related to Plans of Improvement:

- The Psychiatry Department should continue to work with the QIDPs and other members of the IDT to ensure that the relevant information related to Sections J.8, J.9, and J.10 is discussed during the individual's ISP Meeting, and incorporated into the final ISP documentation as well.

SECTION K: Psychological Care and Services

Description of Any Safety or Health Issues Noted:

While touring the Facility, members of the Monitoring Team noted an area between Residence 786 and Day Habilitation 731 in which there were numerous cigarette butts on the ground. This was reported to Facility Administration, because many of the individuals served in the Facility display pica behavior. Another matter discussed with the Facility Administration was the type of prompting displayed by a staff member working with Individual #288 at Workshop 544. As discussed with Facility Administration, the staff member used both inappropriate verbal and physical direction with the individual. It was agreed that the Facility would follow-up with the staff involved. Lastly, a member of the Monitoring Team was informed that staff were conducting checks every two hours regarding the protective mechanical restraint (mitten) used with Individual #341. Staff indicated that they had been informed that 15-minute checks were no longer required. This information was conveyed to the Director of Behavioral Services. As soon as he was informed, the Associate Psychologist addressed this matter by re-training the staff on the individual's plan.

Findings regarding Areas of Focus:

The focus of this abbreviated visit was on the development and implementation of Positive Behavior Support Plans. To review these supports, the following documents were reviewed in depth: a) the individual's annual Psychological Evaluation that included information related to the Functional Behavior Assessment; b) the individual's PBSP; c) data collection used to track the occurrence of identified problem behavior; d) Monthly Psychology Progress Notes; e) and documentation regarding staff training and fidelity of treatment implementation. Additionally, the Active Record and I-Book were reviewed on site for each individual in the sample.

Psychological Evaluation: The Psychological Evaluation was the document in which staff reviewed the results of the FBA. The document provided to the Monitoring Team for Individual #397 was incomplete. As a result, evaluations were reviewed for 20 individuals in the sample. A summary of this review is provided below:

- Nineteen of the evaluations were completed, updated, or revised within the 12-month period prior to the Monitoring Team's visit. Of concern was the evaluation for Individual #344, which was completed in 2010. (It should be noted that the master list provided by the Facility indicated that an assessment had been completed in 5/13, but this was not provided to the Monitoring Team.) Similarly, the evaluations for Individual #406, Individual #435, Individual #421, Individual #119, and Individual #341 reported on information that was outdated by one to six years. Several of these individuals had experienced increased use of restraint, and/or aggressive behavior or self-injurious

behavior in the previous six months. These changes in behavior should have triggered an updated assessment of behavioral function.

- The evaluations for Individual #406, Individual #421, Individual 403, Individual #119, and Individual #254 included information from assessments completed after the date of the report. Staff should ensure that all documents are accurately dated.
- The Facility provided an undated list of completed FBAs. The identified date of completion on this master list matched the date of the psychological evaluation in only three of the 20 reports reviewed.
- Twelve of the 20 evaluations identified the indirect assessment (e.g., the Questions about Functional Behavior, Functional Analysis Screening Tool, Motivation Assessment Scale) that was utilized to determine behavioral function. The date of completion of the indirect assessment was provided in eight of the 12 evaluations. In only three of these eight evaluations was the indirect assessment completed within the same year as the report.
- Descriptive assessment was alluded to in all of the reports as staff noted that observations had contributed to the results of the FBA. However, only the report for Individual #180 identified dates when formal observations were completed. An updated FBA is advised, particularly when targeted problem behaviors remain stable or worsen, and should include a minimum of current indirect and descriptive assessment.
- Individual preferences were identified in 19 of the 20 reports, but only the report for Individual #406 documented the results of a structured preference assessment. Regrettably, this assessment was completed in 2011. When methods of determining preferences were identified, these included observation, record review, or staff report. The report for Individual #374 noted that the individual and her father had identified preferences.
- Based on documentation the Facility provided, the Identification of Challenging Behavior Form had been completed for 15 of the 21 individuals in the sample. In accordance with Behavioral Services Department guidelines, nine of these forms had been completed shortly before or on the same day as the individual's psychological evaluation report.

As noted in the Technical Handbook developed by the Behavioral Services Department and the Action Plan provided to the Monitoring Team, the annual psychological evaluation should include annual updates of the Functional Behavior Assessment. As described by the Director of Behavioral Services, this should include a minimum of the following: a) completion of the Identification of Challenging Behavior form; b) direct observations; and c) the completion of interview or rating scales. This was not evident in 17 of the reports reviewed.

Positive Behavior Support Plan: The PBSPs for all 21 individual in the sample were reviewed. A brief summary is provided below:

- Twenty of the 21 PBSPs followed a similar format. The quality of the various sections of the plans is discussed below. However, in terms of the format of the plans, the plans began with Staff Instructions that included operational definitions of targeted problem and monitored behaviors, and identified replacement behavior. This was followed by information regarding methods for teaching or strengthening replacement behavior, preventative strategies, and consequences to be applied when problem behavior occurred. Information was included regarding behavioral function. Directions for recording data were also provided. The second section of the plan was identified as Administrative Review. This included diagnostic information, relevant medical conditions, baseline or comparison data, behavioral objectives, a review of previous interventions, and a rationale for the current plan.
- The plan for Individual #344 utilized an older format in which an extensive review was provided before specific treatment strategies were outlined. The original plan development date was 6/10/11, with revisions made four times, most recently on 3/22/12 and 1/29/13. Data were presented through 3/12 and behavioral objectives were to be achieved by 2/13. In sum, this was an outdated plan for an individual who experienced significant difficulties that resulted in frequent restraint. His plan should be rewritten based on a current functional behavior assessment.
- All of the plans provided operational definitions of targeted and/or monitored problem behaviors.
- Seventeen of the 21 plans included operational definitions of replacement behavior(s). Similarly, 17 plans identified replacement behaviors that included the development or strengthening of communication skills displayed by the individual. These included teaching the individual to request a break or turn away from a task to allow him/her to escape, asking for preferred items or activities,

or ways to request attention from others. A concern was noted when reviewing the plan for Individual #374, because her identified replacement behavior was shopping twice weekly. It was unclear how this behavior was functionally related to her targeted problem behavior. Further, the schedule for implementation was very limited.

- The plan for Individual #435 included a differential reinforcement of other behavior (DRO) program, revised on 7/16/13. It appeared that this was designed to teach the individual to leave her bed and her room. The schedule of training was twice during the first and second shifts, with three trials conducted during each session. It was unclear whether she was to wear her helmet, because the PBSP indicated she should wear her helmet whenever she left her bed. Also unclear was the reinforcer to be used to strengthen this behavior. A DRO program involves providing reinforcement to an individual for the absence of the targeted problem behavior, presumably self-injury in this individual's case.
- Twenty of the 21 plans identified the potential function(s) of the targeted problem behaviors.
- All of the plans included strategies to address identified setting events and antecedent conditions. The quality of these strategies varied across plans with some providing clearer and more comprehensive interventions. For example, the plan for Individual #403 addressed a range of matters including medical issues related to her diabetes and menses, and provided suggestions for active engagement prior to meals.
- Nineteen of the 21 plans included guidelines for staff to follow when the individual displayed each of the targeted problem behavior. The PBSP for Individual #30 did not include consequences for inappropriate touching, and the plan for Individual #142 did not address her stereotypic behavior that was being monitored.
- Similarly, plans for other individuals that included behavior to be monitored typically did not provide guidelines for staff to follow when these behaviors did occur. Of the eight additional PBSPs that identified behavior to be monitored, only the plan for Individual #421 included staff instructions related to these behaviors. For the remaining seven individuals, guidelines were not provided. This was concerning, because many of the monitored behaviors had the potential to cause harm or otherwise negatively impact the individual's life. Examples included Individual #2 pulling out his catheter, Individual #409 disrobing, Individual #344 refusing to participate in hygiene care, Individual #119 attempting to harm others, and inappropriate elimination displayed by Individual #220 and Individual #359. It would be advisable to provide guidelines for staff so that they know how to react (or not) when these behaviors do occur. In the absence of such guidelines, staff may inadvertently reinforce these unwanted behaviors.
- Individual preferences or potential reinforcers were identified in 12 of the 21 PBSPs. One of these plans identified attention as the only reinforcer.
- Specified schedules of reinforcement remained limited to only eight PBSPs. Staff were to provide attention to Individual #421 once every five minutes. Staff were to interact with Individual #254 and Individual #202 once every 30 minutes. Similarly, Individual #220 and Individual #341 were to receive staff attention every hour. Staff were instructed to "try to provide one reinforcer every waking hour," if Individual #409 was not displaying targeted problem behavior. Individual #202 was to receive edible reinforcement whenever he used the bathroom appropriately.
- Three of the PBSPs clearly noted the dates of approval by the IDT, the Behavior Support Committee, and when necessary, the Human Rights Committee. The time frames for obtaining all necessary approvals was 59 days, 78 days, and 115 days for Individual #56, Individual #403, and Individual #359, respectively. As plans are developed to address serious problem behaviors, including self-injury and aggression, it is critical that these move through the approval process in a timely manner, to ensure implementation as quickly as possible.
- The direct support professionals who were interviewed reported that PBSPs were clearly written with training and support provided by behavioral services staff. They did indicate that more hands-on training would be helpful.
- A review of the Active Record, the I-Book, the PBSP master list, and the documents provided to the Monitoring Team reflected consistent dates for only three of the 21 individuals in the sample. The PBSP was not included in the I-Book for three individuals, and for four individuals, the PBSP included in the I-Book was outdated.

In general, PBSPs should be updated annually or more frequently when worsening behavior is observed. Antecedent and preventative strategies should be designed to address all variables identified in the FBA, and

dense schedules of reinforcement should be outlined to ensure the individual is reinforced for the absence of problem behavior and/or appropriate alternative behavior.

Data collection and graphing concerns: A total of 21 I-Books were reviewed, either on site in the residence or day program, or in the conference room provided to the Monitoring Team. In every case, recordings were incomplete on at least one day without explanation for the absence of data (e.g., furlough). Further, when reviewing the current day's data sheet, data were not recorded for hours that had already passed in the day, or in two cases (i.e., Individual #180 and Individual #359), replacement or targeted problem behavior data were recorded for an entire shift prior to the end of that shift. Lastly, a review of identified individuals' data sheets for the week of the Monitoring Team's visit reflected an absence of data at times when the Monitoring Team observed problem behaviors. A brief summary is provided below:

- Five individuals were observed displaying unusual or potentially problematic behavior (e.g., light slaps to one's face, loud/distressed vocalizations). No data sheets were provided, because these individuals did not have a PBSP. Another five individuals were observed displaying atypical behavior that either was not included in any operational definition or was not targeted in the PBSP. The Facility should continue to observe all individuals to ensure that plans are developed for those in need, and are comprehensive in addressing all unwanted behavior for those who do have plans.
- Individual #355 hit a member of the Monitoring Team at 2:32 p.m. on 8/19/13. This behavior was not recorded on his data sheet.
- Individual #4 was observed to hit her head 10 times at 5:48 p.m. on 8/20/13. This behavior was not recorded. Following a review of her PBSP, it was unclear whether this behavior was included in the operational definition of self-injury. If not, staff should revise her PBSP to include this behavior.
- Upon entering the residence of Individual #397 at 1:16 p.m. on 8/20/13, the Monitoring Team member was informed that he had just had a "behavior." A review of his data sheet reflected targeted problem behaviors occurring between noon and 1:00 p.m.
- Individual #435 was observed to hit her chin six times at 5:27 p.m. on 8/21/13. Three occurrences of this behavior were recorded on her data sheet. As this individual spends most of her day in her room, without constant supervision, the accuracy of her data is highly unlikely.
- Individual #246 was observed biting her hand four times at 5:50 p.m. on 8/21/13. This was not recorded on her data sheet.
- Individual #267 was observed biting his hand at 10:47 a.m. on 8/22/13. This behavior was not recorded on his data sheet. This same individual was observed engaged in hand biting later in the day (i.e., 4:45 p.m.). Again, this data was not recorded.
- Individual #409 hit himself in the chin three times at 2:20 p.m. on 8/22/13. This behavior was not recorded.
- Individual #358 was agitated and grabbing a staff member's shirt at 5:03 p.m. on 8/22/13. This behavior was not documented.
- Individual #32 was observed leaving his home at 5:20 p.m. on 8/22/13. This behavior was not recorded.
- In every case there was data missing for the week of the visit.

When interviewed, the Director of Behavioral Services reported that measures of inter-observer agreement were not being collected. As noted in the past, the data collected by the Facility must reflect valid, accurate, and reliable measures of identified target behaviors, because important clinical decisions are guided by this data.

Monthly Psychology Progress Note: Six months of progress notes were requested for the 21 individuals in the sample. These were provided for 14 individuals. For the remaining seven individuals, two to five monthly progress notes were provided. A review of these progress notes revealed the following information.

- Monthly data were presented in graphic format for both targeted problem behavior and replacement behavior in at least one month's progress note for every individual in the sample. Concerns were noted for 19 of the 21 individuals in the sample, because interval data were reported in the earlier progress notes, while later progress notes reported frequency data. However, although an obvious change in recording methods had occurred in 4/13 or 5/13, later progress notes included graphs that depicted frequency rates of behavior even when interval data had been collected.

- Measures of treatment integrity were reported in every progress note for only four individuals. As integrity checks are expected each month, behavioral services staff should make every effort to complete this task to ensure that direct support professionals are implementing PBSPs as written.
- Individual-specific comments are provided below:
 - For Individual #397, identical recommendations were provided for six consecutive months. Two recommendations were particularly concerning. The first was to: “follow-up with information regarding urology consult for swelling to scrotal area.” As this was a healthcare matter, it should have been addressed immediately. The second was to: “conduct direct observations during identified problem times to gain a better understanding of problem behavior.” The individual’s psychologist should have completed this and reported the results in the next progress note.
 - For Individual #374, in 2/13, changes to her behavioral objectives were recommended, but were not implemented. Similarly, an update to her PBSP was recommended for three consecutive months, from 5/13 to 7/13. Both of these recommendations should have been addressed in a timely manner.
 - For Individual #180, a recommendation was made to schedule a team meeting to review three months of worsening disruptive behavior. While this was appropriate, the recommendation was included in two consecutive months’ progress notes and should have been scheduled when first suggested.
 - For Individual #435, for six consecutive months, a recommendation was identified to: “add treatment integrity data to monthly assessment.” Similarly, assessment of treatment integrity was noted to be “in progress” for three consecutive months for Individual #56. These assessments should have been initiated when first suggested to ensure appropriate implementation of the PBSP.
 - Although there was significant worsening of behavior for Individual #421 from 4/13 on, the only recommendations provided in her progress notes were to continue her PBSP and psychiatric consultation. There were no measures of treatment integrity reported, nor were there recommendations to observe the individual at identified difficult times or to assess the fidelity of program implementation.
 - For Individual #30, data were not reported regarding inappropriate touching or one replacement behavior for five consecutive months. Similarly, for Individual #119, data were not reported for two replacement behaviors for three consecutive months. The reason provided was that an established baseline was needed. It is suggested that baseline data could be collected within a much shorter period of time so that problem behaviors can be treated and replacement behaviors can be taught.
 - For Individual #409, for three consecutive months, it was recommended that specific sign language be incorporated into the PBSP. This should have been accomplished when first suggested.
 - For Individual #2, data from 4/13 to 7/13 regarding treatment integrity were included in the progress notes from 2/13 to 3/13. Similarly, all graphs included in the progress note from 5/13 included data from 6/13 to 7/13. Staff should review all reports to ensure that reported data is relevant to the date of the report.
 - In the 3/13 progress note for Individual #341, data were graphed on a daily basis to determine whether there was a correlation between increased rates of problem behavior and his infrequent bowel movements and limited sleep. This was a very promising practice.

Staff should use the monthly review of progress to critically assess the efficacy of treatment plans. When progress is not observed, steps should be taken to identify and address the variables contributing to the problem behavior, to ensure fidelity of PBSP implementation, and when appropriate, to make changes to the PBSP. Recommendations should be addressed in a timely manner.

Staff Training and Treatment Integrity: Six months of documentation related to staff training was requested for the 21 individuals in the sample. A review of these documents indicated that training had occurred at least once during this period of time for everyone except Individual #142. Training occurred once each month for Individual #406 and Individual #341. With the exception of Individual #435, the assessment of training was conducted through staff interview or test completion. As suggested by the

training roster for Individual #435, staff were asked to demonstrate support plan strategies. Documentation also was requested regarding assessment of fidelity of treatment implementation. For nine individuals, there was no indication that behavioral services staff had assessed treatment integrity. For Individual #406, Individual #254, and Individual #341, there were documents indicating monthly assessment of treatment integrity involving observation of direct support professionals. For the remaining nine individuals, treatment integrity was assessed between one and five times over the six-month period.

Additional concerns: While the majority of Associate Psychologists in the Behavioral Services Department were actively pursuing board certification as behavior analysts, either through coursework and supervision or exam preparation, there was only one Board Certified Behavior Analyst (BCBA) on staff at the time of the visit. This was the Director of Behavioral Services. Direct responsibility for PBSP development and oversight remained with staff members who were not demonstrably competent in Applied Behavior Analysis.

At the Sunrise Unit Meeting observed on 8/19/13, the group discussed Individual #13's recent refusal to participate in a speech and hearing evaluation. The attending speech therapist suggested rescheduling the evaluation so that it would not interfere with the woman's regularly scheduled work activities. Although this was a thoughtful suggestion that considered the woman's preferences, the only documentation in the minutes was the psychologist's plan to increase the woman's compliance. While learning to follow the demands and routines of daily life might be an issue for this individual, the suggestion to identify a better time for the appointment reflected a simple and considerate solution to this particular problem. The team should have documented it, and followed-up on it.

Other Findings:

Similar to past visits, members of the Monitoring Team visited many of the residences and day program sites while on site. Measures of engagement or Planned Activity Checks (PLACHECKS) were collected during these visits. While not included in Section K (but rather in Section S, that was not included as part of this review), the opportunities provided to an individual to participate in varied, interesting, and meaningful activities are of critical importance when working to support positive behavior change. PLACHECK measures were collected in residences, workshops, and day habilitation sites. In general, engagement was highest in the workshop areas, ranging from 33% to 100% with a mean of 78.91%. While new tasks had been introduced in one workshop, the same tasks were often found in all other settings. Jigs were often poorly designed for the task, and teaching strategies were inconsistently applied and were not designed to foster skill development and greater independence. Other than the computer lab, where engagement was consistently 100%, other day habilitation sites reflected limited engagement, ranging from 0% to 50%, with a mean of 21.57%. Generally, the more complex the needs of the individuals and the leaner the ratio of staff to individuals, the poorer the engagement. In the residences, engagement ranged from 0% to 100%, yielding a mean of 35.57%. Engagement was best during meals. With the exception of a few residences, the activities available to individuals were very limited.

The DADS Consultant described plans for improving all programming conducted outside of the residences. For example, hours for workshop and day habilitation programs will be staggered to ensure that individuals can get to these sites and that long transition times are avoided. Activities will be individualized, with program sites designed to meet the needs of those served. Specialized programs will be developed for individuals with unique needs, such as those who experience visual impairment, or those who have multiple sensory impairments. Based on the descriptions provided, if implemented fully, the proposed changes should result in improvements.

Status of Facility's Plans to Comply with Section K:

- The Director of Behavioral Services provided a document entitled Service Task Tracking and Trending. Although due dates for assessments and progress notes were clearly identified for department staff, the report reflected very poor compliance with these tasks. Similarly, staff were expected to conduct checks of treatment integrity at a minimum of once each month. This same report indicated that integrity checks were completed less than 40% of the time over an 11-month period. While collecting data on timely completion of tasks is informative, it will only be useful when it results in improvement of staff response to their assigned duties.

- The Director of Behavioral Services explained that all staff are expected to pursue certification in Applied Behavior Analysis. Staff continued to make progress towards this goal.
- The Action Plan for Section K indicated that data collection and treatment integrity was monitored each month. Documentation provided to the Monitoring Team indicated otherwise. The Director of Behavioral Services indicated that inter-observer agreement measures were not being collected, although this would be addressed in the future. He also reported that staff would begin reviewing the completion of data sheets when on site.
- The Action Plan for Section K indicated that annual updates to individuals' FBAs were "in process." The Director of Behavioral Services indicated that the expectation was that this would be completed at the time of the annual ISP meeting.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- Staff should ensure that FBAs are updated annually or more frequently if a worsening of behavior is observed. These should include, at a minimum, the completion of indirect and descriptive assessment. When possible, preference assessments also should be completed.
- Staff should ensure that PBSPs are clearly written, with comprehensive preventative and antecedent strategies designed to address the range of variables identified in the FBA. Reinforcers should be identified and dense schedules of differential reinforcement should be clearly outlined.
- Necessary consents should be obtained in a timely manner to ensure that PBSPs are implemented as developed to support positive change.
- PBSPs should be consistent across all records including the Active Treatment Record, the I-Book, and the master list maintained by the Department of Behavioral Services. Staff should ensure that the most current PBSP is included in the individual's I-Book.
- Inter-observer agreement should be assessed on a regular basis to ensure that data collected by direct support professionals is accurate and valid.
- Monthly progress notes should be completed on time, with thoughtful analysis of treatment efficacy. When recommendations are made, these should be addressed in a timely manner.
- Regular assessment of treatment integrity should occur. Psychologists and their assistants should be observing across all settings in which the individual is served to ensure that staff are implementing the PBSP with fidelity. These observations also should be used to enhance FBA findings and staff training.

SECTION L: Medical Care

Description of Any Safety or Health Issues Noted:

As discussed in Section I, a number of issues were identified that impacted individuals' health and safety. As discussed there as well as below with regard to Section L, the incidence of pneumonia and other respiratory illnesses, as well as related deaths was concerning and required an interdisciplinary approach to resolve. Amongst the issues noted were concerns regarding adherence to clinical guidelines, and completion of necessary medical assessment to ensure treatment approaches were appropriate. In addition, as discussed in greater detail with regard to Section I, for one individual, the IDT made a decision that went against consultant recommendations and test results. From the documentation, it was unclear that this had been communicated to or agreed upon by the Medical Director in collaboration with the PCP, and/or what clinical guidance the PCP provided to the team. Clear justification would need to be found for going against a consultant's recommendation, and in this case such justification was not found.

Findings regarding Areas of Focus:

For the Monitoring Team's abbreviated review, for Section L, the focus was on the delivery of medical care and mortality reviews.

Since the Monitoring Team's last visit, Medical Department staff changed. A Medical Secretary and Medical Compliance RN were recruited. Two PCPs had left, and one was replaced in November 2012. The other PCP was scheduled to start the last week of August 2013. Two respiratory therapy positions remained vacant. One of these was filled through a contract.

Morning Medical Meetings: The Morning Medical Meetings followed a routine agenda. Attendance was documented on a signed roster sheet and subsequently tracked by the Medical Program Compliance Nurse. There were 11 parts to the agenda: on-call physician report, ER visit review [by the primary care practitioners (PCPs) and team members], Infirmary report (by the PCPs), hospitalizations (by the Hospital Liaison Nurse), 24-hour log (by the Infirmary Nurse Manager), incident management (by the Facility Nurse Investigator), consultations (by the RN Case Manager, Clinic Nurse, and/or PCPs), discussion of closure items (by the Medical Program Compliance Nurse), Facility significant events (all), pre-treatment sedation (dental), and weekly report (by specific departments). Departmental and program updates were assigned days each weekday for a weekly report. These included: Monday – Physical Nutritional Management Team, Tuesday – Infection Control, Wednesday – Physical Therapy/Occupational Therapy, Thursday – ISPA, Individual Support Plan recommendations, and Friday – number and reasons for missed appointments both on and off-campus.

The attendance sign-in sheets and attendance-tracking database were submitted for the Morning Medical Meetings from 8/5/13 through 8/16/13. The database did not include the attendance for 8/15/13, which was extracted from the daily sign-in sheets in order to derive the percentage of daily attendance by departments:

Department	Number of Days Attended	Department	Number of Days Attended	Department	Number of Days Attended
Nursing Administration	8/10 (80%)	Infirmary	0 (0%)	Hospital Liaison	9/10 (90%)
Infection Control	0 (0%)	Habilitation Therapy	8/10 (80%)	PNMT	10/10 (100%)
QIDP	10/10 (100%)	Residential	3/10 (30%)	Dietary	7/10 (70%)
QAQI	2/10 (20%)	Chaplain	6/10 (60%)	Pharmacy	10/10 (100%)
Psychology	9/10 (90%)	Psychiatry	10/10 (100%)	Dental	9/10 (90%)
Medical	10/10 (100%)	Incident Management	7/10 (70%)	Case manager	10/10 (100%)

Representation from many departments was documented. The Medical Department, PNMT, Pharmacy, Case Management, QIDP, and Psychiatry had representation at 100% of the meetings. The Infirmary nurse/representative and infection control nurse positions were vacant. Psychology, the Hospital Liaison Nurse, and dental departments attended 90% of meetings. The database should be reviewed to ensure it is complete. The reason for the lack of data in the submitted chart for 8/15/13 was not indicated. A policy should be developed, which includes required attendance by department, and identifies which departments would be expected to attend at least weekly to provide a report or provide information through discussion.

Morning Medical Meeting minutes were submitted for 10 days, from 8/5/13 through 8/16/13. These were reviewed for content. A 24-hour log was included for review in 10 of 10 of the daily meetings. These daily logs contained from 15 to 61 entries concerning the health status of individuals. Infirmary admissions were reviewed in 10 of 10 meetings. The daily Infirmary reports reviewed one to seven Infirmary admissions. Ten of 10 morning medical meeting minutes reviewed hospitalizations. This ranged from one to seven hospitalized individuals reviewed at each meeting. Information of those attending onsite clinic appointments for that day, as well as in the near future, was included in the minutes as applicable. There was one of 10 meeting minutes that discussed the on-call information from the prior evening by the PCP. There was an additional entry in the on-call section for an after hours concern. There was a section entitled weekly reports. During the 10 days of minutes reviewed, there were entries for three habilitation and PNMT reports. There was notification of missed off-site appointments twice during the 10 days of meetings. There were no other routine weekly reports documented. Look-back reviews for individuals hospitalized or admitted to the Infirmary were assigned for two individuals during the 10 meetings. Look-back reviews were completed and presented for four individuals during the 10 meetings. The minutes indicated when there was a lack of timely documents in the shared drive that could be reviewed for presentation by the Medical Compliance Nurse. For one of the 10 meetings, an assignment of follow-up was given. There were reviews of significant consults in none of 10 meeting minutes. There were eight systems issues previously discussed and carried along in the minutes, or added as new systems concerns in these 10 days. Six of these issues were located in the "Review Follow up Items" section, and remained unresolved as of 8/16/13. These had been initiated at various dates

at the Morning Medical Meeting (i.e., 5/29/13, 7/17/13, 8/1/13, 8/2/13, 8/6/13, and 8/8/13). None had documented closure. Two of the items needing closure were listed elsewhere in the Morning Medical Meeting minutes, but did not appear to have further tracking. There were reviews of six ISPAs (i.e., post-hospital/post-Infirmary) that were presented during these 10 days. There were three ISPAs due that were not available for the 8/8/13 morning report. One was later reported on 8/15/13. There were three additional ISPAs identified as not completed or not available at the 8/15/13 meeting. One was later presented during the week of the Monitoring Team’s visit. There were four ISPAs outstanding that were not reflected in the minutes as being tracked or resolved.

The attendance sign-in sheets and attendance-tracking database were submitted for the Morning Medical Meetings of 8/20/13, 8/21/13, and 8/22/13. The following table summarizes the attendance by department:

Department	Number of Days Attended	Department	Number of Days Attended	Department	Number of Days Attended
Nursing Administration	3/3 (100%)	Infirmary	0/3 (100%)	Hospital Liaison	3/3 (100%)
Infection Control	0/3 (0%)	Habilitation Therapy	3/3 (100%)	PNMT	3/3 (100%)
QIDP	3/3 (100%)	Residential	0/3 (0%)	Dietary	3/3 (100%)
QAQI	0/3 (0%)	Chaplain	3/3 (100%)	Pharmacy	3/3 (100%)
Psychology	3/3 (100%)	Psychiatry	3/3 (100%)	Dental	2/3 (67%)
Medical	3/3 (100%)	Incident Management	3/3 (100%)	Case Manager	3/3 (100%)

Internal to the Medical Department, attendance should be further categorized by medical administration, PCPs, and clinic nurses. For Medical Department review, it is suggested that each PCP’s attendance be tracked.

A member of the Monitoring Team observed three Morning Medical Meetings (i.e., on 8/20/13, 8/21/13, and 8/22/13). The minutes were subsequently reviewed for each of these three days. There were 17 to 27 individual reviews on the 24-hour log. Six to seven Infirmiry admissions were discussed each day. For the week, there were 10 Infirmiry admissions discussed. From four to seven hospitalizations were reviewed by the Hospital Liaison Nurse each day. A total of eight hospitalized individuals were discussed. Specialty onsite clinics were announced. There was one general announcement during the three days of meetings. There was one weekly report by PT. The minutes indicated the PT report was due and not provided to the Medical Department when the minutes had been finalized. There was a comment in the PT section of the minutes, referring to an individual with a wheelchair and a chair chain for head of bed elevation measurement, but the individual was not named, and it appeared that some information might have been erased. During these three days, six look-backs were reported and reviewed. There were three post-hospital/post-infirmiry ISPAs reviewed. Two appeared to include preventive measures, but one did not appear to address the reason for the Infirmiry admission. There were two additional concerns assigned for follow-up during these three days. One was subsequently closed and the other remained open. However, it was noted that the QIDP Coordinator was to follow the closed concern related to providing refresher training to staff, but there was no information concerning the timeline of training, which staff or departments were to participate, and when it would be expected to have been completed.

In comparing the two weeks of reports reviewed and the onsite observation of three Morning Medical Meetings, it was noted that components of the original agenda appeared to be optional or intermittent. The on-call physician report was only documented twice in the minutes. There was no incident management review, review of content/recommendations of consultations, or weekly reports by infection control. Although currently, the Infection Control Nurse position was vacant, the Nursing Department would be expected to provide ongoing tracking and reporting of important infection control issues.

In terms of the quality of the meetings and resulting actions, documentation in the minutes concerning steps to prevent a hospitalization or Infirmiry admission did not occur in all six cases reviewed (i.e., those from 8/5/13 to 8/16/13). There were clear steps outlined in four ISPAs, but the information selected for the minutes made it unclear if preventive steps had been discussed and implemented in the other two cases. It

was not determined if there was discussion that was not documented, or whether there was no discussion of preventive steps in two ISPAs. In relation to the observation of the Morning Medical Meetings of 8/20/13 through 8/22/13, two of three ISPAs appeared to have steps for prevention documented in the minutes. The PCPs demonstrated detailed knowledge of their caseloads, and engaged in critical thinking during discussions at the morning medical meetings. However, the clinical discussions would benefit from quality contributions from all clinical departments.

A copy of the "Look-Back Tool" template was submitted and this included questions specific to the Nursing Department, the Medical Department, PNMP, Medication Administration Record (MARs)/treatment record, and response from nonclinical staff and clinical staff interviews. The various indicator probes appeared appropriate. It was somewhat unclear how new information identified as a result of the reviews was routed, (e.g., if early warning signs and symptoms were discovered during review of the record, where this information would be located and whether it would be communicated to the IDT). A sample log was submitted referencing event dates of 8/1/13 through 8/11/13. The date of the document was not provided, but entries in the database were as recent as 8/16/13. For these entries (e.g., hospitalizations, ER visits, Infirmary admissions), the total was 21. Of these 21, three were determined not to require a look back review. Of these 21, four had closure recorded. Several were overdue, which was approximately seven days after the event date. According to this information 14 of 21 were still pending results.

A copy of the "Process for Look Backs," dated 4/24/13, was also submitted. This provided information concerning the purpose of this tool, and the staff responsible for completion of the tool. The tool was to be completed within five business days of qualifying events (exclusions were listed, and these included scheduled surgery and routine dental procedures, etc.). The process included a review of the record beginning 30 days prior to the qualifying event (i.e., hospitalization, etc.). A list of documents to review was included as guidance. Interviews were to be completed with direct support professionals and nursing staff assigned to the care of the individual at the time of the qualifying event. The review also might include interviews with direct support professionals and nurses from the prior shift. Evidence that the IHCP was followed and that the IHCP agreed with physician orders was to be reviewed. A second review was indicated when results of the initial look-back were inconclusive or resulted in further concerns and questions. This second review was to be assigned to a Nursing Department Program Compliance Nurse or to the Medical Program Compliance Nurse. When it was determined that the qualifying event was related to a breakdown in services or supports, this was discussed at the Morning Medical Meeting, and an ISPA was then requested. Commencement and completion of the look-back review was to be documented in the IPN notes.

The quality of the look-back review needed further analysis. Although the RN Case Manager in the residence or other clinical management was assigned the task, in part because that staff was familiar with the individual, it potentially decreased the opportunity for a truly objective review. Assignment of others not associated with the residence might be more objective and provide an outside review of documentation. To an outside person, the record might not be complete or provide evidence of steps taken and rationale, when a staff in that residence, familiar with the person, would have background information. The record should be able to "stand alone" in providing the required information. The Medical Director should consider assigning staff also based on the issues. If there is a habilitation concern, then a member of that department may be best at reviewing the record or assisting the primary reviewer with that aspect. PCPs should be asked to review more complicated cases, but choosing a PCP that is not the assigned PCP in that residence might provide valuable insight. Concerns were noted with the quality of the look-back reviews, which needed improvement and might not have captured all the issues. At this point, the Medical Compliance Nurse was dependent on the reviewer completing the look-back to provide a quality document.

The Facility submitted templates of forms to be completed when an individual was discharged from the ER, hospital, or Infirmary. Each type of event had its own template for completion and was to be placed in the IPN section of the record. The summary plan was to be part of the Morning Medical Meeting report. Completion and presentation at the Morning Medical Meeting was to occur prior to discharge from the ER/hospital/Infirmary. Contents included the admission and discharge diagnoses, any work-up completed while at that site, consults obtained, and summary plan components (e.g., medical, medical follow-up, nursing, infection control, respiratory therapy, habilitation, PNMT, dietary, psychology, dental, pharmacy, referrals and consults, residential services, IDT meeting date/results, and level of supervision). These forms provided

a detailed structure for the process. However, the observations of the three Morning Medical Meetings, as well as a review of the two weeks of minutes of the Morning Medical Meeting did not indicate these had been integrated into the meeting process or included in the minutes. It was not determined if these documents became part of the IPN section of the active record, and if so, in a timely manner, or were part of a future implementation process.

Annual medical assessments and quarterly medical reviews: The Medical Department provided a list of dates of completion for the annual medical assessments for the past two assessments, as well as the dates of the three most recent quarterly medical reviews completed. The number of individuals listed totaled 289. The number of the most recent annual medical assessments completed within 365 days of the prior annual medical assessment totaled 154. This represents a 53 percent completion rate. The dates of the prior annual medical assessments were not included in the data for many individuals, which might have contributed to the low percentage. It was not indicated if the prior annual medical assessment could not be located, was not done, or was done and not entered into the database. Additionally, the timeliness of the current annual medical assessments was reviewed to determine the number completed in the past 365 days. Of the 289, 245 (85%) individuals were listed as having had a current annual medical assessment completed. The timeliness of completion of the quarterly medical reviews was measured in two ways. For the months of April through July 2013 (allowing for 13 additional days beyond the 90 days of the prior review for timely completion), a quarterly medical assessment or an annual medical assessment was completed for 257 of the 289 (89%) of the individuals. The Medical Director indicated that the annual medical assessment was independent in timing to the quarterly medical reviews and that four quarterly medical reviews were expected throughout the year. Based on this criteria, the number of quarterly medical reviews completed from late December 2012 through August 19, 2013 was 465, and the number quarterly medical reviews expected was 867 (289 x three quarters). The completion rate was 54 percent (465/867).

A template for the “Quarterly Medical Review” was submitted, with a revision date of 8/13/12. This included key components to be reviewed and documented for each quarter. It is recommended that the section “active and chronic significant medical problems” be reviewed with focus given to new diagnoses (e.g., new onset diabetes mellitus) and significant changes in diagnoses (e.g., worsening congestive heart failure), rather than including the entire active problem list. The quarterly review should highlight changes in the prior quarter.

Active record review: On site, the Monitoring Team member selected eight active records for review. Selection focused on those individuals with several clinical areas considered high risk according to the IRRF. The active record was made available for each of the selected individuals. Focus of review was on the following documents located in each of the active records: preventive care flow sheet, physician orders, integrated progress notes, any quarterly medical review, Behavior Support Plan, ISP and subsequent ISPs, labs, x-rays/ Computed Tomography (CT) scans, Magnetic Resonance Imaging (MRI) scans, ultrasound scans, other radiograph test results, integrated risk rating form, the IHCP, annual medical assessment and physical exam, DNR forms if applicable, nursing assessments, any hospital discharge summaries or ER reports in the record, and any consult and procedure reports in the record. Each aspect is discussed as the relevant preventive or routine care topic is discussed below. Although this was not a compliance review, details about the Monitoring Team’s findings are provided below to assist the Facility in identifying areas in which focused efforts are needed prior to the next compliance review.

From eight active medical records reviewed:

- Seven of eight (88%) annual medical assessments had been completed in the prior 365 days.
- Active problem lists appeared to be thorough in seven of eight (88%).
- A smoking and/or substance abuse history was recorded in seven of eight (88%).
- Family history was documented (or attempts at obtaining this information) was included in three of eight (38%).
- Three of eight (38%) records had two quarterly medical reviews completed for 2013. Four of eight (50%) had one quarterly medical review completed for 2013. One record had no quarterly medical reviews. The most recent quarterly medical review was April through August in four of eight records (50%).
- PCP IPNs were recorded in Subjective, Objective, Assessment, and Plan (SOAP) format with date, time, and vital signs for acute problems in eight of eight (100%) records.

- Additionally, another individual's information was filed in one of eight active records.

Preventive Care:

- For the eight active records reviewed on site, preventive care flow sheets were updated with entries through December 2012 in four of eight (50%). This document needed updating in the other four records reviewed. For three of the four that needed updating, the last entry was March 2012. It was noted that the preventive care flow sheet was a single page. Other SSLCs have an additional page for other areas of care, and the Facility is encouraged to review this area with the State Office SSLC Medical Services Coordinator.
- Current vision screening was documented within the prior 12 months in six of eight (75%). Current vision screening was documented within the prior 24 months in eight of eight (100%).
- Audiological screening was documented in the prior three years in eight of eight (100%).
- The influenza vaccine was administered in a timely manner in 2012 in eight of eight (100%).
- Whether the individual needed to receive a hepatitis B vaccine (depending on immunity, carrier state, etc.), and whether the series was completed if indicated (or being tracked to completion) was recorded in eight of eight (100%).
- Whether the individual needed to receive the varicella vaccine (depending on birth date and immunity status), and whether it was given if indicated, was recorded in eight of eight (100%).
- A pneumococcal vaccination had been given to eight of eight (100%).
- For individuals age 60 or over, a zoster vaccine had been administered to two of two eligible individuals. One additional individual had a contraindication to the vaccine.
- A Tdap vaccine had been given to seven of eight (88%). However, Tdap vaccine administration might need to be verified (versus Td administration or TT administration).

The Medical Department had begun to develop a computerized database for several preventive tests/procedures and a copy was submitted. For colonoscopies, the total eligible population was 194 (i.e., those individuals age 50 to 75). There were 12 individuals for whom there was a contraindication for the colonoscopy. Two individuals were at age 50, and the ordering/scheduling process had not been completed (the individuals would be expected to complete the exams by the end of the 50th year of age; one individual recently turned age 50 and one was approaching age 50). Removing these 14 from the eligible list provided a final list of 180 individuals for whom routine preventive colonoscopy should have been completed according to national guidelines. Twenty-five individuals were overdue for a colonoscopy, and 155 individuals were current in completion of a colonoscopy or alternative procedure/testing. This was a completion rate of 86 percent (155/180).

From the eight active records reviewed, there were five of eight in the age range of 50 to 75. One of these was not considered a candidate for colonoscopy due to other comorbid conditions. Of the four remaining eligible individuals, four (100%) had a colonoscopy completed in the prior 10 years.

The Medical Department submitted a copy of the "Mammogram Tracking" report, which appeared to list all individuals, male and female, of all ages. Information included the date of the last mammogram, the date the next mammogram was due, confirmation of information, and comments. From this list, females born from 1938 through 1963 were identified (i.e., ages 50 to 75). Ninety-seven women were identified in this age range. There was one individual with a contraindication for the mammogram. Of the remaining 96, 75 (78%) were current in completion of a mammogram. The Facility followed the recommendations of the United States Public Service Task Force for breast cancer screening with biennial mammography.

From the eight active records reviewed, three women were eligible for mammograms every two years. For one of three there was a contraindication. For the remaining two, both (100%) were current in mammography.

The Medical Department submitted a chart entitled "Bone Density Tracker." From this database, 160 individuals were identified as having osteoporosis and 19 as having osteopenia. Information tracked included last exam date (i.e., DEXA), next due, whether the information was confirmed, and risk factors. This database appeared to be in the process of development, because the DEXA scan dates were often lacking. The database did not appear to include DEXA scores, or whether medications to treat osteoporosis, such as

calcium, vitamin D, or additional medications, had been prescribed. The risk factor column was left blank for all individuals. The Action Plan included a “revised bone density tracker” that included these components, and was to be completed on 7/19/13. The Action Plan stated this had been completed. It appeared the template had been developed, but was not helpful to the Medical Department at this time, because it was lacking considerable data.

From the eight active records, two were considered to have osteoporosis. In two of two (100%), a DEXA had been completed in the prior three years. Each individual was on supplemental calcium, and vitamin D, and each was prescribed an additional medication to treat osteoporosis.

From the eight active records reviewed, one individual had a contraindication for a pap/pelvic exam. Two women were eligible for a pap and pelvic exam. One of two (50%) was current with this preventive screening test.

The Medical Department provided two draft documents. An undated template for “annual medical assessment” was submitted. This appeared to have many of the necessary components of the annual medical evaluation. It is recommended that this also include an area dedicated to each of the following: family history, smoking/alcohol/drug abuse history, and transition information. Additionally, it is recommended that the immunization section be expanded to include Tdap, varicella vaccine or titer, and zoster vaccine. An undated “QA/QI Tool for Annual Medical Assessments” was submitted as a preliminary draft form. The contents of this draft included monitoring of family history, whether clinical care was up-to-date on various preventive guidelines (i.e., vision, hearing, mammogram, pelvic exam/pap, colonoscopy, podiatry, and immunizations), monitoring of lab work completed to determine whether it was consistent with clinical guidelines, review of the prior one year of medical history that included a nutrition review (the document did not indicate further details as to the content of the nutritional review), and monitoring of whether pre-treatment sedation needs were addressed. There was no information as to the QA staff that would complete the monitoring using this document, or the number per month or quarter that was the goal for review. This appeared to be a highly complex document if used for monitoring.

Consultation Process, ER visits, Hospitalizations, Infirmiry Admissions: The Facility submitted a document entitled: “State Supported Living Centers: Process for On-campus and Off-campus Consultations,” with a revision date of 6/12/13. This document provided detailed guidance for the consultation process, including the initial physician orders and documentation of reason for the consult, contents of the packet of information, appointment scheduling and notification of key departments, required content of the notification, transportation arrangements, completion of the consult form/transcribed document, routing of the completed consult to the PCP, and tasks the PCP was to complete in reviewing the consult report. Of note, if the PCP disagreed with the consult recommendation, the PCP was to notify the IDT. For significant consults, the PCP was to present this information at the Morning Medical Meeting. The RN Case Manager was to present the consult results to the Unit Morning Meeting, along with the PCP’s response. The RN case manager was to notify the Legally Authorized Representative (LAR) or primary correspondent of the results, and document the plan for the consultant recommendations or concerns needing IDT review, as well as request an IDT meeting for an ISPA. Contents of a database for consult tracking also were included in this document. This included tracking of time from the consult order to completion, along with tracking the number of times a consultation was missed and rescheduled. This was a comprehensive and helpful procedure.

Documentation was provided for Emergency Room visits from November 3, 2012 through July 15, 2013. The following chart lists this raw data by month, the number of emergency room visits for the month, and the diagnostic categories most commonly initiating the ER visits, based on the primary or most definitive diagnosis provided (categories with small numbers are not listed in the following chart):

Month	Number of ER visits	Trauma	GI	Respiratory	Neurological	Infection (UTI, etc.)	Allergy	Cardiovascular	Bleeding
November 2012	6	3	0	0	2	0	0	1	0
December	9	5	0	0	2	2	0	0	0

2012									
January 2013	12	6	1	1	0	2	1	0	0
February 2013	12	5	2	0	0	3	0	1	0
March 2013	15	8	0	1	0	4	0	0	1
April 2013	17	5	1	4	2	4	0	0	0
May 2013	14	6	4	2	0	1	1	0	0
June 2013	22	10	1	2	2	2	1	0	4
July 2013	8	6	1	0	0	1	0	0	0
Total	115	54	10	10	8	19	3	2	5

This information indicated a need for focus on trauma, which was responsible for 47 percent of the ER visits.

Documentation was provided for hospitalizations from November 2, 2012 through July 15, 2013. The following lists the month, the number of hospital admission per month, and the most frequent diagnostic categories associated with/causing the illness leading to the hospital admission, based on the primary or most definitive diagnosis provided for the raw data submitted. Diagnostic categories with small numbers are not included:

Month	Number of Admissions	Respiratory	Neuro - logical	Genito-urinary (GU)	Gastro Intestinal (GI)	Bleeding	Infection - Not otherwise Specified	Allergies
November 2012	18	8	3	2	1	0	3	0
December 2012	14	8	1	2	1	0	1	0
January 2013	28	17	0	3	5	0	3	0
February 2013	12	2	1	1	3	0	2	0
March 2013	13	4	0	2	2	0	3	1
April 2013	13	5	1	2	3	0	1	0
May 2013	19	10	2	2	3	0	0	0
June 2013	27	7	3	5	3	1	5	1
July 2013	13	1	2	3	2	2	2	0
Total	157	62	13	22	23	3	20	2

This information indicated the need to focus on respiratory illness, as it was responsible for 39 percent of hospitalizations.

Documentation was provided for Infirmiry admissions from January 4, 2013 through July 21, 2013. The following lists the month, the number of Infirmiry admissions for the month, and the category of diagnosis for the admissions, based on the primary or most definitive diagnosis provided for the raw data submitted:

Month in 2013	Total Number	Trauma	GI	GU	Respiratory	Infection	Fever	Metabolic /Endocrine	Neuro	Dental / Post op	Other
January	40	1	6	3	10	13	3	1	1	2	0
February	20	1	7	3	4	2	1	2	0	0	0
March	36	5	7	8	4	4	1	1	0	4	2
April	29	1	4	4	5	5	1	1	2	3	3
May	37	4	9	4	6	1	3	0	3	1	6
June	51	9	4	6	12	4	0	1	5	3	7
July	27	3	1	5	2	3	2	0	3	5	3
Total	240	24	38	33	43	32	11	6	14	18	21

It was noted that the January Infirmary census spike in the infections category was due to influenza admissions. There appeared to be a spike in respiratory illness causing Infirmary admissions in June 2013. Admission census to the Infirmary per month varied from 20 to 51. The information indicated future need for clinical guideline review and internal Medical Department auditing for the most frequent categories of illness: gastrointestinal, genitourinary, respiratory, and infections. These categories are broad and each includes several diagnoses. The Medical Department is challenged to identify the most common diagnoses and begin to create and/or ensure the use of clinical guidelines and monitoring tools applicable to these diagnoses.

Fractures, Decubiti, Pneumonia Cases, Seizure Disorders: The Facility provided a list of 14 fractures, which occurred from 11/5/12 through 7/10/13. One fracture occurred in June 2012 or prior and was removed, leaving 13 fractures occurring during this time. Four fractures occurred in the upper extremity, and six occurred in the lower extremity. There were two cases of rib fractures, and one tooth fracture. ISPAs were requested for review as follow-up to determine preventive steps to prevent a recurrent event leading to another fracture. Four of 13 (31%) ISPAs discussed and implemented steps to prevent a recurrence. For four of 13 (31%) cases, no ISPA was submitted and it appeared that an ISPA was not found in the individual's record. It was not known if an ISPA did not occur or whether ISPA documentation was created, but was not placed or kept in the record. Five of 13 (38%) ISPAs did not address steps to prevent another fracture. The nine ISPAs submitted were dated within one to seven days of the fracture. Eight of nine occurred within four days of the fracture.

The quality and completeness of the fracture data submitted needed to be reviewed. An additional document entitled: "ER/Hospital admissions and discharges due to injuries" listed an additional fracture not included in the list submitted. It occurred on 6/14/13. Additionally, this document indicated there were 53 ER visits from 11/18/12 through 7/22/13 for injuries (other than diagnosed fractures), or a need for injuries to be ruled out. This information also should be analyzed to identify various residences and/or individuals for which "look back" reviews should be conducted to determine approaches to reduce potential injuries.

The Facility submitted data concerning the number of new cases of decubitus ulcers, bowel obstructions, and pneumonias over the prior year. Also included was the number of documented pica events. The following chart includes information from this data:

Month	Decubitus Ulcer	Bowel Obstruction	Pneumonia	Pica Event
November 2012	0	2	6	3
December 2012	0	1	7	2
January 2013	2	1	12	2
February 2013	0	1	4	2
March 2013	1	1	4	0
April 2013	1	1	3	0
May 2013	3	0	9	0
June 2013	1	1	5	1
July 2013	1	2	3	1

Total	9	10	53	11
-------	---	----	----	----

From a separate report submitted, the following information was reported for pneumonia incidence:

Month	Number Of Pneumonia Cases	Aspiration Pneumonia	Bacterial Pneumonia	Pneumonia Not Otherwise Specified	Viral Pneumonia
November 2012	6	4	0	2	0
December 2012	10	5	2	3	0
January 2013	13	5	4	3	1
February 2013	4	1	2	1	0
March 2013	5	0	5	0	0
April 2013	2	1	1	0	0
May 2013	9	5	3	1	0
June 2013	4	3	1	0	0
Total	53	24	18	10	1

Some discrepancies were noted between the two lists per month. Although the two tables each had a total of 53 pneumonias listed, the first table included an additional month to attain that number. The Facility is encouraged to review databases for accuracy and completeness. As noted above with regard to Infirmiry admissions and hospitalizations, respiratory illnesses, including pneumonia was an area that required specific focus to ensure that clinical guidelines were being followed and preventative measures taken to the extent possible.

The Facility submitted a list of individuals with a diagnosis of seizure disorder who were prescribed anti-epileptic drugs (AED). The list totaled 137 individuals (137/288 = 48% of AUSSLC census). The number of individuals with a seizure disorder not prescribed medication could not be determined from the information provided. The following information was derived from this list:

Number of Anti-Epileptic Medications Prescribed	Number of Individuals	Percentage of Individuals with AEDs
1	60	43.79%
2	41	29.93%
3	24	17.52%
4	9	6.57%
5	3	2.19%
As needed medications (PRNs)	53	38.68%

The Facility indicated that 25 individuals were identified as having a refractory seizure disorder and a Vagal Nerve Stimulator (VNS), from a document entitled: "VNS Client List: List of Individuals with Refractory Seizure Disorder." From a list entitled: "ED [Emergency Department]/Hospital Admits due to Seizures," there were nine visits involving seven individuals requiring ED treatment or hospitalization. From the list of individuals prescribed anti-epileptic medications, the number of individuals prescribed "older" AEDs was calculated. The following indicates this information:

Name of AED	Number of Individuals Prescribed the AED	Percentage of Individuals Prescribed AEDs
Dilantin	21	15.33%
Phenobarbital	13	9.49%
Primidone	3	2.19%
Felbamate	0	0%

DNR orders: The Facility provided a list of individuals with “Out Of Hospital Do Not Resuscitate” (OOH DNR) orders, and this included 16 names. The terminal condition/diagnosis was listed, as well as the effective date of the OOH DNR, whether the individual was enrolled in hospice, and whether the individual had a guardian, and if so, whether the guardianship was current. Two of the 16 were enrolled in hospice services. Fourteen of 16 had guardians, all of which were current.

Diagnoses listed included dementia (five), end stage lung disease such as restrictive lung disease (three), recurrent aspiration (two), congenital heart disease (one), and anatomic conditions rendering CPR ineffective (one). For four of the 16, further information was requested, as the diagnosis did not readily indicate a terminal condition.

- One individual had renal insufficiency, with a long history of urological interventions (i.e., lithotripsy of right kidney for staghorn calculus, bladder neck resection, placement of ureteral stents with later removal, suprapubic catheter placement, and left nephrectomy). Urological interventions dated at least from 1980. This individual had reduced creatinine clearance and proteinuria, and as of 5/28/11, had stage three chronic kidney disease. The documents provided indicated the individual had no guardian, and there was no mention of active family involvement. The individual was noted to have profound Intellectual/Developmental Disability (IDD) and dementia since 3/07. However, the reason listed for the DNR was renal insufficiency. There was no information submitted to indicate the long-range plan for the kidney disease, and the individual’s IDT was to meet 8/22/13 (the week of the Monitoring Team’s onsite visit) to review this DNR status and appropriateness for dialysis. The list of DNRs indicated the DNR effective date for this individual was 10/26/11, but the annual medical assessment documented the DNR started 6/11/07. There was no information as to the person deciding the DNR status at that time. The individual’s level of decline from dementia was not clear, especially the degree of functional loss over time. However, the terminal condition of renal insufficiency appeared to need further clarification if it was to be considered an acceptable reason for DNR status. Other individuals have received dialysis when severe renal impairment occurred, without the need for ordering a DNR. The dementia, if advanced, could have been a terminal condition consistent with the need for a DNR, but this was not recorded on the list as the reason for the DNR. Further, the date of the DNR on the list needed clarification. It was also unclear the reason for not obtaining a guardian at an earlier date. The documents reviewed suggested the need for a surrogate decision-maker to represent this individual with dementia and profound IDD and such complex issues as end-of-life decisions. Given that the dementia and renal insufficiency had been progressing over years, the Facility had time to ensure a guardian/family representative was obtained. However, it appeared this had not occurred. It is recommended that the Facility review this case and call an Ethics Committee Meeting if indicated, to resolve whether the individual is a candidate for dialysis (with clear reasons documented should the decision be made that the individual is not considered a candidate), along with a review of the DNR status, with clear identification of the terminal condition.
- Another individual was listed as terminal due to “right lower lobe soft tissue mass.” A family member ordered the DNR after a hospitalization for pneumonia. The individual was noted to have silent aspiration on thin liquids, but appeared to do well with nectar and pureed consistencies. The family member refused to consent to a feeding tube. The individual also had dementia, with a worsening in mobility, independence skills, and medical issues. The individual was transferred to the hospital later in 2012 for hypoxia and hypothermia, and responded to antibiotics. A CT of the chest at the time indicated a “right lower lobe soft tissue mass” and recommendations were for a repeat CT in three to six months. This “right lower lobe soft tissue mass” was provided as the reason for the terminal condition and the DNR. A follow-up CT of the chest indicated the mass was no longer apparent. However, the reason for the DNR was not changed on the list, and there appeared to be no reason based on record review for the DNR. The family member continued to request a DNR. The guardian allowed the individual to be hospitalized in 2013 for evaluation of her lethargy and hypoxia. The individual was subsequently treated for pneumonia, according to the annual medical assessment. An earlier ISP addendum of 2/8/12 indicated that the family and team had agreed: “to change the resuscitative status to Category II, indicating no CPR or intubation would be performed when a cardiac or respiratory arrest occurs. This was based on age, declining health, consideration of long term survival, and respiratory distress/ pneumonia/ UTI.” As mentioned above, there was also a diagnosis of dementia, which if advanced, could potentially be an additional indication for the

DNR. However, the diagnosis of a soft tissue mass in the right lower lobe was given as the terminal diagnosis, indicating the need for further review and clarity in defining the terminal condition. The IDT should review this individual's specific circumstances as well as the list to ensure updated information is documented in a timely manner.

- A third individual had a DNR order due to an autonomic dysfunction. The individual was hospitalized for seizures and fever, and placed on intravenous antibiotic, subsequently developing liver failure. The individual did not improve and was placed on hospice services and returned to AUSSLC. However, the individual recovered from liver failure spontaneously, and the cause was determined to be the antibiotics given. It appeared the reason for the DNR order no longer applied, but the individual was still listed as DNR for the autonomic dysfunction. The IDT and Ethics Committee should review this individual's circumstances as well as the list and provide updated information.
- A fourth individual had orders for DNR due to a left ovarian mass. On 1/22/13, this elderly individual was placed on hospice. An annual medical assessment was submitted, dated 6/26/13 on the first page but dated 7/18/12 on subsequent pages. An MRI of the pelvis from 3/12/12 demonstrated a nodule in the area of an ovary consistent with a benign or malignant growth. An MRI of the abdomen demonstrated a kidney lesion. An abdominal CT scan of 9/11/12 showed an enlargement of the growth, as well as the complex kidney mass. On 1/11/13, a meeting was held with the guardian. The guardian decided on DNR status and refused further diagnostic evaluation. Given the age, comorbid conditions, and further procedures needed to rule in a malignancy, hospice appeared to be an appropriate choice. If the lesion were benign, then there should be minimal decline due to the pelvic mass. If the pelvic mass were malignant, the risks of the treatment options might outweigh the benefit. However, the list of DNRs did not communicate the presumption of malignancy, and the Medical Department should review the terminal condition to reflect the probable malignancy as a qualifying condition for DNR status. However, if the individual has not declined in health or function, then the PCP should review the current status and discuss further with the guardian.

From the DNR list, it appeared four of 16 needed further review for updating and correcting of information, as well as ongoing review to determine appropriateness of the DNR order.

Mortality Reviews: At the time of the review, the Facility had no outstanding clinical death reviews for deaths that occurred more than 30 days prior to the Monitoring Team's visit. There were no outstanding administrative death reviews. Since the start of the Monitoring Team's last visit, nine deaths had occurred:

- The average age was 70 (varied from 50 to 93).
- Four died under the age of 65, and five died at age 65 or greater.
- Of the deaths, two were females, and seven were males.
- The causes of death were: respiratory (four), cardiovascular (one), cancer (one), neurological (two), and hematological (one).
- An autopsy was performed in one of the nine (the record was unclear, because in one section it indicated there was no autopsy, and in other sections, an autopsy was completed). Results were not available.

Six of the nine were chosen for further review.

- DNR status was ordered while residing at AUSSLC for four of the six, and ordered for three of six while in the hospital.
- Two died in a hospital setting.
- Four died at the Facility.
- None died at another site.
- Six of six had one or more hospitalizations within 12 months prior to death.
- Three of six had an enteral feeding tube.
- Six of six included documentation indicating they were aggressively treated or aggressively treated until a decision of DNR was made.
- Three were enrolled in hospice.
- Two were considered ambulatory (either independently or with assistance), and four were considered non-ambulatory.

Since the Monitoring Team's last visit, for these six selected deaths, six clinical death review investigations were completed. Six administrative death reviews were completed. Two of the clinical death reviews had recommendations. For one clinical death review, recommendations were focused on response to a regulatory survey. For one clinical death review, focus was on nursing documentation and monitoring of equipment in the residence. The administrative death reviews did not include additional recommendations. The administrative death reviews had an additional follow-up review. For one of these six, the follow-up administrative death review had not occurred due to the death being recent. Four of six deaths had no recommendations from the clinical or administrative death reviews.

There appeared to be missed opportunities to review significant diagnoses (which may or may not have been directly related to the individual's mortality) and determine if clinical guidelines existed and had been followed, or whether clinical guidelines needed further detail or updating. As one example, constipation was a significant problem for one or more individuals. This was a missed opportunity to collaborate with community gastroenterologists and colon and rectal surgeons in developing an aggressive guideline addressing severe constipation, tests to be considered, the rigorous documentation system required in the residence and at day programming, a review of medications by pharmacy to reduce medications contributing to constipation, a review of all medical and surgical options, and specific indications for additional medical, consultation, or surgical treatment.

An assessment of these death review documents demonstrated lack of detail, such as the age of the individual at death or the cause of death. There was a narrow focus on the medical and nursing aspects of the decline and death. There were missed opportunities for each department at AUSSLC to review their role in the health, safety, and quality of life of the individual. This should not be considered a punitive exercise, but an opportunity for learning. It was noted that the State Office SSLC Medical Services Coordinator had developed guidelines for both the clinical death review and the administrative death review, both dated 4/17/13. The administrative death review also included a draft of contents for the death discharge summary. The QA Department should have an oversight role in ensuring all areas of health and safety directly or indirectly related to the decline of the individual are reviewed. Lastly, the administrative death review should include a clear response as to whether the death was preventable or not. For the clinical death reviews, the draft template was an important progress step.

Other Findings:

The Medical Department submitted graphs of results of the External Medical Peer Review (Round 7). There was no information identifying the dates of this review. The graphs indicated that the PCPs were 67 to 86 percent compliant with essential components. The PCPs were 77 to 90 percent compliant with non-essential components. Graphs also were provided for the PCP results of the External Medical Management audits for Round 7, with compliance from 55 to 60 percent per PCP, but this was not broken down by diagnosis reviewed per PCP, making interpretation difficult. A separate graph for the external medical management audits of Round 7, identified compliance by diagnosis. For diabetes mellitus, compliance was 60 percent. For osteoporosis, compliance was 50 percent. Medical management audits included three diagnoses, but the third diagnosis was not identified.

Internal Medical Peer Review (Round 7) results also were provided in graph form. For the Medical Management Audit per PCP, compliance was 52 to 83 percent. For the Medical Management Audit per diagnosis, compliance for diabetes was 100 percent, for osteoporosis 83 percent, and pneumonia 51 percent. The results of the External Medical Management data per diagnosis mentioned in the prior paragraph were significantly different, but no explanation was provided. This suggested inter-rater reliability was problematic. An additional graph of Medical Management Compliance by diagnosis for internal audits (Round 7) indicated 97 percent compliance, but no diagnosis was listed, and compared to prior information appeared to be based on additional data not submitted. Interpretation and context of the graph could not be determined.

The Medical Department provided several templates of internal quality tools with clinical indicators for frequent diagnoses. These were listed under a document entitled "Settlement Agreement Cross Referenced with ICF-MR Standards: Section H - Minimum Common Elements of Clinical Care," and included three to six

clinical indicators for each diagnosis or event (e.g., constipation, diabetes mellitus, ER/Hospital Visits, Hypertension, Osteoporosis, and Seizures). Implementation of these monitoring tools began on 7/1/13. No data was available from these tools.

Status of Facility's Plans to Comply with Section L:

- At the Morning Medical Meeting, attendance was tracked according to department, and there were plans to further determine specific attendance rates for each PCP.
- Tracking post-hospital ISPAs was an identified need. Currently the QIDP, QA Director, and the Medical Compliance RN reviewed the ISPAs for quality content. From the Action Plan document, updated 8/1/13, the Medical Department indicated that it had a goal of implementation of an ISPA Tracker as of 9/3/13 with completion date of 9/30/13. Identified concerns requiring follow-up and closure were being tracked as part of the Morning Medical Meeting documentation. There was no information concerning closure rates. The projected completion date was 8/30/13, and it appeared the Medical Program Compliance Nurse was involved in goal completion.
- There remained two vacant respiratory therapy positions. Recruitment efforts continued.
- The Medical Department had developed databases to track preventive care procedures. They currently had databases for colonoscopy and mammography testing. The DEXA scan database was incomplete, but was being developed.
- The Medical Department had created a database that listed those individuals with DNR orders, the terminal condition, the effective date, hospice involvement, and whether there was a guardian.
- The Medical Department had begun to track missed appointments for both on and off-campus appointments. A monthly meeting was held to review this information with delegation of responsibility to ensure a follow-up appointment was completed. Database management and trend analysis appeared to be future tasks.
- The Action Plan indicated that there were several action steps to be taken with implementation dates in 2012 and completion dates in 2013. However, there was no discussion or presentation of data as evidence the Medical Department was currently fulfilling the timelines. Important steps necessary for successful compliance with the Settlement Agreement remained outstanding. For example:
 - These action steps included monthly audits conducted for 10 percent of on-campus specialty clinic consults, quarterly reports and trend analysis reports, and quarterly feedback to PCPs.
 - The Medical Department action plan included monitoring of clinical diagnoses for which clinical guidelines, best practice guidelines, and protocols had been developed. This monitoring was to start 7/1/13, and this was discussed as part of the Medical Director's presentation to the Monitoring Team on 8/19/13.
 - Action steps important to substantial compliance with future dates of completion by the end of 2013 included the following: review records for documentation to support most current International Classification of Diseases (ICD) codes, audits of medical assessments and active problem lists to ensure consistency with ICD codes, monthly and quarterly monitoring reports for selected diagnoses (e.g., constipation, diabetes mellitus, ER visits/hospitalizations, hypertension, osteoporosis, and seizures), monitoring of the clinical data tracking system, development and implementation of a preventive care policy, establishing a process for how to relay information from the tracking system to the PCPs, monitoring a monthly sample to determine compliance with annual medical assessments and quality of annual medical assessments, and ISPA tracking to ensure quality recommendations.
 - The DEXA scan, tracking database appeared incomplete, and the projected completion date of 7/19/13 appeared to need revision.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- The Facility should develop that includes required attendance at the Morning Medical Meetings, by department, and defines which departments would be expected to attend at least weekly to provide a report or provide information through discussion.
- Internal to the Medical Department, attendance should be further categorized by medical administration, PCPs, and clinic nurses. For Medical Department review, it is recommended that each PCP's attendance should be tracked.

- The Morning Medical Meeting and the minutes to these meetings should be reviewed further for efficiency and effectiveness.
 - There were on-going system concerns that remained unresolved. For longstanding items, not keeping them in the daily minutes would reduce volume of paper. A weekly review until closure would be sufficient. However, a separate log of such items as system concerns, post-hospital ISPAs, look-back reviews, and other assigned concerns would allow tracking of the necessary documentation until closure by the Medical Compliance Nurse.
 - Additionally, the Medical Director should assign due dates for ISPAs, systems concerns and other concerns, and look-back reviews that are discussed at the morning medical meeting. Several of the look back reviews, ISPAs, and system issues remained unresolved and there appeared to be no expectation of when these were to be completed and reported.
 - Information from the on-call PCP should be logged separately in the minutes for ready reference and not made part of the 24-hour log or other part of the minutes.
 - Concerns with follow-up training components should not be closed until documentation of training is completed.
 - Overall, the minutes were lengthy (over 25 pages for most days), making it difficult to quickly reference a concern. There was much empty space on the 24-hour log, which could be removed. Follow-up concerns could be logged and tracked separately. Clinically important information from the on-call PCP report, the Infirmary and hospital admissions, and time sensitive and priority concerns of the 24-hour log should be listed separately to ensure the PCPs and clinical staff are aware of current information.
- Look-back review assignments should be made to allow objectivity (i.e., nursing staff not assigned to the individual or residence being reviewed) as well as the necessary clinical expertise (e.g., as appropriate PCPs not associated with the case and/or Habilitation Therapies). Quality assurance mechanism also should be considered.
- A quality check also was needed to ensure the post-hospital ISPAs addressed prevention of another hospitalization or Infirmary admission, along with a database capturing the monitoring results.
- In reference to the quarterly medical reviews, the section “active and chronic significant medical problems” should be reviewed with focus given to new diagnoses (e.g., new onset diabetes mellitus) and significant changes in diagnoses (e.g., worsening congestive heart failure), rather than including the entire active problem list.
- The template for the annual medical assessment also should include an area dedicated to each of the following: family history, smoking/alcohol/drug abuse history, and transition information. Additionally, the immunization section should be expanded to include Tdap, varicella vaccine or titer, and zoster vaccine.
- The ER data indicated a need for focus on trauma, which was responsible for 47 percent of the ER visits. This information, along with incidents related to fractures, should be analyzed to identify residences and/or individuals for which “look back” reviews should be conducted to determine approaches to reduce potential injuries.
- The Medical Department should begin to identify frequent diagnoses from hospitalizations and Infirmary admissions, and begin to create and/or ensure implementation of clinical guidelines and monitoring tools to address these areas of clinical concern.
- Respiratory illnesses, including pneumonia should be an area of specific focus to ensure that clinical guidelines are being followed and preventative measures taken to the extent possible.
- The Facility is encouraged to review pneumonia databases for accuracy and completeness.
- With regard to the DNR list, for the four individuals discussed in detail above, further review should occur to update and correct information, as well as to determine appropriateness of the DNR orders.
- With regard to the clinical death reviews, the draft template was an important progress step. The QA Department should provide oversight in ensuring all clinical departments provide a critical review of their areas and, as appropriate, provide recommendations. QA also should follow through to ensure closure of any recommendations from the administrative death reviews. Lastly, the administrative death review should include a clear response whether the death was preventable or not.

SECTION M: Nursing Care

Findings regarding Areas of Focus:

In reviewing the areas of focus related to the identification of changes in individuals' health status, including processes necessary to do this, and medication variances, the Monitoring Team's made the following findings:

- Since the last review, the Nursing Department experienced a number of changes in nursing leadership positions. Since July 2013, the Chief Nurse Executive position had abruptly become vacant and the Nurse Operations Officer (NOO) had been designated as the Acting CNE, and also maintained the NOO position. During an interview, the State Office Coordinator for Nursing Services reported that there had been a substantial breakdown in communication between her and the previous CNE, and consequently, little to no information regarding the overall issues of AUSSLC's Nursing Department were known to State Office. Due to this issue, the State Office Coordinator for Nursing Services indicated that when the CNE position became vacant, she had brought in a CNE and a NOO from two other SSLCs to come and assess the overall status of AUSSLC's Nursing Department and staffing issues. She also indicated at the time of the review, the CNE position had been filled, and the new CNE would be starting at the beginning of September 2013. The Facility Director confirmed that a new CNE had been hired. In addition, since the last review, the Infection Control Nurse position had been vacant twice, most recently since June 2013. Also, the Nurse Educator had experienced an unplanned extended leave of absence for approximately three months, but was back in the position at the time of this review. Unfortunately, as a result of these staffing issues, it was extremely difficult for the Monitoring Team to get an accurate status update from nursing regarding a number of nursing systems and processes addressing the requirements of the Settlement Agreement that focused on individuals' health status. Clearly, the chronic lack of formalized systems in the Nursing Department coupled with the position changes and vacancies had resulted in the functioning of the department being chaotic at best. For example, a number of duties and responsibilities that had been assigned to the different nursing positions in the past had not been reassigned or maintained throughout the staffing changes. For example, while the Nurse Educator was on leave, the Medication Administration Observations and Emergency Equipment drills were not reassigned and consequently, not conducted as required. In addition, Case Manager positions that had been vacant during the review period resulted in some of the paperwork that would have been assigned to those Case Managers being late, incomplete, or not completed at all. As the Monitoring Team attempted to gather information regarding nursing services, it became obvious and troubling from the interviews conducted that staff in the Nursing Department itself could not provide basic information about issues such as staffing or concrete plans to address ongoing deficiencies related to nursing systems and processes. Further attempts to determine if Facility Administration and/or State Office staff could provide such information revealed that although there was recognition that numerous concerns existed with the Nursing Department, no one at the Facility or at the State level had an accurate picture of the full status of the Nursing Department. In its response to the draft report, the State indicated: "There was a plan already in place and was shared [sic] during the time of the monitoring visit. SO [State Office] Coordinator reviewed with the monitor [i.e., Monitoring Team member] what the state had already accomplished and what our next steps were in this process." Although the Action Plan for Section M, which had not substantively changed since the last review, included some necessary action steps, overall, what the State presented as a "plan" was inadequate. The following provide just a few examples from the "plan" that the Facility submitted of "action steps" that were clearly insufficient to achieve the goals:
 - "Fill 100% of the direct care nursing staff positions" – no specific action steps were provided regarding how this would be done, or what would be done differently from the past to ensure it occurred;
 - "Nursing Protocol monitoring tools implemented" – despite major problems with the implementation of nursing protocols, inexplicably, this "action step" was described as "completed." There was no recognition in the action plan of the need to correct the deficiencies. Some action steps around monitoring and training were included, but these in no way addressed the seriousness of the problem.
 - For Section M.2, related to nursing assessments: "Develop corrective action plans as necessary to address deficiencies identified" – Given that nursing assessments have consistently been found to have deficiencies, the plan should have identified the necessary steps to address the deficiencies, and should not have been a plan to develop a plan.

- For Section M.3: “Develop individualized Acute Care Plans in response to acute changes in health status” – Again, inexplicably, this step was identified as completed, despite clear quality issues with acute care plans. Other action steps in this section identified the need for competency-based training, and although many were identified as having been “completed,” they obviously had not had the desired impact.
- “Implement a facility LVN/RN preceptor program to assist new nurses acclimate to their role” – This was the only pending action step for Section M.4, which addresses the “development and implementation of nursing protocols.” Other competency-based training action steps were marked as completed, despite considerable evidence that the nursing protocols were not being implemented, and this was placing individuals at risk.
- An interview with the Acting CNE indicated that at the time of the review, no new plans of improvement were in place to address Section M other than what had been developed prior to the previous review. In addition, she reported that she did not know if anyone had reviewed the existing plans of improvement, and was unfamiliar with their content.
- At the time of the review, from interviews with the Acting CNE, the Facility Director, and the State Office Coordinator for Nursing Services, there was clearly much confusion regarding the current number of allotted positions for nursing at AUSSLC. The State Office Coordinator for Nursing Services reported that she had noted the Facility was using Agency nurses, but she could not find any vacant nursing positions posted. She stated she had spent much time trying to determine the current number of nursing positions at AUSSLC, in addition to bringing in a NOO from another SSLC and a nurse consultant to assess and evaluate the Facility’s current nursing staffing positions and staffing needs. Although there had been, and continued to be at the time of the review, much attention focused on clarifying the nursing staffing issues, no clear plan appeared to exist to address AUSSLC’s on-going nursing staffing challenges. The combination of the chaotic functioning of the Nursing Department, the lack of formal systems, and the increased use of Agency nurses was very concerning in light of the fact that interviews with the ADOP and Habilitation Therapies Director indicated that there had been a significant increase in hospitalizations since the past review related to aspiration/respiratory issues.
- In April 2013, one of the staff, who worked in the Roadrunner and Hummingbird buildings, was found to have active pulmonary tuberculosis (TB). An interview with the Medical Director indicated that the results of the two rounds of screening that were then conducted found that six individuals had converted, meaning these individuals previously had a negative tuberculin skin/blood test, but had developed a positive test indicating there was an exposure to TB. The Medical Director reported the chest x-rays for these individuals were found to be negative and no signs or symptoms of active TB were present. However, after collaboration with the local and regional public health physicians, it was decided that treatment with Isoniazid (INH) for nine months would be initiated, because once exposed, an individual has the potential of developing active tuberculosis. In addition, the Medical Director presented the plans for ongoing assessments and monitoring of appropriate blood work during the lengthy months of treatment with INH to ensure the individuals involved had no adverse effects from the treatment. Although during this extensive process the Infection Control Nurse position became vacant, the Medical Director’s consistent and vigilant attention to this crucial issue resulted in timely, clinically sound interventions for the individuals. However, it was of grave concern when during an interview, the Acting CNE was not able to identify the individuals who had converted and were receiving INH as a result of their exposure to active TB. In addition, a review of records for Individual #174, Individual #450, Individual #347, Individual #72, and Individual #268 found there were no care plans in place addressing the change in status regarding the new diagnosis of latent tuberculosis infection (LTBI) or the initiation of INH, which has a range of side effects requiring on-going monitoring. Also, no integrated progress notes (IPNs) were found addressing the initiation of a new medication as required by SSLC protocol.
- Regarding other acute infectious illnesses, at the time of the review, no system was in place to ensure the reliability of infection control data. In addition, since the last review, only one Infection Control Committee meeting had been conducted in February 2013, and the minutes from that meeting contained no analysis of the infections occurring at the Facility. When asked about infection rates and outbreaks, Nursing Department staff were not able to provide any information addressing these areas. Clearly, at the time of this review, AUSSLC’s Nursing Department had no system in place to ensure that individuals with infectious diseases were being tracked, monitored, and provided care

plans that included the appropriate infection control measures, clinically appropriate interventions to prevent the spread of infections, and individual-specific information that would warrant on-going clinical monitoring.

- From previous problematic issues the Facility had identified, in July 2012, a written procedure to ensure nurses noted and implemented physician/practitioner orders in a timely manner was developed and implemented. However, from a review of the records for Individual #73, Individual #180, and Individual #174 who had been hospitalized since the last review, the documentation indicated continued, on-going problems regarding the consistent implementation of physician/practitioner orders. Specifically, problems were noted with regard to the completion of specific nursing assessments and/or vital signs in alignment with the frequency and parameters designated in physician/practitioner orders.
- The information the Nursing Department provided during the entrance meeting indicated that in April 2013, training was provided to nurses on five new statewide nursing protocols. At the time of the review, the Facility reported that a total of 23 nursing protocols had been implemented. However, from the Monitoring Team's review of the Risk Action Plans/IHCPs/Health Management Plans (HMPs), and IPNs for 11 individuals (i.e., Individual #73, Individual #243, Individual #180, Individual #274, Individual #50, Individual #423, Individual #204, Individual #93, Individual #246, Individual #363, and Individual #13) who were hospitalized due to changes in status, little to no evidence was found in the care plans or in the nursing documentation reviewed that the nursing protocols were actually being used to drive the identification and implementation of the specific responsibilities of disciplines, provide clear and appropriate timeframes for initiating nursing assessments and the type of assessments that should be conducted, assist in determining the frequency of these assessments, and/or identify the parameters and time frames for reporting symptoms to the practitioner/physician and Physical Nutritional Management Team (PNMT), if indicated. Although few were found, there were some IPNs that contained an adequate nursing assessment. However, the lack of consistency of the nursing assessments rendered the overall care of the individuals clinically inadequate in addressing the individuals' specific health needs. Although the Facility reported that all 23 nursing protocols had been implemented, there was no indication they were being used consistently to guide nursing assessments and documentation. Due to the number of individuals with complex medical needs at AUSSLC and the notable increase in hospitalizations related to aspiration/respiratory issues since the last review, this area should be considered a priority for Facility review, and the development and implementation of specific action plans addressing the continuing problematic issues that exist in the nursing care.
- Regarding care plans, at the time of the review, the Facility continued to have a variety of formats of care plans that included Risk Action Plans, Acute Care Plans, and Health Management Plans, although in February 2013, they had begun the process of transitioning to using the IHCP format. From the Monitoring Team's review of the Risk Action Plans/IHCPs/Health Management Plans for 11 individuals (i.e., Individual #73, Individual #243, Individual #180, Individual #274, Individual #50, Individual #423, Individual #204, Individual #93, Individual #246, Individual #363, and Individual #13) who were hospitalized due to changes in status, the care plans reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicators, were not adequately individualized, and none of the nursing action steps found in the care plans were in alignment with the clinical assessments required by the nursing protocols for the specific health issues. In addition, the generic nature of many of the action steps contained in the care plans such as "encourage fluids," prohibited validation that the step was actually being implemented.
- Since the last review, one of the Facility's regulatory reports indicated that there were problematic issues regarding nurses not consistently responding to Mock Code Drills. Due to its potential impact on the emergency services provided to individuals, the Monitoring Team added this to its focused review. Unfortunately since the last review, due to staffing turnover in the Competency Training Department (CTD) position responsible for tracking and trending data related to the Mock Code Drills, the Monitoring Team found that data had not been timely aggregated, tracked and entered into the Facility's database. However, while on site, the Facility was able to aggregate data addressing the number of drills conducted from December 2012 through July 2013, including the number of drills designated as passed and failed. The Monitoring Team's review of the data indicated the Facility had not conducted the required number of drills from December 2012 through July 2013, and that the percentage pass rate was 55%, 55%, 71%, 100%, 82%, 80%, 70%, and 90%, respectively. Although

the data indicated some recent improvement regarding the passing of the drills, the available documentation demonstrated that there continued to be problematic issues regarding nurses' not responding to the drills. An interview with the Acting CNE, the QIDP Director, and Employee Resources staff person, who had previously worked with the Mock Code Drills before moving into a different position at the Facility, indicated that they were not aware if any documentation was being kept that would demonstrate how this problematic issue was being addressed on a Facility-wide basis. In other words, except for some disciplinary action that was mentioned on some but not all relevant drills forms, the issue had not been addressed on a systems level. However, they did report that since it had not become a formal citation, no action plan was developed to address this issue. Aside from individual-specific disciplinary action that the Acting CNE thought might have taken place, it was very troubling that this significant problematic issue was not being addressed aggressively, especially given the number of individuals the Facility supported with complex medical needs.

- Interviews with the Pharmacy Department staff indicated that since the last review, problems with communication and collaboration between the Nursing and the Pharmacy Departments regarding the medication variance system resulted in the Pharmacy Department essentially taking over the collection and analysis of the medication variance data in order to increase its reliability. The Pharmacy Department, in conjunction with Nursing, Medical, and Dental Departments had begun working with the Facility's Systems Analyst to enhance the reporting and thus, the trending of the medication variance data. The Facility had developed a number of draft forms to accurately track and increase accountability regarding Controlled Substance administration and medication excesses and shortages. In addition, in November 2012, the Pharmacy Department initiated medication room inspections in conjunction with the QA Nurse. Although the Facility's data indicated there continued to be a significant number of unexplained excess and/or shortages of medications each month, systems that had been implemented, such as the Pharmacy and Nursing Department counts and the nursing shift-to-shift counts, had contributed to an overall decreasing trend in these numbers.

Other Findings:

While reviewing the active records on site, the Monitoring Team noted that there were a number of missing documents, including Quarterly/Annual Nursing Comprehensive Assessments, Risk Rating Forms/IRRFs, Medication Administration Records, and Health Management Plans/Integrated Health Care Plans. Although the Facility was able to retrieve most of the requested documents, clearly they were not available and accessible from the active record, which would be a clinical barrier for anyone trying to assess the health status of individuals.

Status of Facility's Plans to Comply with Section M:

Although the Facility submitted plans addressing Section M, at the time of the review, Nursing Department staff were not able to provide any additional information to the Monitoring Team due to a number of factors related to the chronic changes in the nursing leadership positions, the overall lack of formal nursing systems in place, and the lack of maintenance of a number of systems that were not reassigned when positions were vacant. These, along with several other variables, such as the lack of accountability and responsibility within the nursing department, resulted in the functioning of the Nursing Department being disorganized and fragmented. Consequently, it was not possible for the Monitoring Team to determine an accurate status of the Facility's plans to address Section M.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- In order for any meaningful and sustainable progress to be made regarding Section M, it is imperative the Facility stabilize the staffing issues in the Nursing Department and systematically determine, based on clinical priority, on which specific areas the Department should focus.
- The Facility should critically review its Action Plan in relation to the areas it determines to be priority areas of focus to ensure action steps designated as completed, have in fact been completed, have been adequately maintained, and are meaningful to the overall outcome.
- In addition, when reviewing the current Action Plan, the Monitoring Team encourages the Facility to review the many recommendations regarding Section M included in previous reports.

SECTION N: Pharmacy Services and Safe Medication Practices

Findings regarding Areas of Focus:

For the Monitoring Team's abbreviated review, it was agreed the focus would be on medication variances.

The Pharmacy Department continued to provide guidance in resolving the number of unknown excess medications returned to the Pharmacy and unknown shortages of medications. The Pharmacy Department had several meetings with the Nursing Department (i.e., weekly Nurse Manager meetings) discussing the need to complete excess/shortage forms in order for nursing staff to understand the need to report information such as refusals, furloughs, wastage, etc. The Pharmacy Department created a new tracking form, which listed choices for the reasons for an excess return or a shortage. To minimize the amount of writing necessary, the nurse would simply check the appropriate box designating the reason for the excess return or shortage. These were reviewed on a daily basis in the Pharmacy Department, and reasons were logged for the return. True unknown excesses or shortages were copied to the RN Case Manager and forwarded for immediate review. As a result, considerable progress had been made in the area of excess unknown medication returns and unknown shortage of medication. The Pharmacy Department continued to work with the nursing staff to improve compliance, which appeared to increase when the nurses understood the rationale for the process. The Pharmacy staff invested considerable time in educating the nurses in this endeavor.

A graph entitled "Shorts/Excess Trends" was provided for May 2012 through July 2013. From this information, excess unknown returns had a peak in June 2012. With the new tracking system in place in which the Pharmacy forms were used, this improved over the following months. In July 2013, the excess unknown returns totaled 52, a 74 percent reduction in excess unknown returns. A graph for the same time period entitled "Doses Returned to Pharmacy: Excess Unknown and Refusals" indicated that as the excess unknown returns diminished over time, the excess due to refusals by the individual increased, as a major cause of the excess returns. This is an important finding, because it identifies a cause for many of the excess returns, and allows an opportunity for the Facility to take the next step to resolve this concern. For refusals, the IDT needs to be aware of this behavior. For repeated refusals, psychology should be consulted, and meet with the IDT for action plans to resolve the refusals.

The graph "Short/Excess Trends" also indicated that shortages had a peak in July 2012 of 122 medications. This had been reduced to 32 in July 2013. This was a drop of 74 percent. A graph entitled "Replacement Doses Requested from Pharmacy: Short Unknown and Short Dose Wasted" indicated that nursing had identified issues of wastage, lost medication, spit out by individual, etc., as causes, which represented the majority of the unknown shortages. This is important information for the Nursing Department concerning wastage and spilling, and important information for the IDTs and Behavioral Services Department in relation to issues such as spitting out medication. The Pharmacy Department had provided information that other departments should be used to improve nursing administration of medication and improve medication compliance by the individuals. This is a major breakthrough in determining the etiology of unknown excess returns and shortages.

To assist the Pharmacy and Nursing Departments to further reduce the excess returned medications and shortages, a database was developed that tracked these concerns by residence, by individual, by medication, and by date. Five homes were identified with trends of excess unknown medication returns and shortages. Eleven individuals were identified with excess unknown returns and shortage of medications. Two medications (Lamictal and Vitamin D) were noted as contributing to the most medication shortages. A total of 20 medications were identified as contributing toward shortages. Eight medications were the focus of excess unknown medication returns. The most commonly reported were Keppra and Lactulose.

This aspect of addressing medication variances was a major advance resulting from the leadership of the Pharmacy Director and Clinical Pharmacist. It will be important to continue to train nurses until they understand and take ownership of the process, and partner with Pharmacy in having the process succeed. Focusing attention on those medications most involved in medication excess returns and shortages is recommended, as well as focusing on residences with significant numbers of excess unknown returns and shortages. The Pharmacy Department should ensure the IDTs and Behavioral Services Department are aware of the refusal pattern, and spitting out of medication by individuals. The Pharmacy Department should have

evidence of communication of this information to the Behavioral Services Department and IDTs in order for them to address these concerns.

The Medication Variance Committee met on a monthly basis. Minutes were submitted from January 2013 through August 2013 (except July 2013). The following data from these minutes summarizes the total number of medication variances by department:

Month	Pharmacy Department	Nursing Department	Medical Department	Dental Department	Total
December 2012	33	44	*	*	
January 2013	41	108	6	0	155
February 2013	36	84	2	0	122
March 2013	28	102	0	0	130**
April 2013	32	129	0	0	161
May 2013	30	263	1	0	294**
June 2013	****9	161	2	0	169***
July 2013	12	72	1	0	85

*Not available prior to Jan 1, 2013.

**Discrepancy with tabulation in the minutes.

***Discrepancy in August 2013 minutes in which it was noted that there were 182 total variances in June 2013, but only 169 categorized.

****The data for June 2013 was not submitted separately in meeting minutes. There appeared to have been a meeting scheduled for July 9, 2013, which would have provided the data for June, but the Facility did not submit minutes for this meeting. However, in the Facility's comments on the draft report, the Pharmacy Department provided this information.

Month	Category A	Category B	Category C	Category D	Category E
January 2013	54	21	71	8	1
February 2013	41	17	55	9	0
March 2013	49	18	61	2	0
April 2013	55	37	67	2	0
May 2013	63	74	153	4	0
June 2013	15	79	71	4	0
July 2013	11	24	47	2	1

The January 13, 2013 minutes indicated the number of medication variances the Pharmacy Department compiled did not match the numbers the Nursing Department compiled. It was noted that the medication room inspections done by nursing were not done consistently. A new process was to be developed. There was no information concerning an assigned due date for completion of the task, or how it was to be tracked for progress.

The February 12, 2013 minutes indicated the data had started to include all four departments in medication variance tracking as of January 2013. Pharmacy also was completing medication room inspections. The Nurse Educator had completed a monitoring of the medication room inspections, and found that bulk medications, insulin, and refrigerated medications were not being labeled with the date, time, and initial of the nurse at the time of opening. According to the minutes, it was also discovered the Medication Administration Policy did not address this issue, and would require an addendum or revision. During the medication room inspection monitoring, expired medications were still found at the residence.

The March 19, 2013 minutes indicated the Data Systems Analyst began to assist with the data analysis and reporting. It is recommended that the Pharmacy Department provide guidance in choosing analysis most valuable to the various departments. Additionally, a tabulation of categorization of medication variance (A, B, C, etc.) with a total number across campus for all departments would be helpful, as noted in the above chart, and such handouts should be made part of the minutes of each meeting. Although it was helpful to determine categorization by department for internal review and corrective actions, it would be helpful to determine

how many Category A's, B's, etc., occurred in the month regardless of department to determine trends for each category.

The April 9, 2013 minutes indicated that the Pharmacy Department had begun weekly meetings of the Pharmacy Technicians with the Pharmacy Director to review the variances found during cart checks. Additional meetings also were occurring with the dispensing pharmacist.

The May 14, 2013 minutes indicated that in the Pharmacy Department, technicians were documenting the quantities on the fill sheets during cart fills. This was an attempt to reduce the number of incorrect medications placed in the cart. The Nursing Department had begun in-service education concerning the appropriate documentation on drug logs, and appropriate documentation of wasting medication. A policy and procedure was to be written by the Residential Services and Nursing Services for administration of dental medications by the direct support professionals. The policy would include how the medications were to be purged and steps to ensure the medication was not outdated. It was not clear the reason for and the role of the direct support professionals in administering dental medications. It was not clear how this assigned task was to be tracked to closure. There was no due date given for completion of the task.

The June 11, 2013 minutes indicated that the Pharmacy Director met with all the pharmacy staff to address reduction of distractions in order to maintain accuracy of the cart fill process. Due to the seasonal increase in furloughs for individuals, there was a redistribution of responsibilities among the pharmacy staff to accommodate the increased workload. Nursing indicated the most recent in-service concerning the correct procedure for drug logs was dated 5/22/13.

There were no meeting minutes for July 2013. It was not indicated if a meeting was held and minutes were not submitted, or if there was no meeting for that month.

The August 11, 2013 minutes indicated that duplicate forms for shorts/excesses were ordered so Nurse Managers would immediately receive a copy for follow-up. A new controlled drug administration record form had begun to be utilized for improved tracking and accuracy of documentation. Liquid medications were filled in smaller amounts for tracking and accountability. The RN Case Managers were to ensure that refusals of medication were documented in the Medication Administration Record (MAR). There was a second set of minutes dated August 11, 2013, which included additional charts.

Calcitonin nasal spray tracking occurred from July 2012 through June 2013. Data indicated that the excess returned medication indicated no improvement over time. In July 2012, the percentage of medication returned correctly was 21 percent and in June 2013 was 33 percent. Sixty-two percent of Calcitonin nasal sprays had been returned with excess amounts remaining based on calculations of dosages, which should have been administered. This continued to be a problematic medication in terms of excess doses. Medication observations of administration of Calcitonin were to occur in residences with excesses and shortages of this medication. It is recommended that the Pharmacy Department discuss this concern with other SSLCs to determine their current use of the medication, whether other medications have been prescribed to replace this medication given recent Federal Drug Administration (FDA) updates, and to determine any causes of excess returns/shortages or other trending information available from other SSLCs concerning nursing staff's administration of Calcitonin. Although this appears to be a nursing challenge, it continues to be helpful for the Pharmacy Department to provide guidance in determining the root cause of the medication variance.

Other Findings:

Two sets of Pharmacy and Therapeutics Committee meeting minutes were submitted. For the two P&T Committee meeting minutes reviewed, based on the State's comments to the draft report, there were several areas in which statements could be interpreted in more than one way. This appeared in several subsections of the P&T Committee minutes. In the future, it is recommended that these minutes be reviewed to ensure sufficient information is included and potential misinterpretation is minimized.

From the February 28, 2013 meeting minutes, a form for the physicians to write orders at the time of furlough or at the time of transition/discharge to the community was approved. A more detailed documentation process for reviewing furlough medications prior to the medications leaving the SSLC also

was approved. This included an additional form for the nurses to complete. The Infection Control Nurse identified storage concerns for the flu vaccine. The action step was to develop procedures and education for nursing prior to the receipt of the flu vaccine shipment. However, with the Infection Control Nurse vacancy, it was not clear how the Nursing Department was to complete this task and track it to closure. According to the minutes, tracking of chemical restraints and of chemical restraint forms appeared to be efficient. Three adverse drug reactions had been documented, and none required FDA notification.

At this meeting, a follow-up Drug Utilization Evaluation (DUE) concerning anticholinergic use was reported. There was also a Pharmacy review of an article focusing on multivitamins. Although this latter subject was labeled a DUE, it was not reported in the same format as the DUE for anticholinergics (i.e., sample size, specific findings, etc.). In its comments on the draft report, the Pharmacy Department indicated that a formal DUE had been completed, but the Monitoring Team had not requested the information. Considering the effort involved and importance of findings applicable to AUSSLC, as well as the need to document the DUE process was completed, including a review of findings and acceptance of the analysis by the P&T Committee members, in the future it is recommended that a synopsis of all DUEs completed during the quarter and discussed at the P&T Committee be described in the minutes, similar to the DUE findings of the anticholinergic study. The Facility should ensure each component of the DUE, as well as a summary of the analysis, the Committee's acceptance, and any recommendations are recorded in the minutes.

Pharmacy completed two other reviews based on FDA updates for Zolpidem and Chantix. It was noted that a review had been performed for these two medications and it was verified that no individuals were prescribed these medications. These two studies were informational for clinical staff.

At the beginning of each calendar quarter, the Pharmacy Department should review this area to ensure the DUE calendar that was established is completed on schedule. If there are changes that are needed (in topic, order of study, a concern of high importance needing urgent review, etc.), this information should be formally discussed at the P&T Committee meeting and approved by the Committee, with the reason and final decision reflected in the minutes.

From the June 27, 2013 meeting minutes, the policy and procedure for the nursing staff's review of furlough medication as well as the procedure for ensuring appropriate storage of the flu vaccine remained to be finalized. There appeared to be ongoing changes in the route and completion of the chemical restraint forms.

It is recommended that the Pharmacy Department meet with the Psychiatry Department to review the content of the psychiatry section of the chemical restraint form. The contents of both should agree, especially in regard to review of side effects and drug interactions, a determination of justification, and a determination of effectiveness. As the psychiatry section provides guidance to the IDT, along with the other departments involved, it is important that a concise review be included in the psychiatry section, and a standardized template or list of topics covered is recommended. This could include a review of whether the BSP was followed, whether changes in the BSP are indicated (and if so, what changes should be considered), whether the event was preventable, whether changes in emergency medications are recommended for that individual in the future, based on the current medication prescribed and the results of that chemical restraint, whether a change in the routine psychiatric medication is indicated, etc.

At this meeting, a total of eight adverse drug reactions were reviewed. One was reported to FDA MedWatch. No follow up DUEs were reported. One DUE was completed and results reported for Valproic acid/Divalproex. This included the components required for a DUE. There was an area for which a follow-up study would be indicated related to the administration of these medications with meals to reduce GI side effects. Considering the frequency of GI symptoms at AUSSLC, it would be helpful to determine if the individuals on these medications have GI side effects, and whether prescribing them with food would have an impact. Although complete information for this DUE was not requested or submitted, as this was not a full compliance review, the P&T Committee minutes would be expected to provide a summary of this important information, which either would have provided answers to concerns addressed by the DUE or brought up new areas needing action plans. There was no information to determine whether the PCPs were challenged to review their caseload to determine if individuals on these medications also were having vomiting or anorexia, or complaints of GI distress. There was no information discussing a follow-up in six months to

determine if any individual's regimen had been changed to administer these medications at mealtime and whether there was a decrease in GI side effects. If this occurred, the DUE would have a positive clinical impact on health of the individuals at AUSSLC. This was an area the Pharmacy Department had identified, but the minutes did not reflect further action or discussion.

Status of Facility's Plans to Comply with Section N:

The Pharmacy planned to continue the current systems. For Section N.8, in November 2012, the Pharmacy began to try to establish inter-rater reliability for the medication room inspections with the Quality Assurance Nurse.

The Pharmacy planned to continue to play a lead role in medication variance tracking and analysis. Collaboration with the Systems Analyst had led to quality analysis with practical application.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- It will be important to continue to train nurses until they understand and take ownership of the process of medication variance tracking and partner with the Pharmacy in having the process succeed. Focusing attention on those medications most involved in medication excess returns and shortages is recommended, as well as focusing on residences with significant numbers of excess unknown returns and shortages, with evidence of interventions and trend analysis. The Pharmacy Department should ensure the IDTs and Behavioral Services Department are aware of the refusal pattern, and spitting out of medication by individuals. The Pharmacy Department should have evidence of communication of this information to the Behavioral Services Department and IDTs.
- The Pharmacy Department should discuss the medication variances for Miacalcin with other SSLCs to determine their current use of the medication, whether other medications have been prescribed to replace this medication given recent FDA updates, and to determine any causes of excess returns/shortages or other trending information available from other SSLCs concerning nursing staff's administration of Calcitonin. Although this appears to be a nursing challenge, it remains helpful for the Pharmacy Department to provide guidance in determining the root cause of the medication variances.
- The Infection Control Nurse identified inadequate storage concerns for the flu vaccine. Although the minutes did not provide details, the Nursing Department was assigned responsibility for developing a procedure (once it had left the Pharmacy) for storage on the unit, administration, and documentation. The action step was to include development of procedures and education for nursing prior to the receipt of the flu vaccine shipment. However, it had been pending for months and with the Infection Control Nurse vacancy, it was not clear how the Nursing Department was to address this issue and track it to closure. It is recommended that the Pharmacy Department assist in resolution of this problem.
- The Pharmacy Department should collaborate with the Psychiatry Department to review the content of the psychiatry section of the chemical restraint form. The contents of both should agree, especially in regard to review of side effects and drug interactions, a determination of justification, and a determination of effectiveness. As the psychiatry section provides guidance to the IDT, along with the other departments involved, it is important that a concise review be included in the psychiatry section, and a standardized template or list of topics covered is recommended.
- DUE results that indicate a potential area for improvement should be considered an opportunity for follow-up focused monitoring reviews to document changed/improved clinical practice patterns and impact of the DUE.

SECTION O: Minimum Common Elements of Physical and Nutritional Management

Findings regarding Areas of Focus:

As part of the Monitoring Team's abbreviated review, the primary areas of focus for Section O included the implementation and monitoring of mealtime and positioning plans, the status of the PNMT, and development of plans to address individuals at highest risk. This limited review was accomplished by conducting interviews with the Director of HT as well as completion of direct observation of a number of individuals in multiple residences, dining rooms, and day programs. In addition, a sample of individuals was chosen who had experienced a change in status and/or were supported by the PNMT. A document review was completed

for these individuals. The samples selected for the abbreviated review of Section O are described above in the documents reviewed section.

Positive Initiatives

Based on the Facility's status update, since the last review, the following initiatives were completed and documentation was presented to confirm the completion of these initiatives in the Presentation Book for Section O:

- Individuals' PNMPs were audited to reconcile 180-day doctor orders and a process was developed for changes made to PNMPs that require doctors' orders;
- An audit was performed for all individuals who require podiatric intervention to ensure all appropriate footwear was ordered, available, and in good repair. Physical Therapists were supposed to review the Shoe Equipment Tracking System weekly to ensure follow-up of recommendations and appropriate corrective actions were in place;
- A protocol was developed for specialized positioning in the dental chair, and written and pictorial instructions were developed for individuals;
- A curriculum was developed for Vision 101 and Deaf/Blind Basics and training was provided to staff. The plan was to integrate this training into New Employee Orientation (NEO); and
- Administrative staff were provided training on the revised State PNM policy.

PNM Policy and Role of the PNMT

The Facility had provided training to 17 leadership and supporting staff (i.e., Director, Assistant Director of Programs, Assistant Director of Administration, Settlement Agreement Coordinator, Human Rights staff, Unit Directors, Medical Director, Clinical Pharmacist, Nursing staff, Quality Assurance Director and staff, Risk and Incident Management Director and staff, Dental staff, Psychiatric Services Director, Qualified Intellectual Disabilities Professional Director, Director of Psychology Services and staff, and Staff Development staff) on the revised State PNM Policy #012.3, effective 3/4/13, which included the following areas:

- The PNMP, who should have one and what should be included;
- Implementation of the PNMP; and
- Purpose, referral guidelines, and responsibilities of the PNMT.

Based on interview with the Director of HT, there was not a Facility-specific PNM policy to memorialize the current Facility-based PNMT process.

Core PNMT Membership

On 8/1/13, the PNMT SLP position had been vacated. On 8/10/13, the PNMT PT went to part-time status. Based on interview, the Director of HT was in the process of recruiting a SLP and PT for the PNMT. A contract Registered Dietician had been hired, effective 8/19/13. Based on interview with the Director of HT and documentation submitted by the Facility, the PNMT was not functioning with the appropriate disciplines as defined in the Settlement Agreement.

Consultation with Medical Providers and IDT Members

The PNMT Attendance Tracking Sheet revealed that no Primary Care Physician attended any of the 199 PNMT meetings conducted between 2/1/13 and 7/31/13. The PNMT should always consult with the individual's medical provider during the completion of the PNMT assessment and ongoing follow-up, because they provide medical consultation and supports to high-risk individuals with significant health, physical, and nutritional concerns.

PNMT Meetings

A review of the Facility PNMT Tracking Sheet, created 9/7/12, for 180 PNMT meetings tracked from 2/1/13 to 7/31/13 (i.e., as discussed below, minutes showed additional meetings had occurred) revealed the following:

- PNMT RN attended 34% of the meetings (62/180);
- PNMT OT attended 98% of the meetings (177/180);
- PNMT SLP attended 82% of the meetings (148/180);
- PNMT RD attended 0% of the meetings (0/180); and
- PNMT PT attended 99% of the meetings (179/180).

However, the Monitoring Team was not able to substantiate this data, because PNMT meeting minutes did not have attendance sheets attached.

PNMT Meeting minutes were reviewed from 2/1/13 to 7/31/13. During this time period, there were 199 meetings. As stated above, the PNMT Attendance Tracking Sheet indicated there were 180 meetings. It was unclear why there was an incongruity between the numbers of meetings identified in these documents. Consequently, the Monitoring Team did not have confidence in the data that was presented to substantiate the number of PNMT meetings that had occurred and attendance by PNMT members.

A review of these PNMT Meeting minutes did not show consistent documentation of referrals, review of individual health status, PNMT actions, follow-up and outcomes/progress toward established goals, and exit criteria for individuals.

Identification of PNM Risk

Based on documentation provided, dated 8/13/13, PNMPs were in place for 278 of 290 individuals (96% of the census). The Facility had developed procedures describing the process for the development, implementation, and maintenance of individuals' PNMPs, which was a positive development in memorializing the PNMP process. However, as discussed below, additional work was needed to ensure that individuals' PNMPs contained required components to minimize individuals' PNM risks.

Physical and Nutritional Management Team Referral Process

Individuals in Samples #0.1 and #0.2 were reviewed to determine if they met the State and Facility PNM policy criteria for referral to the PNMT. In addition, the PNMT minutes were reviewed to determine if individuals who had received a diagnosis of aspiration pneumonia, experienced a choking incident, and/or received a feeding tube had been referred to the PNMT. Often, individuals that should have been referred and assessed by the PNMT had not been. More specifically:

- *Individuals with Placement of Feeding Tube:* Since the last onsite visit, Individual #45, Individual #57, and Individual #13 had received feeding tubes.
 - Individual #45 received a feeding tube on 6/6/13, but had not been referred to and/or reviewed by the PNMT;
 - Individual #57 had been referred to the PNMT. However, his referral was made after a non-emergency placement of his feeding tube.
 - Individual #13 had not been referred to the PNMT. PNMT meeting minutes, dated 6/24/13, stated: "reason for possible referral was placement of new feeding tube. Has been tolerating feedings and plan IDT has in place progressing without problems. No need for further PNMT involvement at this time." However, this decision did not support the State PNM policy referral criteria that required the IDT to refer individuals to the PNMT for "new and/or proposed enteral feedings."
- *Individuals with Diagnosis of Aspiration Pneumonia:* The Facility Hospital Admission and Discharge list revealed that during the time period between 6/12 and 7/13, 41 individuals had been diagnosed with aspiration pneumonia. The Monitoring Team reviewed this list from 11/12 to 7/13 and found the following:
 - During this time period, 21 individuals (i.e., Individual #21, Individual #204, Individual #454, Individual #398, Individual #434, Individual #81, Individual #302, Individual #45, Individual #89, Individual #452, Individual #318, Individual #13, Individual #90, Individual #243, Individual #402, Individual #423, Individual #50, Individual #189, Individual #287, Individual #138, and Individual #73) received a discharge diagnosis of aspiration pneumonia. Four of these individuals had been hospitalized more than once for aspiration pneumonia (i.e., Individual #454, Individual #45, Individual #90, and Individual #423).
 - Thirteen of these 21 individuals had not been referred to the PNMT (i.e., Individual #81, Individual #21, Individual #204, Individual #398, Individual #302, Individual #45, Individual #89, Individual #452, Individual #243, Individual #50, Individual #189, Individual #287, and Individual #138).
 - Eight of these 21 individuals (i.e., Individual #454, Individual #434, Individual #318, Individual #13, Individual #90, Individual #402, Individual #423, and Individual #73) had been reviewed by the PNMT.

- *Choking Incident:* Individual #97 experienced a choking incident on 5/22/13, but had not been referred to the PNMT.

The State PNM policy stated that the IDT should refer an individual to the PNMT after “two aspiration pneumonia diagnoses in one year,” but as indicated in the Section O Protocol and Metrics, the three Monitoring Teams disagree with this criterion. Any diagnosis of aspiration pneumonia should trigger a referral to the PNMT. During an interview with the Assistant Director of Programs and the Director of Habilitation Therapies, they indicated that there had been a significant increase in hospitalizations since the past review related to aspiration/respiratory issues. Due to this increase, the PNMT should have employed a more aggressive clinical and investigative approach with IDTs, and the PNMT should play a significant role in assessing these individuals. In addition, the PNMT should have been a resource to the medical, nursing, residential, quality assurance, and risk management staff in analyzing why there had been an increase in aspiration pneumonia (i.e., identification of individual-specific and systemic issues), and should have presented not only individual-specific, but systemic strategies to minimize the risk of aspiration pneumonia for individuals.

Although the Director of HT had provided training to AUSSLC leadership staff (i.e., as identified above in the PNM Policy and Role of the PNMT section) on the PNMT referral criteria, IDT members were not referring individuals to the PNMT and/or referrals were not initiated in a timely manner. The following concerns were noted for individuals within Sample O.1:

- Individual #81 was discharged from the PNMT in May 2012. After his discharge, he was hospitalized on three separate occasions with a discharge diagnosis of aspiration pneumonia (i.e., 7/8/12, 11/13/12, and 6/12/13). He had not been referred back to the PNMT.
- Individual 423 was hospitalized three times (i.e., 1/30/13, 5/14/13, and 6/28/13) with a discharge diagnosis of aspiration pneumonia, but had not been referred to the PNMT.
- As noted above, two individuals who received placement of a feeding tube had not been referred to the PNMT (i.e., Individual #45 and Individual #13).

There were individuals who should have been referred to the PNMT, but were not. The Facility and the PNMT should complete additional education with IDTs to ensure they understand their responsibilities in making a timely referral to the PNMT.

PNMT Assessment

For the five individuals in Sample #0.2 who were actively involved with the PNMT (i.e., Individual #260, Individual #90, Individual #213, Individual #96, and Individual #23), it could not be determined if their PNMT assessments were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy).

The PNMT assessment for one of the five (i.e., Individual #23) was completed in no less than 30 days of the date initiated, or no more than 45 days in extenuating circumstances (i.e., critical diagnostics requiring outside appointments, hospitalization, etc. with clearly stated rationale). These timeframes should be followed, but actions that are identified earlier or require more expedient implementation should be implemented as they are identified.

Five PNMT assessments were reviewed for their comprehensiveness and all included the following components: updated risk ratings based on the PNMT assessment and analysis of relevant data, evidence of observation of the individual’s supports at their residence and day/work program, evidence that the PNMT conducted a hands-on assessment, identification of the potential causes of the individual’s physical and nutritional management problems, and evidence of revised and/or new interventions initiated during the assessment process. However, some of the PNMT assessments were missing components such as: the date the assessment was initiated; assessment of current physical status, musculoskeletal status, motor skills, and skin integrity; assessment of posture and alignment for bathing and oral hygiene; assessment of current adaptive equipment; nutritional assessment, including but not limited to history of weight and height, intake, nutritional needs and mealtime/feeding schedule; potential or actual drug as well as drug-and-drug nutrient interactions; assessment of respiratory status; review/analysis of lab work; review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times and side

effects; discussion as to whether existing supports were effective or appropriate; the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; and recommendations for monitoring, tracking, or follow-up by the PNMT.

The Facility was planning to develop and implement a PNMT assessment audit tool. This process should assist in the identification of missing components of a comprehensive PNMT assessment.

These five individuals' PNMT recommendations were tracked through PNMT individual-specific meeting minutes. This format included the following fields: date reviewed and type of review, category, discussion, follow-up, and date of completion. However, a review of individuals' meeting documentation indicated there were missing components such as: appropriate, functional and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan; established timeframes for the completion of action steps; specific clinical indicators of health status to be monitored; identified triggers; and the frequency of monitoring.

Integration of PNMT Recommendations into IHCPs and/or ISPs

The Monitoring Team could not find evidence that recommendations made by the PNMT were addressed and/or integrated in ISPA meetings, Action Plans, IRRFs, and/or IHCPs.

PNMT Follow-up and Problem Resolution

The Monitoring Team was not able to discern if the five individuals' action plans in Sample O.2 had been implemented within 14 days, or sooner as needed, of the plan's finalization. Furthermore, it was difficult to track completion of PNMT action steps and/or action steps did not have established timeframes for completion.

Individuals Discharged by the PNMT

Review of three individuals' discharge summaries (i.e., Individual #198, Individual #340, and Individual #452) developed by the PNMT and ISPA found:

- An ISPA meeting was conducted for Individual #452 to discuss his discharge from the PNMT. However, no ISPA meeting documentation was presented for Individual 198, and Individual #340.
- Objective, clinical data was provided to justify the PNMT discharge for Individual #452, but was not present for Individual #198 and Individual #340.
- ISPA meeting documentation did not provide evidence that new recommendations were integrated into the individual's ISP action plan and/or IHCP for these individuals.
- Two individuals' discharge summaries provided criteria for referral back to the PNMT (i.e., Individual #340 and Individual #452).

There was not a standardized PNMT discharge process that supported a collaborative process between the PNMT and an individual's IDT. Such a process should include a status of current supports and services, objective clinical data to justify the discharge, and recommendations for ongoing supports and services, including frequency of monitoring. The Facility should memorialize PNMT discharge procedures in a procedure or policy.

PNMP Format and Content

Twelve individuals' PNMPs (i.e., Individual #81, Individual #45, Individual #13, Individual #423, Individual #213, Individual #96, Individual #23, Individual #260, Individual #90, Individual #340, Individual #452, and Individual #198) were reviewed for necessary components. Twelve of the twelve individuals' PNMPs and dining plans were current with the past 12 months and included the following components; the individual's risks and triggers; the overall adaptive equipment required by the individual including rationale; handling precautions or movement techniques; dining plans with instructions, including the food texture and fluid consistency; and information about how the individual communicated and how staff should communicate with an individual.

However, some individuals' PNMPs were missing the following components:

- Large and clear color photographs with instructions were not available for the following individuals: Individual #45, Individual #13, Individual #423, Individual #213, Individual #96, Individual #90, and Individual #452;
- Individuals who used a wheelchair as their primary mobility did not have positioning instructions for the wheelchair, including written and pictorial instructions for Individual #45 and Individual #423;
- Type of transfer required was not clearly described (i.e., number of staff required) for Individual #81, Individual #96, Individual #260, Individual #340, and Individual #452;
- Bathing instructions were not adequate (i.e., instructions should include bathing equipment, strategies, independence, and level of staff assistance required) for, Individual #81, Individual #423, Individual #96, Individual #260, Individual #340, Individual #452, and Individual #198;
- Toileting-related instructions were not adequate (i.e., instructions were not provided, including check and change, level of independence, and level of staff assistance required) for Individual #81, Individual #45, Individual #96, Individual #260, and Individual #340;
- Individuals who received enteral nutrition did not have a statement that they were to receive nothing by mouth for Individual #81, Individual #45, and Individual #13;
- Dining plan photographs were not large enough to show sufficient detail for Individual #45, Individual #13, Individual #423, Individual #96, Individual #23, Individual #260, Individual #90, Individual #340, Individual #452, and Individual #198;
- Dining plan adaptive equipment rationale was not provided for Individual #45, Individual #96, Individual #452, and Individual #198;
- Medication administration instructions did not include all of the necessary components, such as positioning, adaptive equipment, diet texture, and fluid consistency for Individual #81, Individual #45, Individual #13, Individual #90 and Individual #452; and
- Oral hygiene instructions did not have general positioning and/or brushing instructions for Individual #13, Individual #23, Individual #260, Individual #340, Individual #452, and Individual #198.

Facility-based protocols had been developed to describe PNMP revision, finalization, delivery, tracking, and consultation. It was a positive step that protocols had been developed to memorialize the PNMP process. However, additional work was needed to ensure individuals' PNMPs included necessary components.

Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs

The Monitoring Team conducted multiple observations of individuals in their residences, dining rooms, and day programs to ascertain if staff were competent and compliant in implementing individuals' PNMPs and dining plans. The Director of HT was present for many of these observations. Similar to previous reviews, these observations confirmed that staff continued to breach individuals' PNMPs and dining plans as prescribed and written. The State requested and on August 29, 2013, the Monitoring Team provided the following summary of concerns noted:

PNMPs			
	Date	Individual	Breach of PNMP Strategies
1	8/20/13	Individual #307	Poorly positioned in wheelchair, seatbelt not snug
2	8/20/13	Individual #372	Poorly positioned in wheelchair, seatbelt not snug
3	8/20/13	Individual #232	Poorly positioned in wheelchair, no direction on tilt range in wheelchair
4	8/20/13	Individual #23	Nurse presenting medication without unbreakable spoon, nurse standing to administer medication while Individual #23 is seated, nurse did not refer to PNMP prior to administration of medication
5	8/20/13	Individual #435	Individual #435 was in bed without wedge, staff placed wedge after the Monitoring Team member entered the room, wedge was in the wrong position
6	8/20/13	Individual #90	Poorly positioned in wheelchair, seatbelt not snug (day program), poor pivot transfer out of wheelchair and brakes not locked, staff member had to be prompted to use gait belt during the transfer

	8/21/13	Individual #90	In residence, sitting in transport chair with no shoes
7	8/20/13	Individual #204	Poorly positioned in regular chair
8	8/20/13	Individual #337	Poorly positioned in transport chair and had not been repositioned in a regular chair
9	8/20/13	Individual #370	Poorly positioned in wheelchair, footrests had not been removed while she was in the day program
10	8/21/13	Individual #251	Poorly performed pivot transfer by staff, environment not set up correctly to conduct a safe transfer and poor handling techniques
	8/21/13	Individual #251	Poorly positioned at the end of the bed, her head and upper body were not elevated
11	8/21/13	Individual #452	Staff not following walking instructions on PNMP
12	8/21/13	Individual #416	Head of bed not at recommended elevation
13	8/21/13	Individual #143	No photographs of wheelchair positioning, no footrests on wheelchair
14	8/21/13	Individual #78	Not wearing shoes, poorly positioned in wheelchair, and leaning to the left
15	8/21/13	Individual #426	Poorly positioned in wheelchair
	8/22/13	Individual #426	Poorly positioned in wheelchair
16	8/21/13	Individual #63	Sitting in transport chair and had not been transferred to another chair
17	8/21/13	Individual #328	Poorly positioned in wheelchair, not wearing palm posey on right hand
18	8/21/13	Individual #456	Poorly positioned in wheelchair
	8/22/13	Individual #456	Nurse administering enteral nutrition, Individual #456 not positioned correctly in wheelchair, and nurse did not refer to PNMP
19	8/21/13	Individual #381	Positioned on her right side, but PNMP states "no sidelying"
20	8/21/13	Individual #62	Positioned in supine position with her head in hyperextension, which places her at risk for aspiration, no directions for placement of chain to achieve safe degree of elevation
21	8/21/13	Individual #51	Mechanical lift with only one staff although transfer instructions require two staff, stays not properly inserted in sling during the mechanical lift transfer
22	8/21/13	Individual #390	Poorly positioned in wheelchair
23	8/21/13	Individual #196	Poorly positioned in wheelchair
24	8/21/13	Individual #398	Poorly positioned in wheelchair, no pictorial instructions for wheelchair positioning
25	8/21/13	Individual #81	Poorly positioned in wheelchair
26	8/21/13	Individual #385	Poorly positioned in wheelchair
27	8/21/13	Individual #15	Poorly positioned in wheelchair
28	8/21/13	Individual #224	Did not observe a RoHo cushion
29	8/21/13	Individual #340	PNMP stated: "recline wheelchair most of the time, sit upright for meals and digestion, then recline chair." Afternoon observation did not find Individual #340's chair reclined.
30	8/21/13	Individual #433	Poorly positioned in recliner
31	8/21/13	Individual #453	Poorly positioned in bed, did not follow bed positioning instructions
32	8/21/13	Individual #239	Head of bed not elevated to correct chain position
33	8/21/13	Individual #2	Nurse administering medication, did not have nosy cup on med cart which was required for presentation under medication administration,
	8/22/13	Individual #2	Individual #2 was being transported in his wheelchair by staff without footrests on his wheelchair.
	8/21/13	Individual #2	Asleep without pillows between his knees and ankles
34	8/21/13	Individual #216	Nurse administering medication with a paper cup. PNMP states: "use nosy cut-out cup glass if medication given with liquid."

35	8/21/13	Individual #328	Poorly positioned in wheelchair
36	8/22/13	Individual #93	Individual #93 was in the Infirmary. Staff reported she was in a loaner chair and her wheelchair was at her home. She was poorly positioned in her wheelchair. The nurse was providing suction tooth brushing in a reclined wheelchair position. Her PNMP required "use most upright position in wheelchair & staff performs oral care."
37	8/22/13	Individual #144	Individual #144 was in the Infirmary. She was wearing shoes in bed. Her PNMP did not address alternate positions. Staff was not able to describe what they monitored related to implementation of the PNMP.
38	8/22/13	Individual #375	Individual #375 was in the Infirmary and poorly positioned in a regular chair.
39	8/22/13	Individual #389	Individual #389 was in the Infirmary and poorly positioned in his wheelchair. Staff was not able to describe what they monitored related to implementation of the PNMP.
40	8/22/13	Individual #182	Individual #182 was in the Infirmary and he was poorly positioned in bed.
41	8/22/13	Individual #186	Individual #186 was in the Infirmary, but did not have a chain on his bed. The Monitoring Team was later informed that staff had shown us the wrong bed and Individual #186 had a chain on his bed.
42	8/22/13	Individual #50	Individual #50 was coughing throughout medication administration. Nurse did not administer medication correctly as observed by the nurse practitioner on the Monitoring Team. There were no pictures for bed and/or modified wheelchair positioning.
43	8/22/13	Individual #323	Poorly positioned in wheelchair.
44	8/22/13	Individual #57	Poorly positioned in wheelchair. PNMP did not have pictures to assist staff with wheelchair positioning.
45	8/22/13	Individual #16	Staff completed a mechanical lift transfer without stays in sling.
46	8/22/13	Individual #310	Poorly positioned in bed and bed was not elevated to recommended degree of elevation with chain.
47	8/22/13	Individual #196	Individual #196's head was not supported during a mechanical lift transfer and his feet were dangling in wheelchair.
48	8/22/13	Individual #188	After the transfer, he was poorly positioned in his wheelchair and was leaning to the right.
49	8/22/13	Individual #171	He was poorly positioned in bed and his bed was elevated above the recommended degree of elevation
50	8/22/13	Individual #269	Poorly positioned in wheelchair
51	8/22/13	Individual #363	Poorly positioned in wheelchair and PNMP did not have wheelchair pictures.
52	8/22/13	Individual #216	Poorly positioned in regular chair
53	8/22/13	Individual #201	Individual #201 was blind and staff was using hand-over-hand techniques and not hand-under-hand techniques as presented in staff training
54	8/22/13	Individual #45	Not wearing shoes

Dining Plans			
	Date	Individual	Breach of Dining Plan Strategies
1	8/21/13	Individual #341	Cup with snorkel lid not present, staff stated: "does not like snorkel lid," but the dining plan's assistive equipment stated cup with snorkel lid, mitten on hand during lunch time but not mentioned on dining plan, not wearing shoes
2	8/21/13	Individual #323	Staff not prompting "encouraging of sips of liquid throughout meal," staff presenting liquid not encouraging independence with drinking
3	8/21/13	Individual #191	Poorly positioned in wheelchair

4	8/21/13	Individual #450	Staff not following techniques for presentation of food and fluid
5	8/21/13	Individual #222	Staff presenting fluids while head is in hyperextension which places her at risk for aspiration
6	8/21/13	Individual #316	Individual coughed nine times, but dining plan did not offer strategies for staff to follow
7	8/21/13	Individual #232	Poorly positioned in dining chair and feet needed support
8	8/21/13	Individual #91	Poorly positioned in wheelchair, table height was too high which resulted in dining platform being too high
9	8/21/13	Individual #15	Table top too high, adaptive equipment at meal did not match dining plan pictures
10	8/21/13	Individual #115	Dining chair too far back from table, eating too fast without prompts from staff to slow down
11	8/21/13	Individual #251	Not sitting in small, narrow dining room chair, poorly positioned in dining chair
12	8/21/13	Individual #147	Poorly positioned in wheelchair, staff presenting food at too fast a pace as dining plan stated: "feed slowly (wait 10 seconds between bites)," staff did not offer two to three empty spoons in between bites
13	8/21/13	Individual #90	Poorly positioned in chair, too far back from table, staff did not prompt Individual #90 to eat at a slow pace with sips of liquid throughout the meal (wait 10 seconds between bites)
14	8/21/13	Individual #63	Table height too high
15	8/21/13	Individual #214	Staff not following presentation instructions
16	8/21/13	Individual #215	Poorly performed pivot transfer from wheelchair to dining chair
17	8/21/13	Individual #181	Poorly positioned in wheelchair and not upright, dining plan did not provide wheelchair degree of angle
18	8/21/13	Individual #280	Staff not using hand-under-hand assistance to guide her during the meal
19	8/21/13	Individual #338	Poorly positioned in dining chair
20	8/21/13	Individual #224	Poorly performed pivot transfer to dining chair, table height too high
21	8/21/13	Individual #143	Instructions required small amount of fluid in cup, but this was not followed
22	8/21/13	Individual #64	Table height too high
		Individual #64	No gait belt for transfer from wheelchair to dining chair, poorly performed pivot transfer
23	8/21/13	Individual #78	Wheelchair not locked, dining plan instructions stated: "eats with hand over hand assistance," dining plan had not been modified to hand-under-hand assistance
24	8/21/13	Individual #239	Poorly positioned in bed and received enteral nutrition
25	8/21/13	Individual #193	Food and fluid not immediately available upon arrival in dining room
26	8/21/13	Individual #452	Receiving snack, dining plan not available and staff did not refer to the PNMP, improper placement of nosy cup
27	8/21/13	Individual #100	Staff standing to present a pudding snack
28	8/21/13	Individual #436	Did not have utensil to cut open his baked potato and/or cut his meat. Although he ate independently, had to ask staff for assistance, dining plan did not indicate the type of regular eating utensils to be provided (i.e., knife)
29	8/21/13	Individual #1	Staff was not providing prompts in dining plan instructions
30	8/21/13	Individual #159	Coughed multiple time during the meal, staff were not successful in slowing her pace, no drinks were available to her when she was eating, although dining plan stated: "encourage sips of liquid after ever 3-4 biters to assist with clearing"
31	8/21/13	Individual #370	Poorly positioned in wheelchair

32	8/21/13	Individual #168	Dining plan stated: "[Individual #168] cannot see. Position plate, cup, utensil, napkin, and food the same way at all meals." Individual #168 had to search with her fingers to locate food and her dishes. The dining plan should provide specific placement of her utensils, napkin and food to assist staff across all three shifts to be consistent.
33	8/21/13	Individual #455	Drinking glasses were too far away from her which impacted her ability to drink independently
34	8/21/13	Individual #368	Dining chair was positioned too far away from table
35	8/21/13	Individual #4	Poorly positioned in dining chair
36	8/21/13	Individual #173	Table height too high, pitchers too large and too full to support independence with pouring a drink, she coughed during the meal and staff did not prompt her to limit her bite size, staff did not encourage her to alternate sips of liquids throughout the meal to assist with clearing food from mouth
37	8/21/13	Individual #253	Staff did not prompt her to slow eating pace and to drink after every five to six bites
38	8/21/13	Individual #457	Staff performed a poorly executed pivot transfer and used poor body mechanics
39	8/21/13	Individual #234	Staff were poorly positioned to slow Individual #234's pace of eating, Individual #234 was right-handed and staff was sitting on her left side
40	8/21/13	Individual #398	Poorly positioned in wheelchair, no pictorial instructions for wheelchair positioning, received enteral nutrition
41	8/21/13	Individual #456	Poorly positioned in wheelchair and receives enteral nutrition
42	8/21/13	Individual #62	Positioned in supine position with her head in hyperextension, which places her at risk for aspiration, no directions for placement of chain to achieve safe degree of elevation. She receives enteral nutrition.
43	8/22/13	Individual #228	Poorly positioned in her power wheelchair.
44	8/22/13	Individual #144	Individual #144 was in the Infirmary. Observation during lunchtime revealed that her dining plan was not available to staff.
45	8/22/13	Individual #375	Individual #375 was in the Infirmary. Observation during lunch time revealed that his dining plan was not available to staff
46	8/22/13	Individual #182	Individual #182 was in the Infirmary. He was poorly positioned in bed and receives enteral nutrition.
47	8/22/13	Individual #186	Poorly positioned in his wheelchair and he received enteral nutrition
48	8/22/13	Individual #196	Poorly positioned in his wheelchair and he receives enteral nutrition
49	8/22/13	Individual #188	Poorly positioned in his wheelchair and he receives enteral nutrition
50	8/22/13	Individual #363	Poorly positioned in his wheelchair and he receives enteral nutrition.
51	8/22/13	Individual #389	Individual #389 was in the Infirmary. He was poorly positioned in his wheelchair and receives enteral nutrition.

As discussed in previous reports, the implementation of individuals' PNMPs should be non-negotiable. PNMP strategies have been developed to minimize and/or mitigate an individual's PNM risk factors. Consequently, when these plans are breached, it has the potential to place an individual at risk of harm. Furthermore, the Monitoring Team is concerned with the increased number of individuals diagnosed with aspiration pneumonia and some of these individuals subsequently died. There is the potential that individuals' PNMPs being breached, particularly over a period of time, could be a contributing factor in individuals' deaths. The following 64 individuals within the observation samples had been identified at medium and/or high risk of aspiration: Individual #307, Individual #372, Individual #232, Individual #23, Individual #435, Individual #90, Individual #204, Individual #370, Individual #251, Individual #452, Individual #416, Individual #426, Individual #328, Individual #456, Individual #381, Individual #62, Individual #51, Individual #390, Individual #196, Individual #398, Individual #385, Individual #224, Individual #340, Individual #433,

Individual #453, Individual #239, Individual #216, Individual #328, Individual #93, Individual #389, Individual #182, Individual #186, Individual #50, Individual #323, Individual #57, Individual #310, Individual #188, Individual #269, Individual #363, Individual #216, Individual #45, Individual #341, Individual #191, Individual #450, Individual #222, Individual #316, Individual #115, Individual #147, Individual #181, Individual #338, Individual #64, Individual #454, Individual #100, Individual #1, Individual #159, Individual #368, Individual #4, Individual #173, Individual #253, Individual #457, Individual #234, Individual #228, Individual #144, and Individual #375. With a sense of urgency, the Facility should initiate an interdisciplinary problem-solving approach to identify the barriers to staff implementation of PNMPs and dining plans. This initiative should result in the development and implementation of strategies to reverse the current practice of not adhering to PNMPs. As has been stated in the past, this should be major focus over the next six months.

The Monitoring Team's observations support the need for improved oversight in dining rooms. Based on interview, the Mealtime Management program had been implemented in Castner. However, observations in dining rooms with Mealtime Supervisors and PNMP Coordinators did not show that these staff were intervening to correct staff and provide coaching and mentoring to staff to demonstrate the correct implementation of individuals' dining plans. The Facility is encouraged to discuss with State Office other SSLCs who have more developed Mealtime Coordination leadership groups, and learn more about their processes for the completion of competency performance check-offs for Mealtime Coordinators. The Facility should move forward with a sense of urgency in implementing the Facility Mealtime Management program campus-wide.

New Employee Orientation

The Facility reported that 434 new employees successfully completed PNM core competency-based training and performance check-offs between from February through July 2013. This training included: deaf awareness, basic sign language, communication with people, augmentative communication, therapeutic handling and positioning, PNMP practicum, lifting and transferring, music therapy, and dietary services. The adequacy of this training was not evaluated during this review.

Annual Refresher Training

The Facility reported that as of August 2013, 605 veteran employees had completed annual refresher training in lifting and transfers. This was the only PNM training for which annual refresher training was provided, which was not sufficient to ensure individuals' health and safety. At that time, 80% of veteran staff were up-to-date with lifting and transfers, and 20% of staff were delinquent in fulfilling this training responsibility. This was a significant concern.

PNM Core Competencies for Current Staff

Based on interview and review of Section O action plans, plans were to be developed to provide competency-based PNM foundational training to veteran staff. The provision of PNM competency-based training and performance check-offs for veteran staff should provide a stronger foundation for staff competence in the implementation of individuals' PNMPs.

Facility's System for Monitoring of Staff Competency with PNMPs

At the time of the Monitoring Team's review, the Facility did not have a policy and/or a procedure that described the current monitoring system to test staff's implementation of PNMPs, including their competence. As stated in previous reports, the HT Department staff should develop monitoring operational guidelines that define the current monitoring system used to test staff compliance with PNMPs and dining plans.

The Facility Compliance Monitoring Report Line Item Report, dated 8/16/13, indicated the number of Compliance Monitoring forms that had been completed by month. This data indicated a decrease in the occurrence of PNMP and dining plan monitoring: November 2012 - 16; December 2012 - 46; January 2013 - 37; February 2013 - 35; March 2013 - 10; April 2013 - 35; May 2013 - eight; June 2013 - eight; and July 2013 - 13. These reports also identified the compliance percentage by month for each question on the monitoring form. In addition, charts were presented to reflect compliance data by month for meals, transferring, and positioning. There were no monitoring results for medication administration, oral care, and/or bathing. The

Facility should take into consideration that the decrease in monitoring might also be a contributing factor in staff compliance with PNMP and dining plan implementation.

Status of Facility's Plans to Comply with Section O:

Based on interview and document review, the Facility was planning to implement the following initiatives to support substantial compliance with Section O:

- Continued recruitment of vacant PNMT positions;
- Development of a system to integrate monitoring results into QA and Risk Management systems to track and trend the frequency, antecedent, and correlations with identified health risk indicators;
- Full integration of action plans for individuals at highest risk;
- Development and implementation of PNMT assessment audit tool and tracking log;
- Provision of competency-based training for PNM core competencies for all required veteran staff;
- Development and implementation of a system to complete staff PNM competency performance checks;
- Monitoring mealtime supervisors to include inter-rater reliability and validation checks;
- Conduct of individual-specific monitoring directed by the integrated Action Plan; and
- Monitoring APENs for completion, relevance, and use in determining continued use of enteral nutrition.

The Monitoring Team agrees that these are reasonable action steps to move the Facility forward in achieving substantial compliance with Section O. However, the Facility faces major barriers in achieving substantial compliance with Section O. Some of the biggest concerns identified during this review included:

- The upsurge in individuals being diagnosed with aspiration pneumonia without corresponding referrals to the PNMT, as well as analysis of potentially contributing factors and development and implementation of plans to address issues identified;
- Individuals' foundation for health and safety was being compromised as staff continued to breach individuals' PNMPs and dining plans;
- Improved oversight in dining rooms to support mealtime safety was needed. Additional recommendations for interventions are discussed below.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- The Facility should identify why there has been an upsurge in individuals being diagnosed with aspiration pneumonia and implement strategies to mitigate this risk for individuals.
- The PNMT should play a significant role in developing and implementing individual-specific and systemic resolutions in reducing individuals' risk for aspiration pneumonia.
- With a sense of urgency, the Facility should initiate an interdisciplinary problem-solving approach to identify the barriers in staff implementation of PNMPs and dining plans. This initiative should result in the development and implementation of strategies to reverse the current practice of not adhering to PNMPs.
- The Facility is encouraged to discuss with State Office other SSLCs who have more developed Mealtime Coordination leadership groups, and learn more about their processes for the completion of competency performance check-offs for Mealtime Coordinators. The Facility should move forward with a sense of urgency in implementing the Facility Mealtime Management program campus-wide.
- The Facility should memorialize the PNM monitoring process in policy and/or procedure.
- The PNM monitoring process should be expanded with an emphasis on enhanced monitoring for individuals at highest PNM risk.

SECTION Q: Dental Services

Findings regarding Areas of Focus:

For the Monitoring Team's abbreviated review, it was agreed the focus would be on the adequacy of dental assessments and services.

A new dentist had been added to the Dental Department, along with an Administrative Assistant. The current Dental Director was transitioning from AUSSLC, and was in a part-time status during the Monitoring Team's visit.

A list of dates of completion of annual dental assessments and dates of prior assessments was submitted for the prior six months. A number of exams were in the completed category (by due date), but review indicated data entry errors so the Monitoring Team could not determine if these had been completed. In addition, a few were overdue and belonged in the past due category. The following table summarizes this information:

Month	Number of Completed Appointments	Insufficient Data	Past Due Completed This Month	Remained Incomplete at End of Month
February 2013	24	4	4	7
March 2013	23	0	9	14
April 2013	12	2	8	13
May 2013	31	5	13	2
June 2013	27	1	2	0
July 2013	6	2	2	0
Total	123	14	38	36

Based on the information provided, for the annual dental assessments completed more than 365 days after the prior assessment, the number of days overdue was based on the time since the missed appointment date or the last annual date. There were a total of 44 overdue annual assessments. These were completed within 30 days of the missed appointment or the annual due date (whichever was provided) in 23 cases, completed within 60 days for 16 cases, and completed after 60 days for five cases. By the end of July 2013, all missed appointments had been completed in a follow-up appointment. There were sixty-eight percent (123/181) timely annual dental assessments, and an additional eight percent (14/181) in which insufficient information was provided to determine whether the annual dental assessments were completed in a timely manner. It appeared there was improvement in the most recent months with regard to timeliness of completion. All annual dental assessments scheduled in June 2013 were completed in June, and all annual dental assessments scheduled for July 2013 were completed in July. It was noted that during these two months, the remaining prior missed appointments were completed for annual medical assessments.

Review of reasons for not completing the annual in a timely manner included: individual illness (often with hospitalization), Dental Department staff illness, individuals with challenging behaviors at time of appointment or refusing appointment, delayed/slow guardian process in completion of consent, time constraints requiring rescheduling for TIVA/GA, and GA backlog.

Ten annual dental assessments completed in the last 30 days were submitted, along with the prior assessment. A new template had been developed that provided a listing of essential areas of information with checkboxes for options for each item. The IDT also used the majority of the “annual dental assessment” form. An additional area provided information for any dental hygiene procedure at the time of the visit. Although this was not a compliance review, the following observations were noted. Nine of 10 (90%) had been completed within 365 days of the prior annual dental assessment. Cooperation/description of behavior was noted in 10 of 10 (100%). Oral hygiene ratings were listed in 10 of 10 (100%). The periodontal condition was noted in nine of nine (100%) with teeth. One individual was edentulous. Oral cancer screening was recorded in 10 of 10 (100%). Findings/treatments and procedures completed during the annual visit were recorded in 10 of 10 (100%). Positioning (i.e., Habilitation Therapies consult for transfer to the dental chair) requirements was recorded as necessary in one of 10. Oral hygiene recommendations were included in 10 of 10 (100%). It was noted that this included specific details for the specific toothbrush type, specific toothpaste, and specific instructions for tooth brushing. A proposed risk rating for the ISP was found in 10 of 10 (100%). A statement of community transition/preparedness was noted in 10 of 10 (100%). A section noting the dental treatment plan listing future needs or concerns was not part of this form. There was difficulty in determining whether the individual underwent general anesthesia in completing the annual assessment in six of 10. For three, general anesthesia was indicated. There were six others in which the choices of oral sedation, mechanical supports, and general anesthesia were checked as recommended, and the individual was described as uncooperative, with an exam completed and x-rays, if indicated. However, there was no clear statement if oral sedation was provided and if so, the medication and dosage and route of administration, nor whether general anesthesia was required in completion of the exam.

The Dental Department indicated that 46 individuals were edentulous. This was a 16 percent edentulous rate. No one had become edentulous since the Monitoring Team’s last visit.

AUSSLC currently had 24 individuals utilizing suction tooth brushing. As of 8/12/13, there were 31 individuals identified or referred for suction tooth brushing for which this procedure had not begun. There was ongoing discussion concerning the staff most appropriate in completing this procedure in the residences. The Facility had determined that selected direct support professionals would complete competency-based training on suction tooth brushing, and members of the Dental Department would complete ongoing monitoring. Documentation of a timeline when these 31 individuals would begin suction tooth brushing was not provided.

The Monitoring Team requested a list of individuals for whom the ISP indicates the individual brushed his/her own teeth, along with the OH scores. The Dental Department submitted a document indicating it did not track ISP records, and no list was provided for individuals-identified as having self tooth-brushing skills. Further clarification of the request will be discussed during the Monitoring Team’s next visit to ensure understanding of the request. The Dental Department had oral hygiene rating scores for each individual, but did not provide evidence of specifically tracking the oral hygiene scores of those with self tooth brushing skills to determine whether the oral hygiene was stable, improving, or worsening. The Dental Department should have a mechanism through which this information is readily available.

The Dental Department submitted the most recent oral hygiene ratings for the entire AUSSLC campus. Two hundred ninety-one individuals were listed. Of these most recent oral hygiene ratings, 100 of 291 (34%) were considered a “good” rating. Ninety-eight of 291 (34%) were considered a “fair” rating. Ninety-three of 291 (32%) were considered a “poor” rating.

A list of dental emergencies was submitted from January 2013 to June 2013. The number of emergencies per month was as follows:

Month	Number of Emergency Visits	Month	Number of Emergency Visits
January 2013	5	April 2013	5
February 2013	8	May 2013	1
March 2013	5	June 2013	5

This was a total of 29 emergencies in six months. The individual was seen the same day as Dental Department notification in 18 out of 29, and the next day in nine out of 29. For one individual, the notification was on a Friday and the PCP indicated a Monday appointment was appropriate. For one individual, the time span of the appointment following notification could not be determined.

Copies were submitted of five recent dental emergencies, from 8/1/13 through 8/19/13. Documentation indicated that one had a complaint of pain and four did not have complaints of pain. Examination documentation indicated three had pain. The one individual with a complaint of pain did not have pain on examination. Time from notification of the Dental Department to appointment time varied from one hour 10 minutes to five hours 40 minutes. All were examined the same day of notification. Follow-up was scheduled in two of five, and was not indicated in three of five. Closure was confirmed for four of five. For one emergency appointment, information was not submitted to indicate this had occurred.

The Dental Department submitted a list of appointments completed for restorative dental care. The following lists the number of completed appointments per month:

Month	Number of Appointments with Restorations	Month	Number of Appointments with Restorations
January 2013	9	April 2013	5
February 2013	8	May 2013	1

March 2013	9	June 2013	17
Total number of appointments with restorations: 49			

A list of those undergoing dental extractions was submitted for January 2013 to June 2013. This information is included in the following table:

Month	Number of Visits with Extractions	One Tooth Extracted	Two Teeth Extracted	Three Teeth Extracted	Four Teeth Extracted	Five Teeth Extracted
January 2013	2	2	0	0	0	0
February 2013	3	1	1	0	1	0
March 2013	5	3	1	0	0	1
April 2013	3	1	2	0	0	0
May 2013	1	1	0	0	0	0
June 2013	2	0	1	1	0	0
Total	16	8 (50%)	5 (31%)	1 (6%)	1 (6%)	1(6%)

The Facility submitted copies of five recent dental extractions. A prior IPN identifying the need and reason for the extraction was included in two of five. Guardian/family consent and Human Rights Committee (HRC) approval was submitted in zero of five. The number of teeth extracted ranged from one to three teeth. One individual had preoperative oral sedation followed by general anesthesia. Three other individuals underwent general anesthesia. One individual had local anesthesia only due to risk of general anesthesia for the individual. A post procedure note was written in five of five cases. From the IPN notes submitted, it appeared that two of five were prescribed or administered pain medication. For two of five, there was no reference in the IPN concerning pain medication (copies of dental orders were not included in the submitted packet). For one, it was noted the IPN was missing from the record. It was noted that the Dental Department utilized new templates that were specific to the reason for the visit (i.e., general anesthesia, extractions, etc.). These templates allowed the dentist to check boxes with a reduction in hand writing requirements. Each entry included many of the areas essential for the dentist to review and provided a mechanism to ensure the dentist reviewed all areas noted on the template.

Information was provided concerning the use of TIVA/General Anesthesia, oral sedation, and mechanical supports for the prior six months:

Month	Completed Appointments	Number with TIVA/GA	Percent with TIVA/GA	Number with Oral Sedation	Percent with Oral Sedation	Number with Mechanical Supports	Percent with Mechanical Supports
February 2013	80	16	20%	0	0%	2	2.5%
March 2013	72	12	16.7%	1	1.4%	0	0%
April 2013	61	17	27.9%	0	0%	0	0%
May 2013	83	1	1.2%	0	0%	0	0%
June 2013	79	8	10.1%	0	0%	0	0%
July 2013	90	12	13.3%	0	0%	0	0%

The decrease in the number of TIVA/GA cases in May and June 2013 indicated the transition time in which the dental contracts for anesthesia changed for providers of TIVA to providers of GA.

Other Findings:

The Dental Department submitted a list of dental appointments, which were not completed due to refusal. These included the following information, per month, along with the dental reason for the visit:

Month	Number of Refused Appointments	Prophylaxis Visit	Exam Scheduled	Prophylaxis and Exam
January 2013	3	3	0	0
February 2013	0	0	0	0
March 2013	2	1	0	1
April 2013	0	0	0	0
May 2013	4	0	4	0
June 2013	2	1	0	1
Total	11	5	4	2

The information submitted indicated that all refused appointments had been rescheduled. Reschedule dates were submitted. A total of 10 individuals refused 11 appointments. It was noted that refused appointments were followed by notification of the QIDP, Residential Supervisor and Unit Director within one to four days from January through May 2013. In June 2013, there appeared to be a delay in communication of this information, because notification to these staff varied from seven to 12 days. Delays in communication of missed and refused appointments should be minimized. There was no information whether the rescheduled appointments had been completed. Tracking should occur to completion of the prior missed appointment.

The Pre-treatment Sedation Committee continued to meet. As of July 2013, 292 individuals (100%) had been assessed for pre-treatment sedation requirements for dental care. Eleven percent did not need pre-treatment sedation, and 16 percent were edentulous and did not need pre-treatment sedation. The Dental Department reviewed the remaining 73 percent using the "Dental Task Analysis," a 12-point questionnaire, and, as appropriate, they were referred to the IDTs for potential desensitization plan recommendations. According to the document "Pre-Treatment Sedation Committee 2013," there were 18 pre-treatment sedation desensitization plans implemented and one additional plan was in the process of being developed.

A separate dental oral hygiene assessment with focus on tooth brushing was still in progress. Three dental task analysis sheets were developed depending on oral hygiene needs (i.e., dental task analysis for those that brush independently, brush with help from staff, and edentulous), and 40 percent of the individuals had been assessed for desensitization need for this separate oral hygiene assessment.

From the "Minutes Pretreatment Sedation 7/25/13," 20 dental desensitization plans were in effect. It was noted in the document entitled "Pretreatment Sedation Committee 2013" that all individuals would receive annual pre-treatment assessments with follow-up review of pre-treatment sedation and desensitization needs in the ISP meetings. However, as only nine percent (20/214) individuals had pre-treatment sedation plans completed and implemented over the prior eight months, this might be an unrealistic goal and place additional burden of reassessment on the Dental Department when the assessments had not been reviewed by the IDTs, and recommendations for plans created and implemented. It is recommended that increased momentum be given to the system to complete the pre-treatment sedation evaluation by the IDT with development and implementation of appropriate desensitization plans.

Two draft documents were provided to the Pre-Treatment Sedation Committee on 8/20/13. One was entitled "Draft 8-2013 AuSSLC – Dental Clinic: Criteria for Determining Usage of Enteral Sedation or General Anesthesia," with implementation date 8/1/13. References for the document were listed. Content topics included "Goals of Sedation Anesthesia," "Determining the need for Enteral Sedation," and "Reducing need for Sedation/Anesthesia." A second document was entitled "Draft 8-2013 – AuSSLC GA Post Treatment Care." This reviewed the reason for changes from TIVA administration to general anesthesia. These reasons included securing the airway via intubation that prevented airway restriction and aspiration during dental procedures, the inhaled gases had a rapid onset of effect (which had potential to reduce the need for pre-treatment sedation), use of general anesthesia with anesthesiology support and monitoring allowed individuals with higher risk to be scheduled on site, and recovery following general anesthesia was faster than recovery from TIVA. According to the policy the Facility provided, to accommodate general anesthesia cases, the Dental Department reviewed the post-anesthesia information. Improved utilization of the dental chairs occurred (while an individual was recovering in one chair, an individual in the second chair was being prepared for the procedure). Post anesthesia monitoring and scoring of alertness was continued by the

anesthesiologist while the individual was in the dental chair. Once transferred to the transport chair, the anesthesiology nurse or dental personnel were to continue to monitor until the anesthesiologist determined the individual was sufficiently alert to be transferred to the Infirmary. Personnel trained in lifting and transfer, following the individual's PNMP, completed transfers from the dental chair. A protocol was developed entitled "Specialized positioning in dental chair," which was a collaborative effort of the Dental and Habilitation Therapy Departments. For those known to have challenges with positioning in the dental chair, Habilitation Therapies provided the appropriate positioning, with application of additional supportive equipment and pillows to secure a safe position. The transport chair allowed for adjustments and other secure features to prevent slumping and prevent forward posturing/positioning of the head and chest to maintain an open airway and prevent barriers to swallowing. Once transported to the Infirmary, the dental staff provided formal transfer of communication to the Infirmary nurse. Content of this formal transfer was included in this post anesthesia care policy/procedure, listing the information and documents to be reviewed. A Post Anesthesia Vitals Monitoring Sheet was then initiated which was completed over 72 hours in the Infirmary and in the residence. Guidelines for length of stay in the Infirmary were provided, with exceptions listed (e.g., an agitated individual unable to comply with care in the Infirmary, a "simple" extraction without complications in a cooperative individual), along with criteria for individuals clarifying who should stay in the Infirmary for at least 12 hours. If implemented fully, the collaborative approach in developing detailed post-treatment care, along with requirements for the quality of documentation outlined in this policy appeared sufficient to meet the health and safety needs of the individuals following general anesthesia for dental services.

When pre-treatment sedation was given, effectiveness of the sedation was to be documented in a tracking database. Nursing documentation of pre-treatment sedation monitoring was tracked and indicated need for improvement, compounded by the requirement to document in two separate locations (Avatar and IPNs). Pre-treatment and post-sedation monitoring results reported in a Quarterly Analysis from May, July, and August 2013 indicated vital signs with pulse oximetry was documented in 49 percent of those undergoing sedation, and in 86 percent of those post sedation back in the residence. Mental status was documented in 51 percent of cases prior to sedation and in 88 percent of cases post sedation. These were averages for the three months. From May to August 2013, according to the Facility's summary data, improvement in nursing documentation reportedly occurred for vital signs and mental status pre-treatment, whereas there was less compliance with documentation for these same parameters post sedation during the same time period.

Status of Facility's Plans to Comply with Section Q:

- The Dental Department continued to track oral hygiene ratings as a key indicator of quality. The presentation the Dental Director made on August 19, 2013, showed data from April to June 2013 indicated good oral hygiene had increased from 31 percent to 34 percent of individuals, and fair oral hygiene ratings had increased from 30 percent to 31 percent.
- Suction tooth brushing remained as a need for focus efforts. Residential Services was to select direct support professionals for competency-based training in suction tooth brushing provided by the dental hygienist and nurse educator. The direct support professional activities were to be monitored by the Dental Department. However, in the Monitoring Team's opinion, selected individuals will require nursing to provide suction tooth brushing, rather than direct support professionals. This remained in a planning stage, and there remained a list of those that would benefit from suction tooth brushing, but without access to this procedure. The action step from the Action Plan, updated 8/1/13, indicated that all residents who were identified for suction tooth brushing were to receive it within 30 days of identification, with implementation date of 9/1/13 and completion date of 12/15/13. This is an ambitious schedule, based on the lack of progress at AUSSLC, but should be a priority goal.
- No monitoring tool appeared to have been developed to track the various steps of dental desensitization, including progress in implementation, but many steps included in this goal had a projected completion date of 11/30/13.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- The Dental Department should review the causes in delay of timely completion of annual dental assessments. Some causes might indicate a role for the Dental Department, such as beginning to

schedule appointments 60 days ahead of the due date for individuals with medical complexities, communicating with families/guardians three or more months in advance in order to obtain timely completion of consent documents, and referral to the IDT and Behavioral Services for individuals with noncompliant behavior.

- The annual dental exam template provided important information. Further clarification was needed in the form, such as the interpretation of whether oral sedation or general anesthesia was administered. Medication names, dosage, and route would confirm use of oral sedation. A clear note that general anesthesia was used when there was a recommendation for general anesthesia, along with the length of time the individual was under anesthesia, would provide clarity to treatment. A concise section for dental treatment plan is recommended, with focus on reducing periodontitis/mobility/tooth loss, improving oral hygiene ratings, improving individual cooperation with tooth brushing, and when the next set of dental x-rays were indicated. The IDT can assist in ensuring the dental treatment plan is completed and completed in a timely manner only if they are aware of the plan contents.
- For dental appointments for emergencies and procedures, all appointments should have notation of closure.
- Entries for procedural visits (i.e., general anesthesia, extractions, etc.) should include verification of current guardian/family consent and HRC approval. There also should be an entry for procedures such as extractions, which lists any pain medication prescribed.
- Facility Administration should determine a timeline for prioritizing individuals that would benefit from suction tooth brushing. It would be appropriate to develop a policy/procedure that includes a description of the selection process of the direct support professionals for training, the competency-based training, and Dental Department's monitoring, along with documentation of monitoring for suction tooth brushing in the homes.
- Delays in communication of missed and refused appointments should be minimized. Additionally, tracking to completion of the prior missed appointment should be maintained.
- Increased momentum should be applied to the system to complete the IDTs' evaluation of pre-treatment sedation, as well as development and implementation of appropriate desensitization plans.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs

Findings regarding Areas of Focus:

For Section T, it was agreed that the following areas would be the focus of the review: development of the CLDP, and the Facility's responses to issues, if any, identified through post-move monitoring.

To provide some basic information about the transition process, based on documents the Facility provided:

- Since the Monitoring Team's last onsite review in November 2012, 21 individuals had transitioned from AUSSLC to the community;
- Based on information provided at the entrance meeting, 22 individuals currently were referred for transition. The teams of two individuals that had been referred were in the process of rescinding the referrals. Based on interview with staff, these teams had referred individuals that could not currently be supported in the community due to a lack of necessary healthcare supports. Examples of missing supports included nursing services and/or respiratory services to support an individual with a tracheostomy, several hours of nursing services per day to support an individual with specific nursing needs related to a gastrostomy tube, and/or the need for two overnight staff for a person requiring a two-person lift.
- Over the preceding six months, 16 individuals had CLDPs developed;
- Two individuals had moved to other State Supported Living Centers (SSLCs). According to staff, Individual #189 moved closer to family at a family member's request due to difficulty the family had travelling to Austin. Individual #74 moved to the SSLC supporting women with forensic backgrounds, after a pre-selection visit during which she allegedly attacked a housemate, resulting in charges being filed, and Individual #74 spending approximately a month in jail.

CLDPs - The following summarizes the results of the review of the sample of CLDPs:

Compromises due to Lack of Available Services/Supports – Based on review of individuals' CLDPs and related documentation as well as interviews with staff, the following concerns were noted:

- Vocational Supports – For a number of individuals work options that they had at AUSSLC were not available in the community, so their teams identified and/or agreed to alternatives that did not offer vocational opportunities. For example, Individual #428 worked at the AUSSLC workshop, but his CLDP indicated he would be supported in a day habilitation program in the community. Similarly, at the CLDP for Individual #101, his team discussed the limited opportunities to make money at his new day habilitation program in the community, but agreed to this option despite the fact that he worked at a workshop on campus. Other examples are provided below. Although some individuals did not make a lot of money on campus, taking away productive work was a step backwards.
- Supports for Individuals with Pica – Based on interview, staff indicated that they had not identified any truly pica-safe day programs. However, individuals with this high-risk behavior had been placed anyways. Based on the Monitoring Team's observations at the post-move monitoring review during the onsite review, the day program selected for Individual #219 exposed him to pica risk (e.g., pebbles being tracked in from the back yard and pica sweeps not effectively identifying and correcting this issue) with reliance on one-to-one staffing to prevent pica, which has its own level of restrictiveness. Four other individuals included in the Monitoring Team's sample had pica or pica-like behavior (i.e., Individual #364, who had a monitored behavior of "putting inedible objects in her mouth," but no diagnosis of pica, even though she "ingested at least four beads" while touring a day program and had other documented incidents of swallowing inedible objects; and the following individuals with diagnoses of pica: Individual #26, Individual #124, and Individual #175). Disturbingly, none of these five individuals had a pre-move support to identify pica-safe environments, and the post-move supports for these individuals were insufficient to ensure that their environments remained as pica-safe as possible.

Quality of Assessments for CLDPs – As Facility staff recognized, the quality of assessments were still in need of improvement. AUSSLC had begun to conduct a pre-CLDP meeting, which occurred five working days before the CLDP meeting. At this meeting, assessments were reviewed and any additional information needed was defined. The Facility also had developed draft summary guides for the assessments from many of the disciplines, and indicated State Office was doing the same. On a positive note, some of the drafts the Facility provided specifically addressed some of the outstanding issues identified below in the discussion about the quality of pre- and post-move supports (e.g., for psychology, daily living skills, and nursing). Although work was still needed to improve the assessment guides to assist in the development of comprehensive pre- and post-move supports, the Facility's efforts to develop these guides was a good start.

Quality of CLDPs – The Facility provided a draft 14-day Meeting template for teams' use within 14 days of the referral to begin identifying the pre- and post-move supports. As noted below, some problems with the template were noted, but the concept of requiring teams to begin preparing for transition 14 days after a referral was made was a good one. The Monitoring Team asked for some draft CLDPs and ISPAs related to community transition for a small sample of individuals on the referral list. For some, it was concerning to see that little, if any planning had occurred (e.g., Individual #360, referred on 5/31/12; Individual #98, referred 1/13/12; and Individual #74). In comparison, individuals that had been referred more recently and for whom the 14-day meeting occurred had drafts of pre- and post-move supports, which, although not fully developed, should be helpful to teams in identifying community providers that can meet their needs (e.g., Individual #107 and Individual #115).

Based on a review of CLDPs, this template, which included prompts for certain types of services and supports, had been used for a number of the recent CLDPs. At times, the prompts or examples were not removed from the final CLDP, and, as a result, it was difficult to determine what the individual actually required and what was left over from the template (e.g., Individual #26's CLDP). Although a template can often be helpful, based on a review of the CLDPs and as illustrated below, the template included some important components, but overall represented an oversimplification of the transition plan development process. In addition, a common problem with templates, which was evident here, is that staff tend to not engage in the critical thinking

necessary to develop comprehensive plans like the ones the Settlement Agreement requires for individuals transitioning to the community.

Based on a review of eight CLDPs and observation of one CLDP meeting during the onsite review, progress had been made in expanding the scope of protections, supports, and services included in CLDPs, and staff clearly were trying to be responsive to the findings and recommendations in previous reports. However, as detailed below, significant more work was needed to define individuals' pre- and post-move supports. The following summarizes the general concerns as well as some of the progress noted, with some limited examples of both. In providing examples, the Monitoring Team would expect the State and Facility to generalize the knowledge gained from these to address issues across the board for CLDPs:

- **Full Array of Supports** - 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 be accomplished by reviewing current assessments, which continued to be inadequate, and then asking each team member what they did for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built.
- **Training of Provider Staff** - The plans often identified the need for training for community provider staff, which was positive. However:
 - They generally did not define which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.). On a positive note, Individual #101's draft CLDP specifically identified staff (e.g., those with direct contact responsibilities, nursing staff, etc.).
 - They also generally did not define what level of mastery of the information was required (e.g., classroom training, demonstration of competence, etc.). Although competency-based training was mentioned in a few supports for most individuals, it remained unclear for which training demonstration of competency was required and/or how competency would be measured. This was complicated by the fact that CLDPs listed multiple trainers and multiple topics for each trainer in one block, and then included evidence that read something like: "staff will be able to ask/answer questions by the trainer to verbalize understanding" (i.e., Individual #219), "Signed In Services Competency Exams" (e.g., Individual #175), or "Competency Based Training Roster" (i.e., Individual #428). It was not clear for any of the individuals what the "competency exams" or questions were. In addition, for the long list of training, it often was not clear which required demonstration of competency, and/or which staff would need to demonstrate competence.
 - Of additional concern, when new staff started, most of the CLDPs indicated that the residential and day habilitation provider would have a "trainer available for ongoing training of [Individual's] supports." It was unclear what qualifications the staff person would have and/or how they would train on clinical information for which AUSSLC had designated clinical staff as responsible.
 - As noted in previous reports, for some individuals, community providers shadowing SSLC staff also would be an appropriate and necessary type of training. When appropriate, these supports should be included as pre-move action steps. For Individual #175, it was positive that after a pre-move visit to the proposed home, the team identified the need for the community nurse to shadow an AUSSLC nurse, particularly around medication time, and for a community direct support professional to shadow their counterpart at AUSSLC. Although these were not included as pre-move supports as they should have been, based on the narrative of the CLDP, the shadowing did occur.
- **Clinical Collaboration** - Missing from the plans was any expectation 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. For example, for Individual #428, although the team discussed the need for him to be seen by a community PCP within 15 days and included this as a post-move support, the reasons

for this were unclear. The team discussed the possibility of the community PCP collaborating with the PCP at AUSSLC, but this was not written in as a support. Given that there clearly were some issues the team thought the community PCP needed to address and/or be aware of, no mechanism was put in place to highlight these issues for the new PCP. The psychiatrist also felt it was important that Individual #428's medication not be changed, but no physician-to-physician communication was included in the CLDP. For Individual #175, no collaboration was required as a pre-move support between the Facility and community psychologists, but from the CLDP narrative, it appeared some conversation had occurred.

- **Coordination between Day and Residential** - Similarly, in the CLDPs reviewed, no coordination was specified as needing to occur between current and future residential or day/vocational staff. Direct support professionals often know important nuances about how supports are provided, and these often are not written down. For Individual #175, it was positive that a direct support staff member from the community provider spent some time at the Facility. However, this was not written into the pre-move supports, and so measuring whether or not the necessary collaboration occurred was not possible.
- **Evaluation of Potential Sites** - The plans generally 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, for Individual #175, it was positive that the OT/PT staff from AUSSLC visited the home prior to her transition, and made a number of recommendations, but the need for such visits were not included as pre-move requirements. For Individual #219, an individual with pica and a visual disability, no action steps were found in the CLDP for psychology and/or Habilitation Therapies to evaluate environment. In addition, although it appeared an Orientation and Mobility (O&M) specialist was involved prior to Individual #219's transition, this was not included as a pre-move support. Five of the individuals for whom CLDPs were reviewed had pica or pica-like behavior. None included evaluation of sites as pre-move supports.
- **Transition Supports** - Most often, the plans did not address any role that AUSSLC staff or community provider staff might play in assisting the individual to make the transition. On a positive note, for Individual #428, two of his current staff were included as supports moving forward. However, in general, it remained unclear if consideration had been given to the need for AUSSLC staff to follow individuals 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, as had appropriately occurred for Individual #175. The CLDPs now often included long, unsummarized lists of preferences of the individuals (e.g., when to shower, favorite foods, relationships, etc.). Some nominal reference was made to some of these items in what appeared to be stock paragraphs from a template that read: "Participation in preferred activities (daily, weekly, monthly) to include but not be limited to..." In addition to these supports generally not being measurable, this paragraph did not successfully identify some of the non-negotiable items or activities that would be important to make sure the individual was comfortable and the transition was successful. Different individuals have different reactions to transitions. However, teams should be cognizant of the stress that transition can cause, and should build mechanisms into CLDPs to reduce this to the extent possible.
- **Coordination with Local Authority** - Generally, the monitoring activities were identified in the CLDPs, including the role of the Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, although as noted elsewhere, this appeared to be occurring for some individuals, 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.
- **Clinical Services** - As noted in the last report, supports related to the clinical services (e.g., psychology/behavior, psychiatry, habilitation therapy, etc.) 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. In a very few supports in the CLDPs reviewed, some definition was provided of what they would do. However, even when this occurred, it was

not a comprehensive list. 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. The following provide just a few examples of some of the concerns noted: For Individual #219, it was unclear if any nursing supports were needed, despite a list of IHCPs. Although a behavior analyst was identified as needed, very little definition of the role or responsibilities was provided (i.e., only that a behavior analyst would review the current plan and "determine frequency of future visits"). For Individual #428, the team discussed a dietician with whom the provider contracted and indicated the dietician could provide ongoing training to staff on diet texture, but unfortunately, this was not included as a support. Similarly, although AUSSLC's IHCPs identified the need for nursing supports, no pre- or post-move supports were included to ensure the community provider had nurses available with the right qualifications (e.g., RN or LVN) and during necessary hours (e.g., 24-hours, on-call, etc.). A post-move support indicated a psychologist/behaviorist would assess Individual #428 within 30 days. However, no other role for the psychologist/behaviorist was defined. He required general anesthesia for dental services once a year, but no support was included to identify a community dentist that could provide this support. Regardless of whether his dental work was up-to-date when he left, this was a clinical support that would be needed moving forward. On a positive note, Individual #175's post-move supports identified the need for consultation with a dietician, OT/PT, and psychologist. However, beyond initial assessment, little detail was provided regarding the qualifications or roles of these staff. For example, no recommendations were included regarding the frequency of supports needed from any of these clinicians. Although the narrative of the CLDP indicated that the community psychologist had told the Facility psychologist that he would "be able to meet with [Individual] and offer immediate intervention during a crisis," this was not memorialized as a post-move support, nor were the responsibilities of the psychologist defined beyond meeting with the individual within 14 days, and revising the reinforcer. In addition, at the Facility, multiple medical specialists saw Individual #175, but in the pre-move support section, only the need to identify a PCP was identified in the section on "community medical professionals and other specialists." In addition, some specialist appointments that were coming due were included as post-move supports, but this did not include all specialists she required (e.g., cardiology). Although more detail was needed regarding qualifications and roles, Individual #107's 14-day meeting documentation defined nursing as needing to be available 24 hours a day with a nurse "checking on him at least twice daily." This gave the provider more information about how much nursing time was needed.

- 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 IHCPs in CLDPs, little, if any, detail was provided about how they would be implemented in the community. Of concern, FCR Department staff defined these references in CLDPs as "informational only." Overall, 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 therapy 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.
- **Supports to Address Needs of "At-Risk" Individuals** - 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. 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. As just a few of many examples: Individual #175 had multiple significant medical issues and risks, but her team included a support for a community PCP to evaluate her within 30 days. This was not sufficient to ensure that her potential health care needs were met. In addition, she had pica, and although team members had identified items that she potentially could ingest during pre-move visits, her CLDP post-move supports were not of sufficient clinical intensity to address this area of risk. For example, the provider was not required to complete pica sweeps as a specific post-move support (i.e., they were included in the BSP, but not in a measurable way), and as opposed to having a seamless transition from one psychologist to another (i.e., the community psychologist on board prior to her transition and working with the SSLC psychologist), the team included a 14-day timeframe for the community provider to have a psychologist assess her. Individual #124 was considered to be at medium risk for behavioral health, but his team allowed 30 days from the time of transition for the provider to establish care with a psychologist. No roles were identified for the psychologist/behaviorist. In addition, he had IHCPs included in his CLDP. However, no specific nursing staffing was included in the CLDP (e.g., RN, LVN, number of hours, etc.), and no definition was provided of who would complete which tasks in the IHCPs, and whether or not this would be different than what occurred at the Facility.

- **Justification for Removal of Supports** - 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. Some examples of where this did not occur included: For Individual #219, it appeared he was on Trazodone for sleep, but no support was included for psychiatry. For Individual #428, the psychiatry assessment identified supports in place at the Facility with no plan included to continue them and no justification provided, including, for example: direct support and nursing staff's monitoring of side effects, and completion of DISCUS and MOSES. Similarly, psychology recommended a behaviorist's regular review and response to BSP data, but the supports were not carried forward. This was similar for many of the other individuals in the sample. For Individual #124, the team removed his pica sweeps. The explanation provided in the CLDP was not consistent with other documentation.
- **Modification to Current Plans** - Some examples were seen of teams factoring in modifications that needed to be made to current programs or plans, and writing such modifications into the pre-move or post-move required supports, but this was an area requiring continued focus. For example, on a positive note, Individual #175's team discussed the community provider's assertion that soda could not be used as a reinforcer in the community. The team decided that the community psychologist would come up with a new reinforcer, and a 30-day supply of soda would be sent to bridge the gap. However, it was unclear why the team, working in conjunction with the community psychologist, did not consider revising the reinforcer at the Facility to ease the transition to a different reinforcer, particularly because it was anticipated this change would be difficult for Individual #175. Moreover, her BSP included restrictive procedures (e.g., use of mittens, and use of searches for pica items), but the CLDP did not identify the process for having these procedures approved for use in the community, or any alternatives. Individual #175 had a fluid restriction due to a history of "fluid overload." It was not clear how this was handled at AUSSLC, nor was there any discussion of any modifications that would need to be made in the community, given that she potentially would have more access to a fully stocked kitchen. Documentation for Individual #124 indicated he required sedation as well as physical/mechanical restraint for dental procedures. No mention was made of the physical/mechanical restraint piece in the CLDP, and it was unclear if/how this could be done in the community.
- **Implementation of Plans** - 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. In addition to plans being missing from the post-move support section, another continuing concern was the lack of definition of where the plans needed to be implemented (e.g., home and/or day/vocational program). Some of many examples include: for Individual #428, the assessment section included what appeared to be the AUSSLC IHCPs that had been revised to indicate the responsibilities of the community provider. Although the plans remained inadequate, this illustrated a potential mechanism for transitioning the nursing supports to the community.

However, this document was in the assessment section, and the action steps were not all included in the post-move support section. It was unclear why some of the supports (e.g., a few of them from the constipation plan) were included in the post-move section, but most were not. Rather, the post-move support stated: "[Individual's] Integrated Health Care Plans (IHCPs) [sic] will be continued and the community staff will follow the action plans to ensure [Individual's] health and well-being." Portions of his PNMP were included as supports, but others were not, for example, in relation to monitoring during mealtimes, wearing shoes, and tooth brushing. Individual #175's CLDP included continuation of some of her plans, such as her BSP and IHCPs (although as noted elsewhere, implementation of these was not sufficiently defined), but despite multiple physical and nutritional support needs, only portions of her dining plan were included as post-move supports. Although the PNMP was referenced in her IHCPs, the CLDP did not provide a mechanism for ensuring it was implemented daily. For Individual #26, although his BSP was identified as a plan that the community provider needed to continue, beyond his diet texture, his PNMP and dining plan were not identified in post-move supports as requiring implementation and/or implementation of a functional equivalent. This was despite the fact that he was at medium risk for choking/aspiration, gastrointestinal, weight, osteoporosis, and skin integrity. Although IHCPs for choking/aspiration pneumonia, cardiac, and pinworms were referenced in a broad post-move support that was not measurable, none of them referenced his PNMP. On a positive note, Individual #101's draft CLDP specifically identified implementation of his PNMP and BSP as post-move supports. Although the draft included implementation of his IHCPs, a number were missing. The Admissions Placement Coordinator asked the AUSSLC nurse to develop some of the missing ones (i.e., aspiration, choking, and falls), but another that was missing was for Hepatitis C, and this was not addressed.

- **Health Care Indicators** - 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.), very few 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. For example, for Individual #428, for no bowel movement in three days, the team did include a trigger and identified the expected response. However, although the physician clearly identified some other triggers, such as facial herpes and vomiting/nausea, that needed to be reported to nursing and the PCP immediately, these were not included as post-move supports in the CLDP. Individual #175's PCP at AUSSLC indicated that given her recurrent history of recurrent small bowel obstruction, suggestive signs needed to be reported right away and she would need to be evaluated. No post-move supports were included in relation to these clinical indicators. Even though the OT/PT section of the CLDP listed a number of other clinical indicators for other risk categories, they were not defined in the post-move supports. Individual #26's PCP provided some clinical indicators that direct support professionals needed to monitor (i.e., for ringworms and for potential signs of prostate cancer), but these were not included as post-move supports. Individual #364 had one indicator identified (i.e., weight), but many others were missing, some of which were referenced in her IHCPs. On a positive note, at the CLDP meeting observed for Individual #101 (i.e., final document not reviewed), the team discussed the need to add indicators from the PCP's list of recommendations as post-move supports. If these were documented as discussed, they would require notification of the nurse, who would make a decision about notifying the physician.
- **Crisis Intervention** - Although the team for Individual #124 required the development of a Safety Plan, as noted below, many problems were noted. In addition, the CLDPs for others 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, Individual #219 had an elopement risk, as well as aggression, self-injurious behavior, etc., but support were included in the CLDP related to the need for the community provider to have staff trained on physical intervention techniques, or what plan would be in place should he elope. For Individual #428, although the team identified the possibility that he might try to leave the home, due to the unfamiliar environment, and an alarm was to be placed on the door, no crisis intervention plan was developed to address the possibility that he might leave the home. Individual #175 had a long history of significant behavioral issues, including behaviors that placed her and others at risk. No crisis intervention plan was included in her CLDP. Her AUSSLC BSP indicated that she could not have physical holds, but that she had a crisis plan at the Facility. Mitten restraints were mentioned in the AUSSLC BSP, but not addressed in the CLDP. For Individual #124, on a positive note, the team included a support for the provider to develop a

Behavior Safety Plan to address property destruction and elopement. However, it was included as a post-move support, which did not make sense, given that a transition can be stressful, and a method for dealing with crises should be set forth prior to the transition. In addition, no timeframe was included in the CLDP for the plan to be developed. It also was unclear what the parameters of the plan needed to include (e.g., emergency response, contact with the behaviorist, staff trained on de-escalation techniques and/or physical management, etc.), or whether the AUSSLC team needed to review the plan. Given that Individual #124 displayed significant behaviors within the first 30 days of his transition and was admitted to the State Hospital, this would have been an important support for the teams to have established prior to his move.

- **Direct Support Staffing Ratios** - Generally, direct support staffing ratios and requirements were not specified, nor was the level of supervision noted. 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.). Some examples of concerns noted included: for Individual #428, a pre-move support read: "*Level of Supervision:* [Individual] will receive Residential Support Services with [names of providers]. He will receive staff assistance with all aspects of his life." This was not measurable, and had little meaning. This individual had staffing supports and levels of supervision included in recommendations, but not included in the plan, such as: the OT/PT recommended "supervision and meal monitoring for all meals and snacks due to [Individual's] risk of choking and aspiration..." For Individual #175, the community provider and her AUSSLC team discussed the potential need for one-to-one staffing. Although she was not receiving it at AUSSLC, the community provider expressed the opinion that it was necessary in the community to prevent her from ingesting inedible objects. Her AUSSLC team agreed it would be beneficial. However, the CLDP did not include this as a support. It indicated that the provider would seek Level 9 funding, and the only other staffing supports were for a residential staff member to accompany her to the day program, and that she "will have additional staff present in the home on Saturday and Sunday." It was not clear what the responsibilities of these staff would be (e.g., one-to-one supervision). For Individual #124, it was positive that his team indicated he should have: "24 hour awake staff..., and ensure that one staff member is able to stay with him if he is in a group setting and decides to leave the group," but this did not define staff's responsibilities or his ability to be alone for periods of time in the home. For example, specific supports were needed due to his pica and other behaviors when he was in the bathroom, near glass, or in the yard, but the CLDP did not define these supports. The term "enhanced supervision" was included in some of the Facility's documentation, but this was not defined for community staff. Individual #364's CLDP did not address direct support staffing ratios, except to say that she would have "Residential Support Services." Based on an ISPA, dated within a week of her transition, significant concerns related to her staffing occurred. Specifically, the ISPA indicated: "The current resident in [Individual #364's] home does not have RSS [Residential Support Services] staff, meaning that there is not 24 hour awake staff currently in the home. The team was not aware of the staffing set up for the other resident..." It is unclear how the team did not know what the staffing was and/or why they would have allowed the individual to move to a home where staffing was not sufficient. Had this been discussed in detail at the CLDP meeting, and the specific staffing requirements outlined as a pre-move support, this likely could have been avoided.
- **Assessment Recommendations** - In reviewing assessments, albeit incomplete, some recommendations were not specifically addressed in CLDPs, but this was an area in which some improvement was seen. Some examples of where this did not occur: For Individual #219, recommendations from O&M assessment were not all included (e.g., competency-based training for staff, orientation to new environment prior to transition). For Individual #428, the psychologist clearly identified in a recommendation what the role would need to be of a community psychologist. However, this recommendation was not included, and no rationale for not including it was provided. There were other similar oversights, including recommendations from OT/PT, the physician, psychiatrist, and the SLP. For Individual #275, many of the recommendations included in assessments were reflected in supports in the CLDP, but a number of others were not. For example, a number from the dietician and SLP were not included, as well as some from the PCP and

psychologist. For Individual #26, the psychologist made some important recommendations related to supports that he needed to maintain his safety with regard to his pica behavior and it appeared from the narrative of the CLDP that the team agreed, but these were not included in the post-move supports.

- **Day/Vocational Supports:** Generally, day and vocational supports were not well defined:
 - For example, little detail was provided in relation to what the expectations were for the types of supports to be provided, they often were not measurable, and expectations were set extremely low, particularly for individuals' vocational experiences after transitioning to the community. For example, Individual #219's support for day supports read: "will enroll in and have the opportunity to attend day habilitation program of his choice for 5 days a week within one week of his move..." For Individual #248, the team agreed to a day habilitation program, despite a statement that he did not like day habilitation when he attended at AUSSLC, and instead continued to work daily at the work center. Moreover, no definition was provided in the post-move supports beyond attending the day habilitation program. Similarly, Individual #26 worked at the AUSSLC work center, but because of his "functioning level," he would not be a candidate for the one workshop the team mentioned in the CLDP, and so the team concluded that: "due to limited options for a sheltered workshop setting, the [day habilitation] program would be able to meet his needs" despite that fact that "it does not offer any type of contract work." Individual #364 worked at the workshop at AUSSLC. She moved to the community without a similar support in place. She was to attend day habilitation, and a referral was to be made within seven days for a sheltered workshop.
 - None of the plans defined the supports that needed to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.).
- **Timely Availability of Supports** - As noted in previous reports, 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. For example, for Individual #428, the team discussed the need for him to be seen by a PCP as soon as possible after transition. The issue related to the Medicaid changeover was discussed, but it was pointed out he had Medicare. It was unclear if the 15 days included in the CLDP was a compromise or not. Except for Individual #175 for whom review by a psychologist within 14 days of transition was included in a post-move support and Individual #83, none of these individuals had pre- or post-move supports for psychologists/behaviorists to be involved with them or their teams within anything less than 30 days. Given that most of them had significant behavioral concerns, which had the potential to place them or others at risk, it is concerning that teams would not identify this as a pre-move support, and require coordination between the Facility and community psychologist.
- **Measurability of Supports** - Many of the supports included in CLDPs were measurable, but supports such as "will have the opportunity to make choices in his daily routine, such as choosing what clothing to wear, what music to listen to, and what lotion to use" were not measurable. However, another significant problem was noted with regard to measurability. Due to supports being written very broadly, such as "follow IHCPs... Infections, aspiration, etc.," it was difficult for community providers to know specifically what needed to be done, as well as for a Post-move Monitor to follow-up on what should be happening. For example, for Individual #428, the IHCP was included in the assessment section with a broad and difficult to measure requirement in the post-move support section that all IHCPs would be implemented. The IHCPs themselves, included some components that were measurable, and others that were not. Examples of non-measurable action steps included: "Encourage physical exercise to be determined by [Individual's] preferences," or "Skin assessments which are done at time of nursing assessments, bathing and as needed" with the timeframes and persons responsible listed as: "To be determined by provider." In addition, for all of the CLDPs reviewed, multiple supports were included in many of the blocks/rows in the pre-move and post-move support sections. Evidence was not then identified for each of the various supports. This made it difficult to determine how each would be measured.

Response to Issues Identified through Post-Move Monitoring – As further discussed below, the revision of the post-move monitoring form had had a negative impact on the quality of the documentation of the post-move monitoring. This also contributed to the inadequate documentation of follow-up activities, and other issues continued to exist with regard to follow-up on issues identified. The following provides examples of the results of the review of post-move monitoring follow-up:

- Individual #124 was psychiatrically hospitalized approximately 30 days after his transition due to self-injurious behaviors. Although the Facility provided email documentation as well as a post-move monitoring report that showed the Facility staff attended a meeting at the State Hospital, it was unclear what information they provided and/or what changes occurred to his program or supports. For example, it appears his medication was revised, but it was unclear what, if any, input the AUSSLC psychiatrist made, particularly given that according to his CLDP, previous medication changes while at AUSSLC had been unsuccessful, and actually detrimental.
- For Individual #175, it was very difficult to follow the post-move monitoring process and related follow-up. This was due largely to the way the Facility provided the documentation. Although voluminous documentation was provided, much of it was repetitive, and key pieces of information were missing. For example, an ISP addendum meeting sign-in sheet was provided, dated 4/3/13. No Addendum was included, but it appeared the Post-Move Monitor sent an email to the provider with some suggestions from the team following this meeting. Other sign-in sheets were provided for meetings the Admissions Placement staff had with the team, but no meeting minutes were found in the documentation provided. A series of emails was provided with regard to follow-up after DFPS confirmed neglect, but ended on June 4th with the team not knowing how to proceed. Although the individual died a few days later, it is not clear what happened in the interim. More specifically, after the substantiation of neglect, the Facility had requested an action plan from the community provider. The community provider essentially said that it would not provide an action plan unless the Facility could further substantiate its concerns in relation to the CLDP. No resolution was included in the emails provided to the Monitoring Team. In addition, it appeared that some of the documentation the Facility provided to the Monitoring Team was collected after the individual's death. This information showed significant concerns in terms of the individual refusing multiple meals in the days leading up to her death. It was unclear, though, what, if any follow-up information was requested. Previous emails showed that the Facility was having difficulty obtaining responses from the community provider in relation to requests for documentation. Although the Post-Move Monitor was clearly sending frequent reminders, no documentation was submitted to show that supervisory staff within the Department, Facility, or at State Office were assisting with this process, and/or that the Local Authority had intervened.
- For Individual #364, it was not possible to determine if adequate follow-up occurred. Because so little information was included in the post-move monitoring checklist, the Monitoring Team could not even determine what the specific problems were. Even with review of follow-up emails, it remained unclear exactly what the problems were (e.g., unclear if IHCPs were not present, or, most importantly, were not being implemented), and/or what the specific follow-up was for each of the numerous supports that were marked "no" on the form.
- For Individual #26, the Post-Move Monitor noted very few issues. It appeared both the Post-Move Monitor and LA followed up on a shaving issue. Training had not been done on the BSP at day program after the community psychologist changed it. Although the PMM obtained agreement that the community provider would correct this, it was unclear how this would be confirmed given that it was identified at the 90-day visit.

Other Findings: During the course of the review, the following additional information was gained:

Department Staffing – In the letter agreement, dated 12/10/12, the State had committed to increase the staffing of the AUSSLC Admissions Placement Department. Since then, the Department had been renamed the Family and Consumer Relations Department. Consistent with the agreement, in addition to a Director, the Department staffing now included an Admissions Placement Coordinator, two Placement Coordinators, two Post-Move Monitors, and an Administrative Assistant. Since the Monitoring Team's last review, the Director, the Admissions Placement Coordinator, one Placement Coordinator, and one Post-Move Monitor were new to their positions. State Office also was providing support through three Transition Specialists, one of whom was new to her position since the last review. Also a new development, State Office had contracted with and

was responsible for directly overseeing three members of a “Transition Team,” including a part-time (i.e., 20 hours per week) psychologist, Physical Therapist, and nurse (RN), as well as a recently-hired full-time Transition QIDP. A member of the State Office Continuity Services team had been working directly with the AUSSLC FCR Department to assist in training and providing technical assistance to the staff. At the time of the current review, the staff person assigned was different from the one assigned during the previous review.

Potentially Problematic Outcomes and Facility Review – As noted above, since the Monitoring Team’s last onsite review, 21 individuals had transitioned to the community. The Facility provided data on eight individuals that had transitioned to the community between May 2012 and April 2013. The eight individuals listed experienced potentially negative outcomes, and presumably other individuals that had transitioned to the community were not listed, because they had not experienced any of the outcomes on the list the Monitoring Team requested. The following summary is provided. Of note, the Monitoring Team found two omissions as a result of review of post-move monitoring documentation. This called into question the accuracy of the summary data the Facility provided. In addition, it is important to note that further analysis would need to be completed to draw conclusions from the following data. Such an analysis should be part of the Facility’s QA system:

- One individual died. At the time of the onsite review, the results of an autopsy were pending. Based on documentation, the community provider had reported the initial cause of death as “natural causes.”
- Two individuals had had been involved in four instances of police contact, with both individuals having two incidents each. All four incidents had resulted in psychiatric hospitalizations.
- Four individuals had been psychiatrically hospitalized with a total of six hospitalizations. This included the two individuals mentioned in the previous bullet, and two other individuals. Two of the four individuals had been psychiatrically hospitalized twice.
- According to the Facility, seven ER visits had occurred, involving four individuals. Based on the Facility’s data, for one individual, the ER visit was due to a medication error. A second individual had two ER visits, including one after falling down stairs at the day habilitation program and another that resulted in admission to the hospital for a bladder infection, increased Dilantin levels, and a seizure while in the hospital. A third individual had three ER visits, including ones for ingesting a drink mix packet, chest pains, and a urinary tract infection. This was the individual that later died. The fourth individual had a seizure and was transported to the hospital, but was not admitted. In reviewing post-move monitoring documentation, the Monitoring Team found that an eighth visit had occurred for a fifth individual (i.e., Individual #83 for blood in stool with a diagnosis of colitis).
- One individual had an unauthorized departure, but was always within line of sight of staff.
- One individual had been restrained.
- No individuals had returned to the Facility from the community. Of note, based on other documentation (i.e., post-move monitoring reports and CLDP documentation), direction had been given to Facility staff, who passed this along to individuals and providers, that individuals could not return to AUSSLC after they transitioned to the community.
- According to the summary the Facility provided, no individuals had moved to alternate sites within the community. However, this was incorrect based on information in the post-move monitoring reports. Individual #83 had moved to both a new home (i.e., reportedly at his request), and a new day program.
- Although this is not information the Monitoring Teams have requested routinely so it was not available for all individuals, based on review of post-move monitoring reports, for one individual, two confirmations of neglect occurred prior to her death in the community.

The Facility was asked for follow-up documentation for three of the individuals for whom the most significant issues had occurred. Based on this review, no root cause analyses had been done, and insufficient follow-up had occurred. The following summarizes the information related to review of this documentation:

- Individual #74 moved to the SSLC supporting women with forensic backgrounds after a pre-selection visit, during which she allegedly attacked a housemate by stabbing her multiple times with a kitchen knife, resulted in charges being filed, and Individual #74 spending approximately a month in jail. Documentation was submitted of a Critical Incident Team Meeting, including members of her IDT, a number of discipline leads, the Facility Director, DADS consultants, and a State Office Discipline Coordinator. What was presented was not a root cause analysis. The document, dated

5/17/13, identified some actions to be taken to address her current situation, as well as to collect and review documentation related to the pre-selection process. However, no further documentation was submitted to show that the record review that DADS Consultants were to conduct and submit to the Facility Director was completed and/or discussed. Facility staff reported that some steps had been put in place as a result of this incident, such as use of a placement history form that listed all previous placements, the reason the placements ended, and the current status of the issue(s) that caused the change in placement; more discussion about the need to re-in-service community staff between pre-placement visits; and more communication with guardians to obtain approval for visits. However, no documentation was presented to show that the Facility had conducted a critical review of the entire process, and/or asked relevant questions about, for example, the quality of the training provided to community provider staff, the amount and quality of the use and fading of Facility staff to ease the transition, the AUSSLC's team's development of a draft CLDP and use of such a draft as a checklist to ensure that the community provider had the skills and staffing to support the individual's needs (i.e., of significant concern, in response to a document request for the draft CLDP, the Facility provided no draft to the Monitoring Team), etc.

- Individual #175 died approximately two-and-a-half months after she transitioned to the community. Although at the time of the Monitoring Team's review, it had been over two months since her death, the Facility submitted the following statement in response to the Monitoring Team's request for any reviews that had been conducted: "We do not have anything here on the death of [Individual #175] since she passed away in the community." Other documentation submitted showed that the provider agency had requested a copy of the autopsy. At the time of the onsite review, the only cause of death the Facility had was from the community provider agency who stated it was from "natural causes." However, AUSSLC submitted other documentation to the Monitoring Team that was from the time surrounding her death, including, for example, notes that showed she had been refusing multiple meals in the week(s) prior to her death. At a minimum, until further information was obtained about the cause of death, the Facility should have obtained and analyzed information from the time surrounding her death, and used such information to conduct a critical review of the transition planning and implementation process, including post-move monitoring activities. Just one example of a key question that should have been asked and answered was whether or not the CLDP included sufficient triggers (i.e., clinical indicators), reporting mechanisms, and nursing supports to ensure the community provider was picking up on and responding to signs and symptoms of illness for this individual who had a history of feigning illness, putting her at greater risk that actual illness might not be detected.
- Individual #83 had two police contacts, both of which resulted in psychiatric hospitalizations. The only documentation submitted in response to the Monitoring Team's request for review of these incidents was an undated summary from the psychiatrist of Individual #83's psychiatric history. No critical review of the transition process or root cause analysis was conducted and/or documented. The document from the psychiatrist indicated he had a history of psychiatric hospitalizations, with one occurring while he was at AUSSLC (i.e., three-and-a-half years prior to his transition to the community). Based on a review of his CLDP, multiple supports were missing in relation to his psychiatric, counseling, and psychological services. In fact, the only related supports were the identification of a psychiatrist and psychologist prior to his transition. No supports were included in relation to the roles of these clinicians beyond conducting "follow-up assessments," the frequency of their interaction with Individual #83, their qualifications, coordination with AUSSLC clinicians, the implementation of his BSP, the qualifications of community provider direct support staff to support an individual with complex behavioral health needs, monitoring of clinical indicators related to his behavioral health diagnoses and target behaviors and reporting of such to clinical staff, and/or the development and implementation of a crisis intervention plan. Despite all of these deficiencies, no critical review was conducted to identify them and make recommendations for future plan development.

Although all of these incidents had significant, and in some instances, irreversible consequences for the individuals involved, critical analyses should have been conducted and the information used to improve future transition processes and potentially prevent negative outcomes for other individuals. However, no evidence was presented to show this had occurred in any meaningful way.

The following provides just one example of the types of analyses that need to be conducted with the data related to outcomes for individuals who transition to the community:

- Except for Individual #175 for whom review by a psychologist/behaviorist within 14 days of transition was included in a post-move support and Individual #83 who's team included a pre-move support for a psychologist to be identified, none of the other five individuals with significant behavioral needs had pre- or post-move supports for community psychologists/behaviorists to be involved with them or their teams within anything less than 30 to 45 days. Given that these individuals had behavioral concerns that had the potential to place them or others at risk, it is concerning that teams would not identify this as a pre-move support, and require coordination between the Facility and community psychologist. Moreover, even though Individual #83's CLDP included a pre-move support for identification of a psychologist to "conduct a follow up assessment upon transition to develop and implement a behavior support plan," this was not supported by additional pre- or post-move supports that set forth the psychologist's role in further detail (e.g., monitoring of the program, coordination with psychiatry, etc.) and the qualifications of the psychologist were not detailed (based on post-move monitoring documentation, a counselor ended up reviewing his plan, but it was not clear she had the necessary behaviorist experience). These types of detailed psychological supports were not seen for any of the individuals reviewed. Although to the Monitoring Team's knowledge, the Facility had conducted no such analysis, it would be important to review these findings in light of outcomes for individuals, such as increases in psychotropic medication use, use of restraints, police contact, and psychiatric hospitalizations after transition. Certainly, anecdotally, there was some correlation, which should be considered in the development of future CLDPs.

Quality of Post-Move Monitoring – In documenting the results of post-move monitoring, the Facility had begun to use the original form from Appendix C of the Settlement Agreement that State Office was now requiring. Significant concerns were noted, including:

- There was no explicit indication of what locations the Post-Move Monitor visited.
- The Monitoring Team could not determine what evidence the Post-Move Monitor was to look for, and what evidence the Post-Move Monitor examined "to assess whether supports called for in the CLDP are in place." Moreover, the Post-Move Monitors had provided no analysis of the evidence they reviewed to substantiate whether or not the pre- and post-move supports had been implemented.

Although this was not a compliance review, it was, therefore, impossible to determine if the Facility was substantially complying with the requirements of Section T.2. This was troubling, because, although concerns were noted during the November 2012 compliance review, since then, the Facility had significantly regressed in with regard to the quality of post-move monitoring.

Involvement of Local Authority (LA) Staff in Post-Move Monitoring – Although the quality of the post-move monitoring that LAs conduct is beyond the purview of the Settlement Agreement, one of the commitments the State made in the letter dated 12/10/12, was to develop and implement a pilot project to enhance LAs' involvement in the transition process. On a positive note, based on both review of CLDPs and interview with Facility staff, LA staff were now assigned more responsibility for monitoring pre- and post-move supports. Based on interview with staff, their involvement varied depending on the LA, but for some individuals, LA staff had begun to coordinate their visits with the AUSSLC Post-Move Monitors and were playing a role in identifying and taking actions to correct problems with the implementation of pre- and post-move supports.

Status of Facility's Plans to Comply with Section T:

The Facility's action plans generally set forth steps that should assist in attaining substantial compliance, if implemented correctly. However, some issues were noted, such as action steps that did not appear to relate to the subject of the subsection of the Settlement Agreement to which they were attached (e.g., a number of the action steps for T.1.a, and T.1.b.3), and for some subsections, action steps were missing, but included elsewhere (e.g., T.1.d related to quality of assessments, and T.1.e related to development of pre- and post-move supports). In addition, without further detail, it was unclear what methodology would be used to address some fairly significant concerns, such as the action step that read: for T.1.c.1, "Re-in-service IDTs on development of comprehensive supports," or for T.1.g, "Provide an annual obstacles report to DADS/State Office." In other instances, key steps were missing altogether (e.g., T.1.b.2 for which no action plans appeared to address the need to significantly improve the individualization of the education process, T.1.f for which no

action steps were included related to conducting root cause analyses or critical reviews of outcomes and/or results of post-move monitoring activities to identify potential changes that were needed to the CLDP process, T.2 for which only the IDTs and LAs were identified in the follow-up process for problems identified during post-move monitoring or T.4 for which no action steps related to improving the quality of discharge plans).

It was good that action steps were included related to defining and training teams on the roles of the "Transition Team." The concept of the separate Transition Team is one that could either be beneficial or detrimental. The potential benefit, in addition to relieving some of the work of the individuals' core teams, would be that an external set of eyes could be helpful in identifying supports that the AUSSLC teams might miss or have difficulty translating into community supports. However, the potential pitfalls would be that the historical knowledge some of the core teams have about individuals would be lost, and transition would become viewed as someone else's responsibility.

Monitoring Team's Recommendations Related to Plans of Improvement and/or Areas Requiring Focused Efforts Over the Next Six Months:

- Focus should be placed on improving the quality of the CLDPs. The Monitoring Team has made numerous recommendations in this regard in previous reports, and these recommendations should be referenced as the Facility moves forward in its development of transition plans.
- The Facility should quickly and clearly define roles and responsibilities of the Transition Team, and ensure continued involvement of the individuals' core teams. The benefit of the Transition Team also should be assessed, and changes made, as necessary.
- In addition to describing the sites visited, the post-move monitoring form should include the following three pieces of information for each pre- and post-move support: a) what evidence was to be reviewed; b) what evidence was reviewed and an analysis of the evidence to show if the requirement was met; and c) the due date.
- Systems should be developed to ensure that when Post-Move Monitors or individuals' teams experience difficulties obtaining cooperation from community providers in providing supports or documentation, there is a mechanism to quickly elevate these issues to Facility leadership and/or DADS State Office staff, including those staff that have the authority to require the community providers to take action.

Appendix A Acronyms

<u>Acronym</u>	<u>Meaning</u>
ADOP	Assistant Director of Programs
AED	Anti-epileptic drugs
ANE	Abuse, Neglect, and Exploitation
APEN	Aspiration Pneumonia/Enteral Nutrition
AUSSLC	Austin State Supported Living Center
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Plan
CIP	Crisis Intervention Plan
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CRI	Crisis Restraint Instructions
CT	Computed Tomography
CTD	Competency Training Department
DADS	Department of Aging and Disability Services
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DUE	Drug Utilization Evaluation
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
ENT	Ear, Nose, and Throat
ER	Emergency Room
FDA	Federal Drug Administration
FCR	Family and Consumer Relations
FBA	Functional Behavior Assessment
GA	General Anesthesia
GERD	Gastro- esophageal reflux disease
GI	Gastroenterology
GU	Genitourinary
HMP	Health Management Plan
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
HRO	Human Rights Officer
HT	Habilitation Therapies
I-Book	Individual Notebook
ICD	International Classification of Diseases
ICF-ID	Intermediate Care Facility for Persons with Intellectual and Developmental Disabilities
IDD	Intellectual and Developmental Disabilities
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IMRT	Incident Management Review Team
INH	Isoniazid
IPN	Integrated Progress Note
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
LA	Local Authority
LAR	Legally Authorized Representative
LTBI	Latent Tuberculosis Infection
MAR	Medication Administration
MBSS	Modified Barium Swallow Study

MOSES	Monitoring of Side Effects Scale
MRI	Magnetic Resonance Imaging
NEO	New Employee Orientation
O&M	Orientation and Mobility
OT/PT	Occupational Therapy/Physical Therapy
NOO	Nurse Operations Officer
OOH DNR	Out-of-Hospital Do Not Resuscitate
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PMAB	Prevention and Management of Aggressive Behavior
PMM	Post-Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	Pro Re Nata (as needed)
PSI	Preferences and Strengths Inventory
QA	Quality Assurance
QAQI	Quality Assurance/Quality Improvement
QIDP	Qualified Intellectual Disability Professional
SLP	Speech Language Pathologist/Pathology
SPCI	Safety Plan for Crisis Intervention
SSLC	State Supported Living Center
TB	Tuberculosis
TIVA/GA	Total Intravenous Anesthesia/General Anesthesia
UIR	Unusual Incident Report
VNS	Vagal Nerve Stimulator
VPA	Valproic Acid

Appendix B Methodology

Section C

Documents Reviewed:

- Section C Action Steps, updated 8/1/13;
- Restraint checklists, Face-to-Face, Debriefing sheets, Injury report (if applicable), Positive Behavior Support Plan (PBSP)/Crisis Intervention Plan, and Individual Support Plan (ISP) for the following:

Individual	Type Restraint	Date	Time for Dates on Which More Than One Restraint Occurred	Number
Individual #421	Physical/ Chemical	5/31/13	All	5
Individual #56	Physical	5/23/13	All	4
Individual #246	Chemical	3/18/13		1
Individual #369	Physical	4/11/13		1
Individual #42	Physical	5/6/13		1
Individual #267	Physical	5/6/13		1
Individual #98	Physical	6/26/13		1
Individual #445	Mechanical	6/23/13	12:00 p.m.	1

- Course Delinquency List for Prevention and Management of Aggressive Behavior (PMAB) Basic, and Restraint: Prevention and Rules for Use, dated 8/21/13;
- List of Individuals with Restraint Instructions, dated 7/19/13;
- Restraint Entries-Audit Report by Individual: between 1/1/13 and 6/30/13;
- Injuries During Restraint, undated;
- Off-Grounds Restraint, undated;
- Restraint Monitors, undated;
- Presentation of Section C at Entrance Meeting, on 8/19/13;
- Active Record (volume I) for: Individual #406, Individual #421, Individual #344, and Individual #56;
- Individual Notebook (I-Book) for: Individual #406, Individual #421, Individual #344, and Individual #56;
- Psychological Evaluation for: Individual #406, Individual #421, Individual #344, and Individual #56;
- Positive Behavior Support Plan for: Individual #406, Individual #421, Individual #344, and Individual #56;
- Crisis Intervention Plan (CIP) for: Individual #406, Individual #421, Individual #344, and Individual #56;
- Individual Support Plan Addenda (ISPA) for: Individual #406, Individual #421, Individual #344, and Individual #56;
- Administrative Review Team meeting for: Individual #421, Individual #344, and Individual #56;
- Monthly Psychology Progress Notes for: Individual #406, Individual #421, Individual #344, and Individual #56; and
- Restraint Reduction Committee meeting minutes, from 2/14/13 to 6/20/13.

Staff Interviewed:

- Jim Sibley, State Office Consultant;
- Jose Levy, Director of Psychological Services; and
- Holly Lindsey, Quality Assurance (QA) Director.

Observations:

- Wood Hollow Unit Team meeting, on 8/20/13;
- Incident Management Review Team (IMRT), on 8/20/13;
- Residences: 783, 786, 794, and 796; and
- Computer Lab and workshops.

Section D

Documents Reviewed:

- AUSSLC: Policy #II.B.4: Incident Management, dated March 2013;
- AUSSLC: Policy #II.B.13: Protection From Harm, dated August 2012;

- AUSSLC Action Plans, dated 8/1/13;
- Course Delinquency Report for ABU0100 and UNU0100;
- Unusual Incidents Trending for All Incident Types, for the period 3/3/13 to 5/31/13;
- Report of Aggression (peer-to-peer) from 2/1/13 to 7/26/13;
- List by individual of all incidents or injuries from 7/1/12 to 1/31/13;
- Handouts from IMRT meeting on 8/20/13, including tracking of staff reassigned due to abuse, neglect, and exploitation (ANE) allegations, and tracking of recommendations and plans of action in response to UIRs;
- Records for the following investigations conducted by Department of Family and Protective Services (DFPS):

Sample #	Name	Date	Facility #	DFPS #	Type
D1.1	Individual #406	6/8/13	678412	42771722	Neglect/Confirmed
D1.2	Individual #74	3/14/13	678340	42682048	Neglect/Confirmed
D1.3	Individual #430	5/27/13	678401	42759060	Physical/Unconfirmed
D1.4	Individual #361	5/31/13	678407	42764151	Neglect/Inconclusive
D1.5	Individual #30	6/17/13	678425	No number on list	Neglect/Confirmed
D1.6	Individual #425	5/21/13	678392	42752399	Neglect/Confirmed
D1.7	Individual #19	4/9/13	678354	42707963	Physical/Unfounded
D1.8	Individual #213	5/24/13	678399	42757404	Exploitation/Admin Referral
D1.9	Individual #19	6/12/13	678416	42775824	Verbal-emotional/Unconfirmed
D1.10	Individual #228	3/30/13	678348	42697333	Physical/Unconfirmed

- Records for the following investigations conducted solely by the Facility:

Sample #	Name	Date	Facility #	Type
D2.1	Individual #180	7/10/13	Not included on list	Fracture of finger
D2.2	Individual #425	3/1/13	Not included on list	Slip/Trip/Fall Sutures required
D2.3	Individual #354	4/29/13	13-137	Fracture: slip/trip/fall
D2.4	Individual #73	7/12/13	678426	Neglect/clinical referral

Staff Interviewed:

- Jennifer Russell, Director of Risk and Incident Management;
- Brian Reinhardt, Senior Investigator;
- Jim Sibley, DADS State Office Consultant; and
- Holly Lindsey, QA Director.

Observations:

- Wood Hollow Unit Team meeting, on 8/20/13;
- IMRT, on 8/20/13;
- Residences: 783, 786, 794, and 796;
- Computer Lab and workshops.

Section I

Documents Reviewed:

- AUSSLC Integrated Risk Ratings list of individuals;
- "Look Back" audit reports completed since April 2013;
- Active Records for the following individuals: Individual #73, Individual #180, Individual #423, Individual #363, Individual #93, Individual #50, Individual #246, and Individual #274;
- Section I Action Plan, dated 8/1/13;
- PNMT action plans for individuals in Sample O.2 (described in the section of this report that addresses Section O);
- List of individuals who received a feeding tube since the last review and the date of the tube placement; and

- List of Medically High Profile Individuals, undated;
- Aspiration Risk Reduction Interdisciplinary Protocol (flow diagram);
- Reducing the risks for Aspiration pneumonia for the PCP: work sheet;
- Gastro-esophageal reflux disease (GERD) Interdisciplinary protocol;
- For the last year, lists of individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia; and
- Active medical record review for the following individuals: Individual #204, Individual #6, Individual #34, Individual #93, Individual #4, Individual #22, Individual #90, and Individual #81.

Staff Interviewed:

- Andy Maher, Assistant Director of Programs (ADOP); and Kim Ingram, Habilitation Therapies Director.

Section J

Documents Reviewed:

- The Comprehensive Psychiatric Evaluations (CPEs) for the following 10 individuals, along with completion dates:

INDIVIDUAL	CPE COMPLETED
Individual #112	5/29/13
Individual #7	6/3/13
Individual #159	6/13/13
Individual #60	6/17/13
Individual #216	6/17/13
Individual #146	6/20/13
Individual #442	6/20/13
Individual #119	7/3/13
Individual #293	7/8/13
Individual #336	7/8/13

- Most recent Quarterly Review documentation for the following individuals: Individual #91, Individual #224, Individual #181, and Individual #353;
- The psychiatric section of the Individual Support Plan (ISP) and completed ISP with the Integrated Risk Rating Form (IRRF) for the following two individuals: Individual #353 and Individual #344;
- Spreadsheet of individuals who had been evaluated with the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS), with scores and completion dates for all individuals followed in Psychiatric Clinics;
- Spreadsheet of individuals (listed alphabetically) prescribed psychotropic psychiatric medication, and for each individual: (a) name of individual; (b) residence/home; (c) psychiatric diagnoses inclusive of Axis I, Axis II, and Axis III; and (d) medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration);
- Presentation Book for Section J;
- Minutes of the monthly Polypharmacy Committee Meetings for the prior six months, as well as the minutes from the review of the July data, which took place on 8/8/13;
- The informational packets submitted by Psychiatry for review at the 8/22/13 Human Rights Committee meeting for the following individuals: Individual #56, Individual #118, Individual #119, and Individual #122;
- List of individuals who have been administered the Reiss Screening instrument;
- List of individuals who, in the last six months, were referred for a psychiatric evaluation as a result of an elevated score on the Reiss screen;
- List of Psychiatrists employed at AUSSLC;
- Curriculum Vitae (CVs) of all Psychiatrists employed at AUSSLC;
- List of individuals psychiatrically hospitalized over the prior year;
- Facility-wide data regarding polypharmacy, including intra-class polypharmacy;
- Minutes of the Pre-Treatment Sedation Committee for the last six months, and the materials distributed at the 8/22/13 meeting; and

- Chemical restraint data for the following episodes of chemical restraint (and dates of restraint): Individual #30 (8/6/13 and 8/17/13); Individual #344 (7/24/13); Individual #98 (7/21/13); Individual #19 (10/1/12); and Individual #1 (6/21/13).

Staff Interviewed:

- Jose Levy, Director of Behavioral Services, and George Race, M.D., Section Chief for Psychiatry, on 8/19/13;
- Judi Stonedale, D.O., Psychiatrist III, on 8/20/13, 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, and Guy Campbell, Pharm.D., on 8/19/13;
- Nicole Hinojosa, Human Rights Officer (HRO), on 8/20/13;
- George Race, M.D., Section Chief for Psychiatry, on 11/19/13, 11/20/13, and 11/21/13 (with Laura LeBlanc);
- The following staff were present during the Psychiatry Section Team Meeting, on 11/19/12:
 - George Race, M.D., Section Chief for Psychiatry;
 - Scott Murry, M.D., Psychiatrist;
 - Judi Stonedale, D.O., Psychiatrist;
 - Philippa Alexander, Psychiatry Assistant/Associate Psychologist I;
 - Laura LeBlanc, Psychiatry Assistant/Associate Psychologist I;
 - Marti Granger, Psychiatric RN/RN II;
 - Susan Hill, Administrative Assistant; and
 - Angie Mata, Psychiatry Assistant/Associate Psychologist I; and
- The following individuals were present for the Section J wrap-up meeting, on 8/22/13: Dr. George Race, Dr. Scott Murry, Dr. Judi Stonedale, Laura LeBlanc, Angie Mata, Philippa Alexander, Marti Granger, and Susan Hill.

Observations of:

- Psychiatry Clinic for Sunrise Living Unit with Judi Stonedale, D.O., on 8/20/13;
- Psychiatry Clinic for Wood Hollow Living Unit with Scott Murry, M.D., on 11/22/13;
- Psychiatry Clinic for the Castner Living Unit with George Race, M.D., on 8/21/13;
- Pre-Treatment Sedation Committee Meeting, on 8/20/13;
- Human Rights Committee (HRC) Meeting, on 8/22/13;
- The following individuals were observed in their residences, in conjunction with their psychiatric reviews: Individual #93, Individual #249, Individual #179, Individual #271, Individual #181, Individual #84, Individual #224, Individual #91, Individual #353, Individual #273, Individual #332, and Individual #281.

Section K

Documents Reviewed:

- Presentation of Section K at Entrance Meeting, 8/19/13;
- Department of Behavioral Services Staff Roster;
- AUSSLC Action Plan for Section K, updated 8/1/13;
- Service Task Tracking and Trending report;
- Active Record for: Individual #397, Individual #406, Individual #374, Individual #180, Individual #435, Individual #421, Individual #30, Individual #403, Individual #409, Individual #220, Individual #4, Individual #119, Individual #359, Individual #254, Individual #202, Individual #2, Individual #142, Individual #344, Individual #371, Individual #341, and Individual #56;
- Individual Notebook (I-Book) for: Individual #397, Individual #406, Individual #374, Individual #180, Individual #435, Individual #421, Individual #30, Individual #403, Individual #409, Individual #220, Individual #4, Individual #119, Individual #359, Individual #254, Individual #202, Individual #2, Individual #142, Individual #344, Individual #371, Individual #341, and Individual #56;
- Psychological Evaluation for: Individual #406, Individual #374, Individual #180, Individual #435, Individual #421, Individual #30, Individual #403, Individual #409, Individual #220, Individual #4, Individual #119, Individual #359, Individual #254, Individual #202, Individual #2, Individual #142, Individual #344, Individual #371, Individual #341, and Individual #56;
- Identification of Challenging Behavior form for: Individual #406, Individual #374, Individual #180, Individual #435, Individual #421, Individual #30, Individual #409, Individual #4, Individual #119, Individual #359, Individual #254, Individual #2, Individual #371, Individual #341, and Individual #56;

- List of individuals with a Functional Behavior Assessment (FBA), and the date on which it was last revised and reviewed;
- Positive Behavior Support Plan for: Individual #397, Individual #406, Individual #374, Individual #180, Individual #435, Individual #421, Individual #30, Individual #403, Individual #409, Individual #220, Individual #4, Individual #119, Individual #359, Individual #254, Individual #202, Individual #2, Individual #142, Individual #344, Individual #371, Individual #341, and Individual #56;
- Data sheets for the week of 8/18/13 to 8/23/13 for: Individual #355, Individual #397, Individual #32, Individual #358, Individual #246, Individual #435, Individual #409, Individual #267, and Individual #4;
- AUSSLC Competency Based Training Roster for: Individual #397, Individual #406, Individual #374, Individual #180, Individual #435, Individual #421, Individual #30, Individual #403, Individual #409, Individual #220, Individual #4, Individual #119, Individual #359, Individual #254, Individual #202, Individual #2, Individual #344, Individual #371, Individual #341, and Individual #56;
- Positive Behavior Support Plan (PBSP)/Safety Plan for Crisis Intervention (SPCI) or PBSP/Crisis Restraint Instructions (CRI) Competency-Based Training – Competency Check Form for: Individual #406, Individual #180, Individual #409, and Individual #254;
- Positive Behavior Support Plan Treatment Integrity Form for: Individual #406, Individual #180, Individual #421, Individual #403, Individual #409, Individual #220, Individual #4, Individual #254, Individual #2, Individual #371, and Individual #341;
- Minutes/agenda for IMRT meeting, on 8/19/13;
- Minutes/agenda for Sunrise Unit meeting, on 8/20/13 and 8/21/13;
- Minutes/agenda for Wood Hollow Unit meeting, on 8/20/13 and 8/21/13;
- Behavioral Health Services Staff Handbook, updated 3/13;
- Department of Behavioral Services meeting minutes, from 2/5/13 to 8/6/13;
- Behavior Treatment Committee meeting minutes, from 1/7/13 to 7/22/13;
- External Peer Review meeting minutes, from 2/8/13 to 4/5/13; and
- Human Rights Committee meeting minutes, from 2/7/13 to 8/8/13.

Staff Interviewed:

- Jose Levy, Director of Behavioral Services; and Clair Thomason, Settlement Agreement Support Specialist, on 8/19/13;
- Jose Levy, Director of Behavioral Services; Kimberly Testa, Assistant Director of Behavioral Services; and Clair Thomason, Settlement Agreement Support Specialist, on 8/21/13;
- Jose Levy, Director of Behavioral Services, on 8/22/13;
- Jim Sibley, DADS Consultant, on 8/22/13; and
- Direct Support Professionals, on 8/19/13.

Observations:

- Residence 729, Residence 732 Eagle, Residence 732 Phoenix, Residence 779 Falcon, Residence 779 Roadrunner, Residence 782, Residence 783, Residence 784, Residence 785, Residence 786, Residence 787, Residence 788, Residence 789, Residence 791, Residence 792, Residence 793, Residence 794, Residence 795, Residence 796, and Residence 797;
- Workshop 503, Workshop 527, and Workshop 544;
- Day Habilitation 512, Day Habilitation 532, Day Habilitation 533, Day Habilitation 731, and Day Habilitation 775;
- IMRT meeting, on 8/19/13;
- Sunrise Unit Meeting, on 8/20/13;
- Wood Hollow Unit Meeting, on 8/20/13 and 8/21/13;
- Behavior Support Committee meeting, on 8/19/13;
- Behavioral Services Department meeting, on 8/20/13;
- Pre-treatment Sedation Committee meeting, on 8/20/13; and
- Human Rights Committee meeting, on 8/22/13.

Section L

Documents Reviewed:

- List of all staff who work in the Medical Department, including names and titles;
- Morning Medical Meeting committee minutes, from 8/5/13 through 8/16/13;
- Attendance rosters for Morning Medical Meetings, from 8/5/13 through 8/16/13;
- Morning Medical Meeting Attendance Tracker for August 2013;

- Morning Medical Meeting agenda (generic);
- Morning Medical Meeting minutes, for 8/20/13, 8/21/13, and 8/22/13;
- Attendance rosters for Morning Medical Meetings, for 8/20/13, 8/21/13, and 8/22/13;
- Annual medical assessment tracker, updated 8/19/13;
- Look-back tool template, revised April 2013;
- Tracking of look-back notices, from 8/1/13 through 8/11/13;
- Process for look-backs, dated April 24, 2013;
- Colonoscopy tracker, undated;
- Bone density tracker, undated;
- Mammogram tracking, undated;
- Annual medical assessment template, undated;
- Quality Assurance/Quality Improvement (QA/QI) Tool for Annual Medical Assessments – preliminary draft, undated;
- Process for on-campus and off-campus consultations, revised 6/12/13;
- Integrated progress note (IPN), change of health status considerations, summary of care plan template for ER visits (revised 5/13), hospitalizations (revised 5/13), and Infirmiry admissions (revised 5/13);
- Quarterly medical review template, revised 8/13/12;
- Since the Monitoring Team’s last onsite review, a list of individuals admitted to the Facility, a list of individuals who have died, including the date of death, and a list of individuals who have transitioned to the community, including the date of transition;
- For the last year, lists of individuals who have been admitted to the hospital, including date of admission, reason for admission, discharge diagnoses, and date of discharge from hospital;
- For the last year, lists of individuals who have been seen in the ER, including the date seen at the ER and reason for visit;
- For the last year, a list of individuals admitted to the Facility’s Infirmiry, length of stay, and diagnosis for Infirmiry admission;
- List of individuals with fractures, date of fractures, and type of fracture;
- For fractures occurring from November 2012 through July 2013, the IPNs describing events, the ISPA addressing prevention of recurrence of a fracture, level of supervision at the time of fracture, and the required/planned level of supervision at the time of the fracture for the following individuals: Individual #163, Individual #371, Individual #287, Individual #61, Individual #306, Individual #456, Individual #246, Individual #372, Individual #153, Individual #354, Individual #82, Individual #274, Individual #308, and Individual #180;
- List of injuries requiring visit to ER or hospitalization since the Monitoring Team’s last onsite review;
- Absolute numbers, per month, of new cases of pneumonia for the year;
- For the last year, lists of individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia;
- Absolute numbers of new cases (prior year, by month) for bowel obstructions;
- Absolute numbers of news cases (prior year, by month) for decubitus ulcers;
- List of individuals with pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the Monitoring Team’s last onsite review;
- List of individuals who died since the Monitoring Team’s last visit. For each individual, information including date of death, death certificate, whether autopsy was completed (with copy of autopsy report if applicable), and medical problem list at time of death;
- Current Do Not Resuscitate (DNR) Order list with reason/criteria for DNR;
- Reason for DNR for the following individuals: Individual #375, Individual #147, Individual #50, and Individual #416;
- Death summary guidelines draft for clinical death review: conference call 4/17/13;
- Death summary guidelines draft for administrative death review and death discharge summary: conference call 4/17/13;
- Clinical and administrative death reviews for: Individual #454, Individual #113, Individual #73, Individual #67, Individual #402, and Individual #28;
- Morning Medical Meeting minutes for Individual #67;
- List of seizure medications per individual for diagnosis of seizure disorder;
- List of individuals with refractory seizure disorder;

- List of those going to ER for uncontrolled/prolonged/new onset seizure, since Monitoring Team's last visit;
- Settlement Agreement Cross Referenced with Intermediate Care Facility for Persons with Intellectual and Developmental Disabilities (ICF-IDD) Standards – Minimum common elements of clinical care – Constipation, revised April 2013;
- Settlement Agreement Cross Referenced with ICF-IDD Standards – Minimum common elements of clinical care – Diabetes, revised April 2013;
- Settlement Agreement Cross Referenced with ICF-IDD Standards – Minimum common elements of clinical care - ER/Hospital Visits, revised April 2013;
- Settlement Agreement Cross Referenced with ICF-IDD Standards – Minimum common elements of clinical care – Hypertension, revised April 2013;
- Settlement Agreement Cross Referenced with ICF-IDD Standards – Minimum common elements of clinical care – Osteoporosis, revised April 2013;
- Settlement Agreement Cross Referenced with ICF-IDD Standards – Minimum common elements of clinical care – Seizures, revised April 2013;
- Medical Provider Quality Assurance Audit: Essential and Non-essential compliance by provider - External audits for Round 7, external medical management audits for Round 7, external medical management audits for Round 7 – compliance by diagnosis;
- Internal medical management audits for Round 7 - compliance by diagnosis, internal medical management audits for Round 7 - compliance by provider; and
- Active Record review for the following individuals: Individual #6, Individual #204, Individual #34, Individual #93, Individual #4, Individual #22, Individual #90, and Individual #81.

Staff Interviewed:

- Chrishanthi Perera, MD, Medical Director;
- Archie Smith, MD, Staff Physician;
- Alfredo Cisneros, MD, Staff Physician;
- Ashton Wickramasinghe, MD, Staff Physician;
- Flor Lopez, Medical Program Compliance Nurse; and
- Chelsea Henderson, LVN, Clinic Nurse.

Section M

Documents Reviewed:

- AUSSLC Nursing Staffing data;
- Presentation Book for Section M;
- AUSSLC Integrated Risk Ratings list of individuals;
- List of Infirmery Admissions;
- List of Emergency Room visits;
- Deaths since July 2012;
- List of Hospital Admissions;
- Active Records for the following: Individual #73, Individual #243, Individual #180, Individual #274, Individual #50, Individual #423, Individual #204, Individual #93, Individual #246, Individual #363, Individual #13, Individual #174, Individual #450, Individual #347, Individual #72, and Individual #268;
- “Look Back” audits from April through July 2013;
- Medication Variance data reports;
- Mock Drill data report, since November 2013;
- Dr. Perera's information regarding Tuberculosis Contact Investigation;
- Draft Controlled Substance Administration Record forms;
- Medication Excess/Shortage form;
- Infection Control Committee meeting minutes, dated 2/27/13; and
- Emergency Equipment Drill data, since January 2012 to current.

Staff Interviewed:

- Interviews with Mary LeFebvre, RN, Acting Chief Nurse Executive (CNE); Lori Z. Cordova, RN, Case Manager Supervisor; Debbie Carnico, RN, Hospital Nurse Liaison; Melissa Ann Klopff Sawyer, RN, Quality Assurance Nurse; Richard D. Sambrook, RN, BSN, Nurse Educator; Chrishanthi Perera, Medical Director; Kenda Pittman, PharmD, Director of Pharmacy; Andy Maher, Assistant Director of Programs; Kim Ingram, Habilitation Therapies Director; Amy Van Vleet, RN, Program Compliance Nurse; Jennifer Mears,

Employee Resources; Valeria Kiefer, RN, MSN, State Office Coordinator for Nursing Services; Guy Campbell, PharmD/Clinical Pharmacist; Cheri Grimm, Systems Analyst; and Tom Cochran, QIDP Director.

Observations:

- Medication administration at the Infirmary, Hummingbird, and Falcon.

Section N

Documents Reviewed:

- Pharmacy and Therapeutics Committee Meeting minutes for the last six months, including 2/28/13, and 6/27/13;
- Medication Variance/Error Committee Meeting minutes for the last six months, including 1/13/13, 3/19/13, 4/9/13, 5/14/13, 6/11/13, and 8/11/13; and
- Specific graphs, including shorts/excess trends May 2012 to July 2013; Doses returned to pharmacy excess unknown and refusals May 2012 to July 2013; Replacement doses requested from pharmacy short unknown and short dose wasted May 2012 to July 2013; Medication Variance by Department January 2013 to July 2013; Un-reconciled Excess/Shortages July 2013; Calcitonin Nasal Spray Tracking July 2012 to June 2013; and Excess/shortages for July 2013 reviewed by home, medication, individual, date.

Staff Interviewed:

- Kenda Pittman, PharmD, Pharmacy Director; and
- Guy Campbell, PharmD.

Section O

Documents Reviewed:

- Presentation Book for Section O;
- Presentations for Section O, P, and R, dated 8/19/13;
- Action Plans for Section O, P, and R, updated 8/1/13;
- A list of Physical and Nutritional Management Team (PNMT) members, including identification of PNMT Coordinator/Lead, PNMT members that are dedicated, and any new PNMT members since the last review;
- A list of all individuals seen by the PNMT to date, current individuals on PNMT caseload including referral date and the reason for the referral to the PNMT, individuals assessed by the PNMT and the date of the assessment since the last review, and individuals discharged by the PNMT;
- A list of individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust;
- A list of individuals who have had an aspiration and/or a pneumonia incident and the date(s) of the hospital, emergency room, and/or Infirmary admission;
- List of individuals who received a feeding tube since the last review and the date of the tube placement;
- List of individuals who have had a decubitus/pressure ulcer, including the name of the individual, date of onset, stage, location, and date of resolution or current status;
- List of individuals who are at risk of receiving a feeding tube;
- List of individuals who have experienced a fracture;
- Schedule of meals by home;
- List of Infirmary admissions and individuals in community hospitals, dated 8/22/13;
- AUSSLC Infirmary/Hospital Transition Policy, number II.A.15, effective January 2013;
- Process for Look Backs, dated 4/24/13;
- Look Back tool completed for the following seven individuals: Individual #423, Individual #13, Individual #45, Individual #81, Individual #340, Individual #23, and Individual #260;
- AUSSLC Risk Follow-Up, dated 4/29/13, completed by Karen Hardwick, PhD., OTR, FAOTA, Coordinator of Specialized Therapies;
- Process for Morning Medical Meetings, revised April 2013;
- Critical Team Review for Individual #318, including minutes and plan of action;
- Morning Medical Meeting minutes for Monday morning meeting when PNMT presented for the months of June and July 2013;
- List of individuals receiving suction tooth brushing and individuals identified to receive suction tooth brushing, dated 8/12/13;

- PNMT Nurse Post Hospitalization Assessment reports completed from April through June 19, 2013;
- Number of new employees completing physical and nutritional management (PNM) core competency training from February to July 2013;
- List of Medically High Profile Individuals, undated;
- Alpha list of individuals with their risk ratings for each risk factor;
- The following documents for 12 individuals (i.e., Sample #0.1, which consisted of individuals with various PNM risks, including: Individual #81, Individual #45, Individual #13, and Individual #423; and Sample #0.2, which consisted of individuals who were assessed, reviewed, and/or tracked by the PNMT since the last review, including Individual #260, Individual #90, Individual #213, Individual #96, and Individual #23, and individuals who had been discharged by the PNMT, including: Individual #198, Individual #340, and Individual #452) including: Preferences and Strengths Inventory (PSI), list of assessments/reports needed for the annual ISP meeting, list of Interdisciplinary Team members to attend the annual Individual Support Plan meeting, ISP Preparation Meeting documentation, Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update, PNMT assessment, PNMT action plan and supporting documentation, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment/tool, 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 Health Care Plan, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan (PNMP) and dining plans with supporting written and pictorial instructions, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, and PNMT Post-Hospitalization assessment;
- Sample #0.3: PNMPs for the following 54 individuals: Individual #307, Individual #372, Individual #232, Individual #23, Individual #435, Individual #90, Individual #204, Individual #337, Individual #370, Individual #251, Individual #452, Individual #416, Individual #143, Individual #78, Individual #426, Individual #63, Individual #328, Individual #456, Individual #381, Individual #62, Individual #51, Individual #390, Individual #196, Individual #398, Individual #81, Individual #385, Individual #15, Individual #224, Individual #340, Individual #433, Individual #453, Individual #239, Individual #2, Individual #216, Individual #329, Individual #93, Individual #144, Individual #375, Individual #389, Individual #182, Individual #186, Individual #50, Individual #323, Individual #57, Individual #16, Individual #310, Individual #196, Individual #188, Individual #171, Individual #269, Individual #363, Individual #216, Individual #291, and Individual #45; and
- Sample #0.4: Dining plans for the following 51 individuals: Individual #341, Individual #323, Individual #191, Individual #450, Individual #222, Individual #316, Individual #232, Individual #91, Individual #15, Individual #115, Individual #251, Individual #147, Individual #90, Individual #63, Individual #214, Individual #215, Individual #181, Individual #280, Individual #338, Individual #224, Individual #143, Individual #64, Individual #78, Individual #239, Individual #193, Individual #452, Individual #100, Individual #436, Individual #1, Individual #159, Individual #370, Individual #168, Individual #455, Individual #368, Individual #4, Individual #173, Individual #253, Individual #457, Individual #234, Individual #398, Individual #456, Individual #62, Individual #228, Individual #144, Individual #375, Individual #182, Individual #186, Individual #196, Individual #188, Individual #363, and Individual #389.

Staff Interviewed:

- Kim Ingram, Director of Habilitation Therapies (HT); and
- Andy Maher, Assistant Director of Programs.

Observations:

- Implementation of the PNMPs and Dining Plans for the individuals listed above in Samples #0.3 and #0.4.

Section Q

Documents Reviewed:

- List of dates of annual dental assessments and prior dates, from February to July 2013;
- Ten annual dental assessments completed in the last 30 days prior to the Monitoring Team visit and the prior assessments for the same individuals (as of 8/21/13): Individual #293, Individual #378, Individual #214, Individual #416, Individual #279, Individual #222, Individual #190, Individual #127, Individual #304, and Individual #428;

- List of those who were edentulous at time of Monitoring Team's last onsite visit, and those who have become edentulous since that time;
- List of individuals receiving suction tooth brushing treatment, dated 8/12/13;
- List of individuals who have been identified as benefiting from suction tooth brushing treatment, but are not receiving suction tooth brushing, dated 7/23/13;
- Individuals for whom ISP indicates brushing their own teeth and oral hygiene scores;
- Lists of individuals who within the past six months have been seen for dental emergencies, including name, date of emergency visit and reason, whether individual complained of pain, dentist documentation of whether pain was confirmed, and treatment documented;
- Five most recent dental emergency exams (including initial evaluation and documentation until closure) for Individual #385, Individual #88, Individual #267, Individual #393, and Individual #397;
- Lists of individuals who within the past six months have had restorative dental care, including name, date of completed restorative work, and for each appointment completed type of restorative work;
- Lists of individuals who within the past six months have had a tooth/teeth extraction including name, date of extraction, and number of teeth extracted;
- Five most recent extractions (including initial evaluation and documentation until healed/closure) for: Individual #36, Individual #214, Individual #274, Individual #72, and Individual #353;
- List of individuals undergoing Total Intravenous Anesthesia/General Anesthesia (TIVA/GA) February 2013 to July 2013;
- Campus-wide oral hygiene ratings through 8/12/13;
- Lists of individuals who within the past six months have refused dental services;
- Percent of individuals receiving TIVA/GA, oral sedation, or mechanical supports during dental visits, dated 8/21/13;
- Draft 8-2013 AUSSLC – Dental Clinic Criteria for Determining Usage of Enteral Sedation or General Anesthesia, Goals of Sedation/Anesthesia, Determining the Need for Enteral Sedation, and Reducing Need for Sedation/Anesthesia, revised 8/1/13;
- Draft 8-2013 AUSSLC – GA Post Treatment Care;
- Pre-treatment Sedation Committee 2013;
- Minutes Pre-treatment Sedation, dated 7/25/13;
- Pre-treatment and post-sedation nursing monitoring: Quarterly Analysis, for May, July, August 2013; and
- Dental Task Analysis (i.e., brushes independently, brushes with help from staff, edentulous, dental office visit).

Staff Interviewed:

- Rhonda Stokley, DDS, Dental Director; and
- James Boston, DDS

Section T

Documents Reviewed:

- Community Living Discharge Plan (CLDP), related assessments, Preference and Strengths Inventory (PSI), sign-in sheet, draft CLDP and/or documentation of Individual Support Plan Addendum meeting(s) (ISPA) at which changes were made to the CLDP, Post-Move Monitor (PMM) visit reports, documentation of any follow-up to concerns identified during post-move monitoring, most recent AUSSLC ISP, IRRF, IHCP(s), and BSP, for the following individuals: Individual #124, Individual #26, Individual #83, Individual #364, Individual #175, Individual #334, Individual #428, and Individual #219;
- Communication binders for community visits for Individual #82, and Individual #115;
- ISP, sign-in sheet, related assessments, PSI, IRRF, IHCPs, BSP, PNMP, ISP Preparation Meeting documentation, draft CLDP, and ISPA's related to community transition, for the following individuals: Individual #115, Individual #107, Individual #74, Individual #360, and Individual #98;
- Any team meeting documentation, root cause analysis, or other review of: 1) death of Individual #175; 2) psychiatric hospitalizations of Individual #83; and 3) incident with Individual #74;
- Vignettes provided to DADS regarding capacity in community;
- Individuals admitted to a psychiatric hospital from 8/20/12 to 8/20/13, including name of one individual;
- Current list of all individuals who have been referred for community placement by his or her team, but not yet placed, including name, original date of referral, and current residential status;

- Since the last onsite review, a list of all individuals who have been transitioned to community settings, excluding those whose discharge would be classified as an “alternate discharge,” including name, date of placement, and location and provider of community placements, including residential and day/vocational setting;
- Since the last onsite review, a list of all individuals who have transferred to other SSLCs, including name and date of transfer;
- For the last six months, a list of all individuals who have had a CLDP developed;
- List of individuals who have moved from the Facility to the community since 7/1/09 and have died, including the transition date, provider name, date of death, and cause of death;
- Since the last review, list of individuals returned from a community placement;
- Since last review, a list of all post-move monitoring visits including the dates for each of the completed visits and due dates for upcoming visits for a) individuals who transitioned from this Facility and receive post-move monitoring from this Facility; b) individuals who transitioned from this Facility and receive post-move monitoring from another Facility, specifying which Facility; and, c) individuals who transitioned from another sending Facility, specifying Facility, and receive post-move monitoring from this Facility;
- For the last one-year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, they have: 1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; 2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; 3) had an Emergency Room (ER) visit or unexpected medical hospitalization, including the reason; 4) had an unauthorized departure, including the date and length of departure; 5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; 6) died, including the date of death and cause; 7) returned to the Facility, including the date of individual’s transition to the community, date of return, and reason; and/or 8) been restrained, and for each instance a brief description of any action the Facility took with regard to any of these occurrences
- Draft CLDP Summary Guides for Nutritional, Psychology, Daily Living Skills, Day Habilitation, Occupational Therapy/Physical Therapy (OT/PT), Nursing, Psychiatry, Qualified Intellectual Disability Professional (QIDP), Speech Language Pathology (SLP), Vision, Active Treatment, Vocational, Counseling, Audiology, Dental, and Medical;
- Guidelines for documenting observation notes during pre-selection visits;
- 14-Day Shell for CLDP;
- Email, dated 8/1/31, from Director of Family and Consumer Relations, regarding CLDP timeframe;
- Timelines for Referral Process, dated June 2013;
- Placement History Shell, undated;
- Action Plans for Section T, dated 8/1/13; and
- Presentation for August 19, 2013 – Section T.

Staff Interviewed:

- Andy Maher, Assistant Director of Programs (ADOP); Sandra Taylor, Director of Family and Consumer Relations (FCR); Keryn Hawthorne, Admissions Placement Coordinator; Jamie White, Administrative Assistant; and Diane Thomas, State Office Continuity Services staff member; and
- Alice Fields, Post-Move Monitor.

Observations:

- Post-move monitoring visit for Individual #219; and
- CLDP meeting for Individual #101, on 8/21/13.